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CPA's guide to medical, dental and other healthcare practices;

Lucy R. Carter

Sara S. Lankford

American Institute of Certified Public Accountants

The CPA's Guide to

MEDICAL, DENTAL, AND OTHER HEALTHCARE PRACTICES

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Preface

Any individual who conscientiously decides to offer consulting services to the medical profession is simultaneously accepting the challenge of providing services to a human service industry. The challenge is multi-level. You must have not only the technical skills but also the people skills to communicate your findings and recommendations efficiently. An understanding of the industry and the people who provide the healthcare services is essential to providing a consulting engagement that will ultimately be deemed valuable by the client.

Where We Are and Where We've Been

Although it is not necessary to have an in-depth knowledge of healthcare policy and its history, it is imperative that you understand the evaluation of the delivery system of healthcare services by physicians in the United States. Economic and social changes have had notable effects on the provision of health services. Changing patterns in disease, changes in the demographics of the population, and changes in pharmacology and technology have causes dramatic evolutions in the manner that healthcare is delivered.

Predominant causes of death have shifted from infectious diseases such as pneumonia and tuberculosis in the early 1900s to chronic diseases in the late 1900s. From the 2000/2001 Centers for Disease Control (CDC) Fact Book, as of 1998, the leading causes of death for the age group 45-64 were (1) cancer, (2) heart disease, (3) unintentional injuries, (4) stroke, (5) diabetes, and (6) chronic obstructive pulmonary diseases (such as emphysema, asthma, and bronchitis). The leading causes of death for the age group 25-44 were (1) unintentional injuries, (2) cancer, (3) heart disease, (4) suicide, (5) human immunodeficiency virus (HIV), and (6) homicide. Societal changes have also affected the types of diseases and injuries of the late 1900s and early 2000s while creating challenges for all providers of medical services. Acquired immunodeficiency syndrome (AIDS) as well as increases in emotional and behavioral problems are two examples of predominant healthcare diseases of today's society that have forced changes to healthcare delivery options. AIDS represented the fifth major cause of death during 1998 for the age group of 25-44. The following table taken from the National Vital Statistics (Centers for Disease Control) compares the top 10 causes of death as of 1900, 1985, and 1995.

TOP 10 CAUSES OF DEATHS AS OF 1900, 1985, AND 2000

Rank	1900	1985	2000
1.	Pneumonia	Heart disease	Heart disease
2.	Tuberculosis	Cancer	Cancer
3.	Diarrhea, enteritis	Cerebrovascular	Cerebrovascular
4.	Heart disease	Accidents	Bronchitis/emphysema
5.	Senility, ill-defined	Bronchitis/emphysema	Accidents
6.	Strokes	Pneumonia	Diabetes
7.	Nephritis	Diabetes mellitus	Influenza/pneumonia
8.	Accidents	Suicide	Alzheimer's disease
9.	Cancer	Liver disease	Kidney disease
10.	Diphtheria	Atherosclerosis	Blood poisoning

As proper health care becomes more important in the prevention of disease, so does the importance of physicians' need for consulting for healthcare compliance. The healthcare industry is growing at a substantial rate and thus the need for consulting and accounting services has become more important. Expenditures for healthcare services increased dramatically during the post World War II era. In 1950, $12.7 billion was spent on healthcare and represented 4.4 percent of the gross domestic product (GDP). Healthcare spending in 2001 consumed 14.1 percent of GDP, up from 13.3 percent in 2000. Health insurance premiums grew 10.5 percent and their corresponding benefits only grew 10.1 percent.

In 2001 the Centers for Medicare & Medicaid Services (CMS) projected that health expenditures will hit $2.8 trillion in 2011, representing 16.97 percent of GDP. The agency expects healthcare spending to grow 3 percent points above the growth rate of GDP for 2001 through 2011. CMS expects public-sector (government) spending to grow much slower than private spending through 2002, partly as a result of continued implementation of the 1997 Balanced Budget Act. From 2003 to 2008, the aging of the baby boomer generation will increase growth in private medical spending relative to Medicare by nearly one percentage point as the number of privately insured people (predominantly under 65) increases more rapidly than the Medicare population (primarily over 65).

Costs and accessibility are two driving market forces that have influenced the evolution of the healthcare delivery system as much if not more than the changes in disease patterns. Physicians no longer carry the tools of the trade in a small black bag. Advances in diagnostic and therapeutic technology spurred the need for accessibility to facilities that provide that technology. Physicians have moved offices out of their homes and into medical office suites, typically adjacent to hospitals or surgery centers. Nursing or other medical technicians via home health agencies now handle house calls with limited physician involvement. Preserving the physician-patient relationship has become more difficult with the advent of managed care plans. Contractual relationships play a major role in the healthcare delivery system as well as compliance with governmental regulations.

This provides opportunities to the CPA consultants on many levels. Physicians are now not only responsible for patient care, but also for running a successful business. Obviously, this is a lot of responsibility to manage, and they need guidance to do both successfully. That is why the consultant may be needed to offer the guidance from an objective standpoint, so the physician can gain help seeing the "big picture."

It is our intent with this book to provide you with enough background in each area that you will have an understanding of the business operations of the medical office in today's environment.

Acknowledgments

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Special thanks to our families for their support of everything we do:

Darrell and Dale Lankford, and Mary (Lankford), Scott and Skylar Poiley

Kirk Ryder and Scott and Chris Carter

Thanks to all our physician clients who have placed their confidence in us throughout the years as we have worked together to address the challenges and complex issues in healthcare.

About the Authors

Lucy R. Carter, CPA is shareholder in charge of the Nashville office of Horne CPA Group and also serves on the board of directors. Lucy has provided consulting, litigations support, and tax services to healthcare clients since 1977. Frequently published in health care periodicals, Lucy is co-author of *Physician's Compensation: Measurement, Benchmarking, and Implementation.* A frequent speaker on healthcare topics, Lucy is the recipient of the Nashville Health Leader award for 2000 and the Healthcare 100 award for 2003. A member of both the AICPA and the Tennessee Society of CPAs, Lucy has served on various national and state committees. Additional memberships include the American Health Lawyers Association, the Nashville Medical Group Managers Association, the American Medical Association Consulting Link, the American Society of Appraisers, the Rotary Club, and the Nashville Chamber of Commerce Government Issues Committee and Partnership 2010. Lucy also serves as chairman of the McKendree Village Board of Directors and serves on the board of Vanderbilt Home Health Care Services, Inc.

Sara S. Lankford, CPA is a shareholder in Horne CPA Group and serves as Director of Physician Services in the Nashville, TN office. Sara provides a wide range of services to healthcare providers in the areas of compliance, healthcare financial management, and operations management. Sara is a frequent speaker on healthcare topics and serves as president of the National CPA Healthcare Advisors Association. Frequently published in healthcare periodicals and publications, Sara is also co-author of *Physician's Compensation: Measurement, Benchmarking, and Implementation, Guide to Consulting for Dental Practices*, and *Guide to Long-Term Care Facilities.* Sara is both a member of the AICPA and the Tennessee Society of CPAs, where she serves on the Healthcare Committee. Additional memberships include the American Health Lawyers Association, the Healthcare Financial Managers Association, the American Medical Association Consulting Link, the Nashville Healthcare Council, and the Medical Group Managers Association (national, state, and local chapters). Sara is a 2001, 2002, and 2003 recipient of the Healthcare 100 award for her significant contributions to the strength of the healthcare industry in Middle Tennessee.

CONTRIBUTORS:

Kurt Myers, CPA/ABV, CBA is a shareholder in Horne CPA Group and serves as the Director of Business Valuation and Litigation Services for the Nashville office. Kurt has been involved in over 300 appraisals of closely held business since 1994. Appraisal clients include healthcare, entertainment, manufacturing, wholesale and retail distributors, and service industry businesses. A frequent speaker, Kurt has served as an instructor for the AICPA Certificate of Educational Achievement Program conducting an AICPA course entitled "Healthcare Industry and Medical Practice Valuations." A member of both the AICPA and the Tennessee Society of CPAs, Kurt serves on the National Business Valuation Conference Virtual Planning Committee and the state Business Valuation and Litigation Support Committee. He is a member of the Institute of Business Appraisers and the Estate Planning Council where he serves as assistant Treasurer.

Jonathan Grigsby is a senior associate with Horne CPA Group Healthcare Group. Jonathan specializes in accounting services, information systems, and consulting for physician practices, including CPT fee analysis, practice assessments, and compliance audits. Jonathan is certified as a Quickbooks ProAdvisor, and a Microsoft Certified User for Excel.

Introduction

Healthcare currently constitutes 16.97 percent of gross national product (GNP), representing a large sector of the economy. The industry continues to experience widespread changes in organizational structure, government regulations, and reimbursement. These changes provide numerous opportunities for CPAs who want to establish a niche in this dynamic industry or for CPAs who desire to increase their existing involvement in medical office consulting.

For purposes of the publication, the term "physician" is defined as set forth in the U.S. Department of Health and Human Services (HHS) Office of Inspector General's (OIG) Compliance Program for Individual and Small Group Practices (*Federal Register*, Vol. 65, No. 194, October 5, 2000): "(1) a doctor of medicine or osteopathy, (2) a doctor of dental surgery or of dental medicine, (3) a podiatrist, (4) an optometrist, or (5) a chiropractor, all of whom must be appropriately licensed by the State. Much of this guidance can also apply to other independent practitioners, such as psychologists, physical therapists, speech language pathologists, and occupational therapists."

In 1965 there were approximately 4,000 group practices. Currently, the number of groups exceeds 11,000. The growth in group practices provides operational as well as tax and accounting opportunities. The current regulatory environment is creating a necessity for compliance plans in group practices. CPAs can provide assistance in the development of plans and periodic audits. Other areas including fee analysis, review of managed care contracts, development of strategic plans, and the design of accounting systems and reporting formats. This resource provides all the practical tools and methods needed to complete these engagements.

The CPA's Guide to Medical, Dental, and Other Healthcare Practices fills a publication void by providing a one-stop, all-inclusive resource. The methods and tools that facilitate engagement opportunities and practical insight is provided along with sample worksheets, reports, checklists, questionnaires, tables, examples, and practice tips. This resource can be used in its entirety or in part as needed and takes a comprehensive approach by providing the CPA with all the necessary ingredients, including background information and ready-to-use documents. Related topics and tools are grouped in five major sections:

SECTION 1: MEDICAL OFFICE OPERATIONS AND MANAGEMENT

Those CPAs who want to use this book to set up an entire medical consulting program can develop some background information in the typical medical practice structure, diagnosis coding, different medical plans, current issues in fraud and abuse, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), reimbursement, Medicare, and government payers by first reviewing Section 1:

- Chapter 1: Effective Medical Practice Structure and Workflow Planning
- Chapter 2: Medical Office Revenue: How and Where It Is Generated and Captured
- Chapter 3: How to Use Resource-Based Relative Value Scale (RBRVS) Units as a Practice Management Tool

- Chapter 4: How Services and Diagnoses Are Coded—Reimbursement and Regulatory Considerations
- Chapter 5: How the Prevalence of Managed Care Affects Providers
- Chapter 6: How Medicare Patients Affect a Medical Practice

SECTION 2: MEDICAL PRACTICE REVIEW

Section 2 provides the CPA consultant with the opportunity for performing either an in-depth analysis of a practice or a separate limited engagement. It shows how to set up the terms of the engagement—from defining the problem and expected outcome to estimating the time frame and setting your fee:

- Chapter 7: How to Define the Medical Practice Engagement
- Chapter 8: How to Form Your Preliminary "Diagnosis": Gathering Data and Interviewing Employees
- Chapter 9: How to Analyze and Test Data to Improve Medical Office Operations
- Chapter 10: How to Present Your Findings and Develop an Implementation Plan

SECTION 3: PHYSICIAN COMPENSATION

The design of a physician compensation plan is a crucial element in the long-term success of a group practice. The CPA consultant can provide an objective perspective in the development of group compensation plans. Operational and regulatory assistance with formulas are included in this section:

- Chapter 11: How to Design Physician Compensation Plans
- Chapter 12: Anti-Referral Laws and Physician Compensation: Stark I and Stark II Regulations

SECTION 4: VALUATION OF PHYSICIAN PRACTICES

The purpose of this section is to cover the appraisal of a physician and not to repeat general valuation principles that may be located in other publications. Whether it be for a solo physician or a 40-doctor multi-specialty group, there are detailed "how to" practice tips to performing the appraisal, examples that illustrate various factors to consider, checklists to use during the process, and tools for implementation:

- Chapter 13: Medical Practice Valuation Opportunities and Issues
- Chapter 14: How to Collect and Analyze Data for a Medical Practice Valuation
- Chapter 15: How to Conduct the Valuation Engagement

SECTION 5: LIMITED MEDICAL PRACTICE ENGAGEMENT OPPORTUNITIES

The medical practice client relies on their CPA for advice and counsel on a variety of operational and financial issues. Each chapter in Section 5 will assist the CPA in identifying opportunities and providing assistance to medical practice clients:

- Chapter 16: Medical Practice Mergers
- Chapter 17: Tax Aspects of Practice Mergers
- Chapter 18: Professional Divorces
- Chapter 19: Corporate Compliance Plans
- Chapter 20: Fee Schedule Analysis
- Chapter 21: Managed Care Contract Review
- Chapter 22: The Strategic Planning Engagement
- Chapter 23: Selecting Practice Management Software
- Chapter 24: Accounting System Review

ACCOMPANYING CD-ROM

Each sample illustration included on the *Toolkit CD-ROM* may be used "as is" or tailored to fit the circumstance, and is keyed to explanation in the corresponding chapter.

Section 1

Medical Office Operations and Management

Chapter 1

Effective Medical Practice Structure and Workflow Planning

Industry Snapshot: *Primary care doctors dominated the physician market prior to World War II. Primary care doctors are what you would consider your general family doctor. Since that time, however, there has been an explosion of technology and knowledge leading to an increased need for specialization in the medical profession. The increase in physician specialists, in turn, gave rise to another trend, the growth in group practices.*

According to the most current data available, the American Medical Association 1999 Report, Medical Practices in the US—A Survey of Practice Characteristics*, between 1965 and 1996 the number of groups increased by* 362 percent *and the number of group physician positions increased by* 628 percent. *The number of groups grew at the greatest rate from 1965 to 1969 and from 1980 to 1984. Overall data indicates that the number of physicians in groups has grown over time and that the groups themselves have become larger each year. The more recent trend seems to be toward single specialty groups of moderate size, approximately 5 to 99 physicians. Will we see a further explosion of groups? The 1999 report concluded that the trend data indicate that physicians will continue practicing in groups, and that the number of groups will probably increase. The report suggests, however, that medical group practices may have reached their optimum size for the current healthcare environment. The size and shape of groups will be influenced by various factors in the healthcare environment and will vary regionally.*

Physicians will not be the only providers of service in the medical practice. Mid-level providers or physician extenders such as nurse practitioners, physician assistants, and clinical social workers are also being employed more frequently to treat patients. Other clinical staff could consist of registered or licensed practical nurses, medical technicians or assistants, medical assistants, X-ray technicians, cast technicians, and any other technician trained in a specific modality (for example, echography technician).

The explosion of technology and knowledge has also contributed to a need for more sophisticated administrative staff. In the past, employees who moved through the ranks from receptionist or medical assistant to office manager directed the administrative side of the medical practice. Today, medical practice administrators and office managers may hold a bachelor's or master's degree in business, health management, or both. Certifications are also available to healthcare management through the Healthcare Financial Managers Association and the Medical Group Management Association.

The increased sophistication in technology has likewise created a need for information technology (IT) specialists. Larger groups employ IT professionals to maintain the practice computer systems for billing and clinical applications. The impact of the privacy standards imposed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will increase the need for technology expertise as practices move toward compliance with the new regulations.

* * * *

Unlike clinical staff, the administrative support staff generally have less formal education (college or graduate degrees) and fewer opportunities for training in the business of medical practice. Understanding Medicare, Medicaid, and managed care contracts and pursuing collections from the terminally ill patient are factors that affect the ability of medical

practice staff to adequately perform their duties. The consultant can prove to be a valuable member of the team if he or she can gain the respect of not only the physician/owners, but also that of the staff.

All processes in the physician office are people-driven. Technology has provided enhancements to operations, both clinically and administratively, but it is the people component in the utilization and application of technology that makes the difference. Adequate, well-trained staff is critical to success. Staff must be well versed in the policies and workflow of the office and must always be amenable to change, when applicable, to improve processes.

Staffing costs represent the largest expense component in the medical office. *The Medical Group Management Association Cost Survey: 2002 Report Based on 2001 Data* indicates that the median support staff cost (wages plus benefits) for a multi-specialty practice (not hospital-owned) equals 29.36 percent of collections. The cost percentage for staffing is greater than the percentages for all other expenses combined (median for other practice expenses equals 27.57 percent). From a purely economic standpoint it is imperative that costs be invested in the most appropriate staff resources.

The CPA adviser can assist the medical practice in the identification of staffing deviations through routine benchmarking with surveys such as the *Cost Survey* mentioned above. Additionally, the CPA can assist physician clients in the identification of staffing or procedural inefficiencies through engagements such as the medical practice review discussed in Section 2.

This chapter covers the workflow and staffing patterns of solo and group practices, multi-specialty versus single specialty, and multi-location practices. This discussion does not address academic practices although there are many universal processes for billing and collections that will apply to any physician practice. Further, the discussion assumes all business functions are performed on site in the physician's office.

UNDERSTANDING THE MAKE-UP OF THE SMALL (ONE- TO TWO-PHYSICIAN) OFFICE

Modern medical practices are generally classified as either primary care, specialty, or multi-specialty. Primary care is defined by the American Medical Association as those physicians trained in family practice, general practice, internal medicine, obstetrics/gynecology, and pediatrics. Specialty practices are further categorized as either specialty or subspecialty.

EXAMPLE

An orthopedic surgeon is a specialist. Within the orthopedic specialty, surgeons may, for example, subspecialize in hand, spine, or sports medicine. The subspecialist is required to complete additional education and training above that of the general or specialty practitioner. It is important to note that obstetrics/gynecology and pediatrics, although included in the definition of primary care, are technically considered specialties as the licensure requires additional training and education over and above the requirements for internal medicine physicians.

Additionally, doctors may obtain degrees in either the medical sciences (Doctor of Medicine-MD) or osteopathy (Doctor of Osteopathy-DO). Both doctorates require a four-year undergraduate degree with an emphasis on science courses, four years of basic medical education, one-year internship, and two to six years of residency training, depending on the specialty chosen. The DO program was established in 1892. The number of DOs in practice today has increased 50 percent in the last decade, with approximately 38,000 physicians treating patients. Both doctors are licensed by state and specialty boards to perform surgery and prescribe medication. It is not unusual today to find a group composed of both types of degreed doctorates. Medical office operations are the same for both types of physicians.

Type of service plays a major role in the workflow and staffing needs of a medical office. The primary care physician will see and treat a greater number of patients in the office setting and may employ a larger support staff to handle various facets of the practice (appointments, billing, assistance). The specialist and subspecialist may spend 50 percent or more of his of her time caring for patients in a hospital or other healthcare institution setting and may not require a large office staff. Examples of these specialists are orthopedic surgeons, cardiologists, and vascular surgeons. Hospital-based physicians are those with a patient population derived primarily from hospital or institutional referrals. Examples of hospital-based specialties are radiology, anesthesiology, and pathology, often referred to as RAPs. Radiologists and pathologists in the hospital setting do not always have face-to-face time with their patients. (See Tool 1-A, "Specialty Categories.")

Tool 1-A: Specialty Categories (*Toolkit CD-ROM*)

Workflow in the Small Medical Practice

No matter what the size, the workflow of the medical office is designed around the needs of the customer—in this case, the patient. The moment the patient calls to schedule an appointment the process begins. The patient visit and all services provided during that visit are considered an encounter. The administrative functions surrounding the encounter will in general include the processes illustrated in Table 1-1, "Patient Visit Workflow."

TABLE 1-1 PATIENT VISIT WORKFLOW

Pre-Time of Visit
Appointment procedures
Telephone triage—clinical needs
Chart pull
Patient registration

(continued)

TABLE 1-1 PATIENT VISIT WORKFLOW *(continued)*

Appointment—Patient Presents for Visit

Patient information forms

- Medical forms
- Demographics

Patient registration

Collection of co-pays

New patient charts

Preparation of encounter forms

Encounter with physician

Post Encounter with Physician

- Scheduling
  - Return visits
  - Tests
  - Hospital admissions
  - Referrals
- Coding encounter forms—CPT and ICD 9—assign fees
- Collection of deductible and/or coinsurance
- Charge entry
- Payment posting
- Medical records filing

Billing and Collection Processes

- Charge and payment entry
- Follow-up
  - Insurance pending
  - Insurance denials
- Statements
- Collections and write-offs

Corporate Compliance

The above processes will be evident in any specialty practice with some variations depending on the size of the practice.

A good method of analyzing the workflow of a physician-patient encounter is to follow the path of the patient's chart throughout the visit process. The chart or medical record is the single most important piece of information in the medical office today. All information that relates to that patient's visit whether preventative in nature or for the treatment or diagnosis of a disease is contained in the chart with the exception of fees charged and the collection activity of those fees. Hence, the medical report provides the documentation of the patient's condition and treatment as well as documentation to support the services for which the patient is billed. Loss prevention specialists have long advised that financial information should not be included in the medical record as it presents the appearance of affecting medical decision making. Although the chart includes patient demographic information including insurance data, all billing information is maintained in the computerized billing system or the ledger/daysheet/hard copy manual system.

What happens to the chart from the time the appointment is scheduled to the moment the billing process is complete? How many different people touch the chart during its course through the office? Are the charts readily available? A good indication of a poorly designed operational system is an office that is covered up with charts on desks, floors, and tops of shelves.

Multi-Tasking Physicians: Staffing in the Small Office

Our experience has shown that internal medicine and small physician practices (one to two doctors) typically employ the same number of administrative personnel. What we have found is that the physicians will often double as office managers in the one- to two-person practice. They take on the responsibilities of payroll administration, personnel management, ordering and buying supplies, and also get involved in claims follow-up and resolution. In this capacity they handle check writing, and on occasion in the solo practice, we have encountered practices where the physician made the daily deposits. Clinical staffing needs vary depending on the specialty. For example, orthopedic surgeons use medical assistants in the office as compared to cardiologists and oncologists who employ registered nurses. Likewise, the internal medicine provider may find it necessary to employ registered nurses to assist with follow-up and telephone assistance to patients. Additionally, the physician may employ a mid-level provider (physician assistant or nurse practitioner). The use of mid-level providers and the provision of various diagnostic and/or therapeutic services in the office suite will dictate the need for additional staff. These services and providers should be included as a full-time equivalent (FTE) physician when determining the appropriate level of administrative and or support staff.

EXAMPLE

Consider the ear, nose, and throat (ENT) specialist who also establishes an allergy clinic in his or her office. Traditionally, the ENT patient is seen in the office for evaluation and management services with a limited number of minor procedures performed in the office. By adding an allergy clinic, clinical staffing needs increase as well as the administrative functions for handling the workflow.

Where can the medical practice consultant turn for information on appropriate staffing levels for the client's practice? The Medical Group Management Association (MGMA) publishes a *Cost Survey* on an annual basis and it is a useful resource for establishing the level of staffing per provider. According to the 2002 survey report, the median support staffing per FTE provider in a family medicine practice was 4.41. Staffing was categorized as follows:

General administrative	.25
Business office	.71
Medical receptionists	1.02
Medical secretaries/transcribers	.34
Registered nurses	.49
Medical assistants	.83
Information technology	.17
Medical records	.33
Licensed practical nurses	.50
Clinical lab	.38
Radiology	.19

The above represents the median for each category and will not total the 4.41. Solo practitioners providing limited diagnostic services such as electrocardiograms (EKGs) typically employ fewer employees. In those cases, the nurse and the administrative staff will take on all the processes listed above. Expanding the practice to two physicians may increase staffing by at least two FTEs. It is not unusual for practices to outsource some services such as transcription services.

The same report indicates the following support staff needs for an ophthalmology practice per FTE provider:

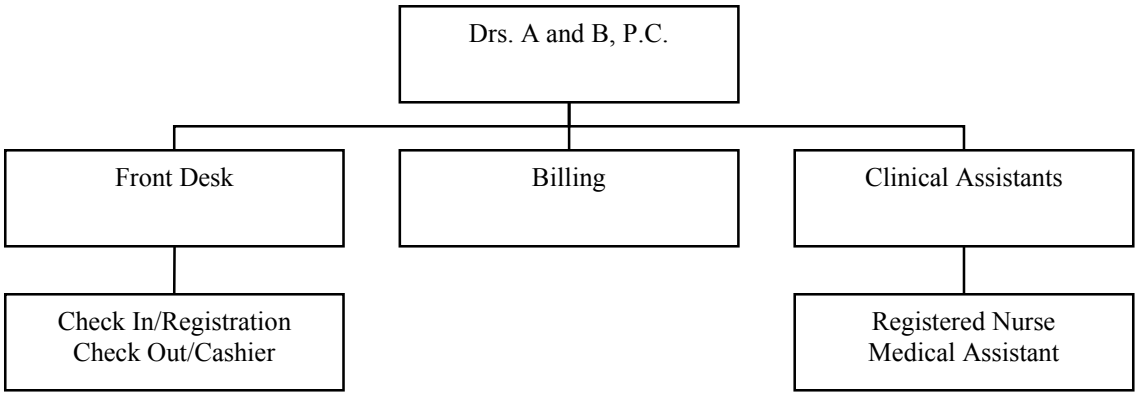
General administrative	.43
Business office	1.04
Medical receptionists	1.68
Medical secretaries/transcribers	.32
Registered nurses	.27
Medical assistants	2.69
Other medical support services	.94
Medical records	.34

The total FTE support staff per provider for ophthalmology was 7.29, up from 5.92 staff in the 2001 report.

Exhibit 1-1 is a sample organization chart which pertains to most specialties and primary care for this size group. See Tool 1-B for sample job descriptions for a one- to two-physician group practice.)

Tool 1-B: Sample Job Descriptions—One- to Two-Physician Group Practice (*Toolkit CD-ROM*)

EXHIBIT 1-1: ORGANIZATION CHART FOR ONE- TO TWO-PHYSICIAN GROUP PRACTICE



Economies of Scale: Workflow and Staffing for Larger Group Practices

Once a group grows to a level greater than two physicians, they should realize some economy of scale in their staffing costs. The processes are the same as noted above, however, they become more segregated and they may become more specialized. Specialty and clinical staffing needs will again dictate the number of administrative or support staff needed to carry out the operational processes. We indicated earlier that according to the Medical Group Management Association (MGMA) 2002 Cost Survey (2002 Report), the median staffing needs for a family medicine practice per provider for 2002 was 4.41. The typical family medicine practice responding to the 2002 Report consisted of six FTE physicians and two FTE mid-level providers. The median staffing requirement for an eight-provider practice is indicated to be 29.60 FTE support staff according to the 2002 Report. Obviously, the number of staff does not increase arithmetically with the number of providers. For example, the practice will only require one FTE office manager irrespective of the number of physicians. Other positions (such as receptionists and diagnostic staff) will not automatically increase with the addition of each provider.

We find that many practices do not have an appropriate assignment of duties which results in overstaffing levels and under-utilization. The most common management response to a physician complaint of low collections is that the practice doesn't employ enough people to handle the extreme administrative burden of today's healthcare market. Management treatment for this disease is "add two bodies to the system and call me next month." However, in our experience most often we have found the processes to be the cause of resulting inefficiencies, not a lack of staff.

EXAMPLE

In a one-physician practice the front desk personnel typically handle a variety of tasks (answer phone, check patients in and out, schedule appointments). As the practice grows, maintaining these duties with front desk personnel may become ineffective. The processes must change to meet the demands of the growing practice. With the addition of more service providers, which in turn means more patients, it is almost impossible for the receptionist to answer the phone and assist patients with their needs. It is imperative that an efficient front desk is both patient-friendly and operationally smooth. If you as a consultant walk into an office and you think you are visiting a circus, then that's exactly how the sick and ailing patient feels. The CPA consultant can gain an understanding of the situation through interviews with front office staff to determine duties and workflow and through observation.

Typically, a realigning of duties can result in a more efficient front office.

EXAMPLE

The patient scheduling/telephone receptionist might be moved from the front desk to a location without patient contact (cubicle or office) to provide more efficiency in handling incoming calls and scheduling visits. Likewise, the check in and check out function might be divided to facilitate collections at the time of service and scheduling of return visits. Obviously the number of staff will increase but more importantly job duties will be realigned to provide more efficiency in operations.

LARGE PRACTICE ORGANIZATION AND COMPENSATION LEVELS

Strong, professional leadership is essential for the effective management of large group practices. In addition to physician leadership, the larger groups will employ professional management to ensure operational success.

How Larger Groups Organize Management

As groups increase in the number of physician positions, the need for strong and organized physician leadership and structured governance also increases. Groups of three or more physicians will often default to the senior physician as managing partner. This individual has claimed the position of leadership due to tenure. Unfortunately, the senior physician may not be the most qualified physician in the group to assume management duties.

This often untitled "administrative partner" has additional responsibilities and no designated time off for handling these responsibilities. While the managing partner must

lead discussion, decisions are usually made by a consensus of the group at formal or informal meetings.

The Use of an Office Manager

Additionally, this size group often employs an office manager, or administrative coordinator. The duties of the office manager will include accounts payable, payroll processing, personnel, and ultimate responsibility for the effectiveness of the collection process.

Physicians in the three- to five-physician practice may take active roles in management of daily operations even though they have office managers to assist in this area. Office managers for this size practice may or may not have a college degree. Experience is the primary prerequisite and the salary level typically runs in the $30,000 to $40,000 range. Experience combined with a college degree may warrant compensation in the $30,000 to $50,000 range. Many local chapters of the Medical Group Management Association conduct annual salary surveys which indicate average salary ranges for office managers/administrators. The CPA consultant should research these averages so he or she can assist the medical practice in establishing a practice budget or assist the practice in employee searches.

The Use of Practice Administrators/CEOs and Other Management

Once physician positions exceed six, the management organization tends to become more structured and the processes become formalized. Professional administrators will be hired to manage all aspects of the medical practice enterprise, excluding those calling for medical judgments and involving medical staff governance. Larger groups may employ a chief executive officer or administrator, chief financial officer or controller, and chief operations officer or business office manager, in addition to clinical department administrators. Salaries for upper level management are upwards of six figures.

The Medical Group Management Association issues a *Management Compensation Survey* annually. The *2001 Report Based on 2000 Data Results* indicated that the median compensation for chief executive officers with 25 or fewer FTE physicians was $122,805 and the median compensation for the same position in groups of 26 and more FTE physicians was $165,000. Practice administrators in groups of 6 or less had a median compensation of $65,217 and in groups of 7 to 25, $83,106. Groups owned by health systems had consistently lower medians for these categories.

The Use of Contracts

Administrators and CEOs in general are employed by contract. Contracts serve to set forth in writing the specific authority, accountabilities, and responsibilities of the parties to the contract. They assist the physician group and the administrator by setting forth the expectations of the parties. Some groups modify an existing physician employment agreement to fit the terms of the administrator's employment (see Table 1-2, "Sample Administrator Contract Provisions").

TABLE 1-2 SAMPLE ADMINISTRATOR CONTRACT PROVISIONS

Employment duties
- Job descriptions

Term

Compensation
- Base salary
- Bonus or incentive compensation

Fringe benefits
- Health, life and disability insurance
- Pension and profit-sharing
- Wage continuation
- Automobile allowance
- Vacations, paid days off

Disability

Authority

Signature authorization—banking

Employee hiring and dismissals

Retirement

Termination

Performance review

Arbitration

Administrators are directly responsible to the governing body of the group and must possess the skills necessary to understand medical practice governance and the effects of physician behavior on operations.

Compensation Packages

Compensation packages for the Administrator/CEO consist of base salary, benefits, and bonuses. Base salary may be established from published surveys or established at a percentage of a physician-shareholder base salary.

EXAMPLE

Employee base salary is set at 80 percent of the base salary paid to a physician-employee with the same length of service with the clinic.

Dr. A has four years of service and a base salary of $400,000.

Administrator/CEO Smiley has four years of service. His base salary would be set at 80 percent of $400,000 or $320,000.

Bonuses under this type of arrangement may be based on the same percent of physician employee formula.

Other methods of bonus determinations are based on evaluations of performance. Examples of performance measurements are:

- Increases in physician compensation
- Net income
- Accounts receivable agings and collection percentage overhead percentage

Contracts developed in recent years tend to favor a provision for bonuses based on a percentage of any increases in physician compensation.

The practice administrator or manager is the top nonphysician professional administrative position in those groups that do not employ CEOs. His or her duties are relatively the same as the CEO regarding practice operations. Administrators differ from CEOs in that they usually have less authority.

Medical group governance is an important factor in the success of the practice. The consultant should obtain an understanding of ownership, directorship, and management. Groups of 10 and greater physician positions will generally operate under an executive committee structure with a president or managing partner serving as chair. As the number of physicians in the group increases, other committees such as a Finance Committee may be established to facilitate operations oversight and decision making. Many of these groups provide for paid administrative time for their managing partners. Other groups have designated a full-time physician CEO or medical director position.

Exhibit 1-2 is a sample organizational chart for a three- to five-physician group practice. (See Tool 1-C for a sample job description for an office manager.)

Tool 1-C: Sample Job Description—Three- to Five-Physician Group Practice (*Toolkit CD-ROM*)

EXHIBIT 1-2: ORGANIZATION CHART FOR THREE- TO FIVE-PHYSICIAN GROUP PRACTICE

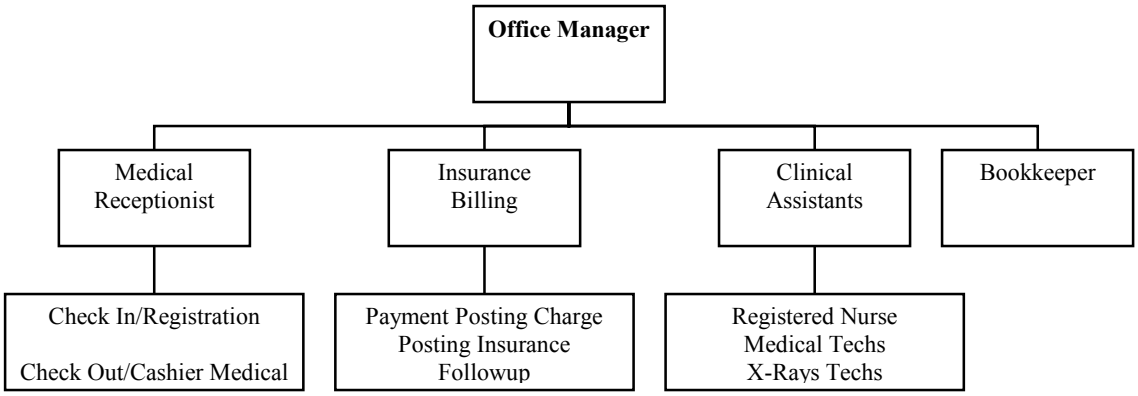
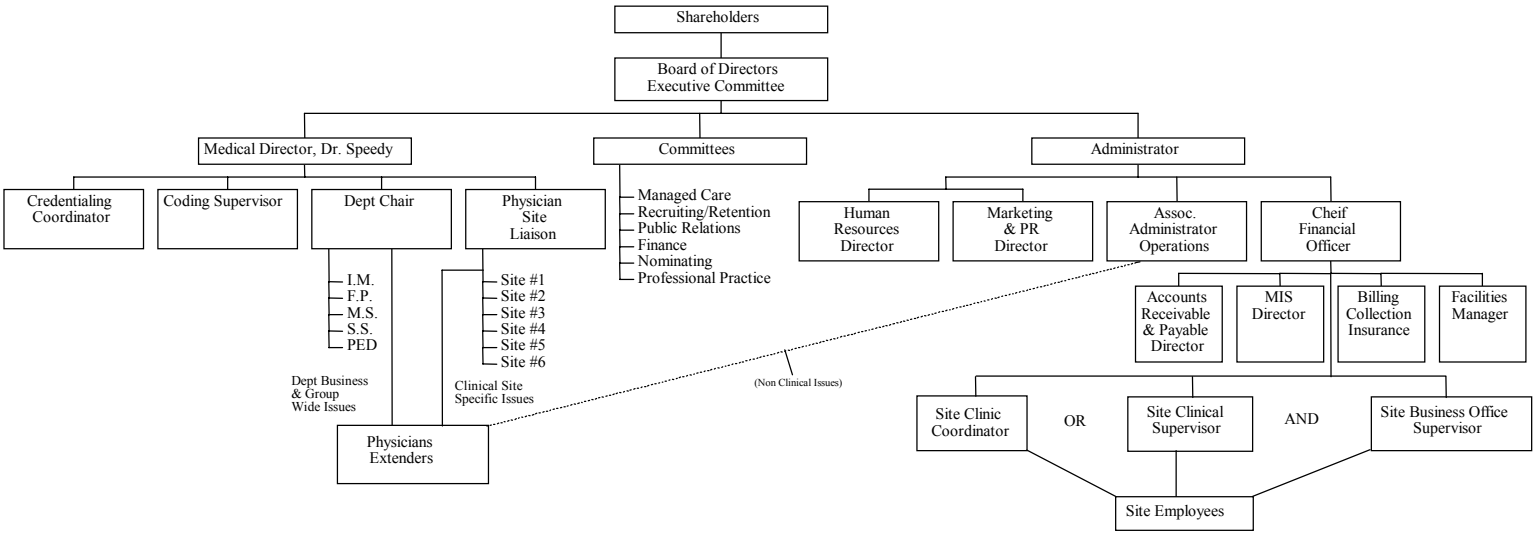


Exhibit 1-3 is a sample organizational chart for a 26+ physician group practice with multiple locations. (See Tool 1-D for a sample job description for an administrator.)

Tool 1-D: Sample Job Description—Administrator 26+ Physician Group Practice (*Toolkit CD-ROM*)

EXHIBIT 1-3: ORGANIZATION CHART FOR 26+ PHYSICIAN POSITIONS WITH MULTIPLE LOCATIONS



Gaining a Handle on Staffing and Workflow in the Multi-Office Practice

In the multi-office practice, each office may be fully staffed, offer limited access, or serve as an outreach clinic. The fully staffed office is one in which all charts are maintained at that facility and the office is staffed at all times. Billing and collections are usually handled at a central location in an effort to maximize on economies of scale. Internal controls may become an issue and are often overlooked. Establishing policies and procedures to ensure the capture of revenue and appropriate accounting for services performed and monies collected requires a concerted effort between the various office sites and the central office. (See Section 2, "Medical Practice Review.") Clinical staffing will be dictated based on the services provided. Diagnostic services (lab, radiology) may be centralized to provide efficiency in the delivery of service and cost. Limited-access offices are those that are owned or leased full time by the physician group with one or two days of actual patient visit time scheduled. In these types of offices either the physician or a staff member carries charts from the main location to the limited-access clinic. The office may be staffed by the same physician or by multiple physicians in the group on a rotating basis. These offices are usually set up under the assumption that it provides convenience for the patient. They may be in remote locations or they may be two blocks away. For a one-physician clinic day, staffing is generally limited to one business office staff for check in and check out and a medical assistant or nurse to assist the physician. Controlling the flow of charts and billing records between the full-time office and the part-time office may become an issue.

The Use of Outreach Clinics

In the past, patients in rural areas did not always have access to the specialty services that patients in cities enjoy. Tertiary facilities and specialists were located only in the major cities of a state. For instance, if a patient with blocked arteries was diagnosed with heart disease by the primary care physician in a rural area, she would be referred to a cardiologist at the closest facility offering cardiac catherization with surgical backup. The patient would have had to travel to the city to receive this service.

Outreach clinics help to solve this issue of patient access and have become popular in the last decade with the evolution of managed care. Outreach clinics bring the specialty services of a larger hospital or regional medical provider into rural areas. Outreach clinics may be staffed full-time in a small office environment or more typically involve a specialist renting space from a local provider for the days that are available in an area. They may also see patients in the hospital outpatient setting. Staff may or may not travel with the physician depending on the facility used for the visits. Transporting charts and other documentation creates risks in these types of clinics.

EXAMPLE

A physician travels to a rural clinic and transports charts and billing records in his car between his full-time office and the outreach clinic. The physician is in an accident in which the car is destroyed along with the charts and billing records. There may be no way to recreate the documentation lost. Computer access to billing software and electronic medical records would reduce the potential risk from transporting records.

How to Prepare a Physician Office for the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—Security Rule

Many physician practices have done what they can to comply with the HIPAA Privacy Rule. However, being prepared for the Privacy Rule deadline will not give justification for most practices to say they are HIPAA-compliant. (See Chapter 7, "How to Define the Medical Practice Engagement," for more on the Privacy Rule aspect of HIPAA.)

On February 20, 2003, the Department of Health and Human Services (HHS) released the final Security Rule for HIPAA, with the rule going into effect on April 21, 2003. Some practices are probably not going to be as concerned with the Security Rule because they are compliant with the Privacy Rule; it will be the CPA or consultant who will need to remind the practice of the significance of this deadline.

The Security Rule applies to all covered entities that transmit electronic protected health information (ePHI). These covered entities have until April 21, 2005, to comply, two years from the effective date of the Security Rule. Small health plans have until April 21, 2006, to comply.

If a practice is not using a billing system or electronic medical records (EMR) to transmit claims electronically, the Security Rule will not affect that practice. Also, the final rule confirms that transmissions of protected health information (PHI) through telephone or fax machine are not covered, due to the fact the transmissions did not originate in an electronic format. This means that if a practice is not sending claims electronically, but is submitting through fax, the practice is still not in the scope of the Security Rule. However, under the Privacy Rule, the practice still needs to have the proper fax cover sheet with a confidentiality statement.

For those practices that are submitting claims electronically and therefore dealing with ePHI, there are steps that will need to be taken to be compliant with the rule.

The rule itself gives two types of implementation specifications for the guidelines. One is "required," which means that the covered entity must implement the specification. The other type is "addressable," which means that, depending on the size and structure of the covered entity, implementation of the specification will take place only if reasonable and appropriate.

The reason for these two types of specifications is because, obviously, not all practices are the same in structure. Therefore, not all practices are going to need to implement all the security measures mentioned in the rule. Whereas some large practices consist of multiple offices with a hundred or more employees, each having their own job descriptions and responsibilities, some smaller practices might only have a small office with three to five employees sharing some of the same responsibilities and job descriptions.

Much like the Privacy Rule, the Security Rule *requires* that every covered entity identify a security official. This responsibility might be a dual role for the security officer in smaller practices; however in larger practices this would not be advised.

There are two words—ensure and protect—that are important in the requirements of the Security Rule. The Security Rule states that a practice not only "ensure the confidentiality,

integrity, and availability of all ePHI the covered entity creates, receives, maintains, and transmits," but also protect ePHI from any reasonable anticipated threats or hazards to its security and reasonably anticipated uses or disclosures not permitted by the rule.

The Security Rule offers standards to go by in order to safeguard ePHI, and a CPA or consultant should refer to these when performing an assessment.

The first of these include four implementation specifications that are *required* by the rule which include risk analysis, risk management, sanction policy, and information system activity review. These four implementations should be the backbone of the practice's policies and procedures.

The risk analysis should be the first step in planning for compliance, as it will show where the practice could have potential risks, vulnerabilities of loss, or corruption of data.

When conducting a risk analysis, one needs to review the Security Rule to get an idea of what risks need to be addressed. Below are some specifications from the Security Rule that should be kept in mind when conducting a risk analysis.

The following are some *addressable* specifications from the rule that should be in the policies and procedures:

- *Procedures for granting full-time and part-time employees, contracted labor, and possibly patients access to the system or network.* By this, the rule wants management to consider if a part-time employee, intern, or contract labor, such as a transcriptionist, really needs to log in to the system or network.
- *Classifications for authorization to information for those with access.* The rule in this case wants the practice to consider if every job classification needs to have the same access to ePHI. An example would be whether or not an administrator really needs access to modify patient's health information or outstanding balances.
- *A termination process* also needs to be considered so that employee screen names and access are eliminated upon termination to ensure disgruntled employees cannot damage the ePHI.
- *Policies to safeguard from employees loading software brought from home or downloading software from the Internet.* Practices have had problems when employees downloaded and installed programs such as Kazaa or Morpheus, which enable file sharing, onto their workstations. Employees also bring disks from home to install software to their workstations. These types of software transfers pose a risk not only by making the system vulnerable to hackers and viruses, but also by violating software licensing agreements. Policies should be in place to document or in some cases restrict the downloading and installing of software.
- *Policies for password management to set standards for creation, sharing, and storing passwords.* The size and structure of the password should be considered. Passwords should not be something as easy as "1234" or "password," but something more integrate such as an alpha-numeric password (for example, "20hippa03"). Passwords should not be shared unless under certain circumstances such as a general online account the practice uses to access the Internet and e-mail (MSN, AOL, and so on). Passwords should not be stored by individuals in open view such as on the monitor or on a desktop. The time between periodic changing of passwords is a practice decision, if at all, as no set amount of time is given in the rule.

- *Automatic logoff or timeout from the network or billing system.* In most cases, billing systems already have this function set up. However, the Security Rule addresses that policies should exist that require computers left unattended to be logged out or have an automatic timeout.
- *Encryption and decryption of ePHI being transferred through e-mails or submitted to payers through a billing software.* Once again, this is something that might already be set up in the billing system. The transmission through e-mails might pose a potential risk if not encrypted. Encryption software on the e-mail probably needs to be considered if there is a high volume of ePHI being transmitted through e-mail and if the practice can afford the expense. Remember that if e-mails are encrypted the receiving party must have similar software to decrypt the information.

These are just part of the specifications in the rule deemed *addressable.* Remember that by *addressable* the rule stresses that these specifications be implemented when reasonable and appropriate. This is based on the size of the practice and the cost to correct the problem.

Several specifications are *required* and need to be considered when conducting a risk analysis. A few of the *required* specifications are given below:

- *Unique user identification.* Although the granting of access and the level of access are considered *addressable* specifications, when access is granted each user must have his or her own unique identification. No two employees should be logging onto the system with the same user name. This will enable any audits of access conducted on the system to pinpoint anyone who might have corrupted or manipulated ePHI.
- *Procedures for data backup and storage.* A backup should be made of the ePHI at least on a nightly basis. These backups need to be kept offsite or in a fireproof box during non-office hours. This will prevent the tapes or disks from being destroyed by fire overnight or during the weekend. Another good habit is to save all documents containing ePHI on a drive that is backed up rather than a workstation hard drive that may not be backed up with the server.
- *Policies and procedures for disaster and recovery plans.* The practice should take measures to keep the ePHI protected in the event of a disaster such as fire, flooding, or severe storms. This means making sure the main data server is protected from overhead water pipes that could burst, the server is elevated from the floor, and all wiring is insulated and protected by surge protectors. A plan should be established that in the event of evacuation of the building the latest backup can be easily retrieved.
- *Procedures for accessing the ePHI in an emergency mode status.* The practice needs to have the main server and at least one terminal on an unlimited power supply (UPS) so that in the event of a power failure, the ePHI can be accessed if necessary or a backup created before complete shutdown. If there is an extended power failure, measures might be needed to keep access available to continue with normal job functions dealing with ePHI.
- *Procedures for hardware and software disposal and media re-use.* When old computers are disposed, sold, or donated to charity, they must be re-imaged or cleaned of all ePHI and programs that might provide outside access to ePHI. Also, media such as backup tapes, CD-RWs (compact disk—rewriteable), and floppy disks should be reformatted before given out for re-use.

Once again, these are just a handful of specifications in the Security Rule. However, once you have a grasp of these and understand where the risks exist at the practice, you can move onto risk management.

Risk management would consist of implementing any policies and procedures needed to comply with the Security Rule and prevent the risk of loss or corruption of data. A sanction policy should be put in place to encourage reporting of any violations of policies and procedures and how those incidents will be handled. An information system activity review needs to be set in the policies and procedures to keep track with audits of the system to monitor invalid access or activity. A report also needs to be kept to track all, if any, security violations. All of these steps are *required* by the rule.

Like the Privacy Rule, the Security Rule also requires a business associate agreement with those entities that might have access to the ePHI. This is a place where a practice might be able to knock out two birds with one stone, so to speak, since most are in the process of collecting business associate agreements to comply with the Privacy Rule.

Although the Security Rule might come across as a lot to take in and implement, it really consists of several points that are probably already in affect at the practice. Those specifications that are not already being implemented need to be considered so that steps are taken to do what is reasonable to meet them. HHS does not expect everyone to run out and buy a new computer network, just take reasonable steps to secure what is currently in place.

SUMMARY

No matter how large a practice gets, the basic processes are universal and are organized around the patient encounter. Although staffing requirements may differ based upon physician specialty (number and expertise), the processes will not differ greatly.

Beginning with the initial patient contact, each employee involved in the process affects the ability of the next employee to efficiently perform his or her respective tasks. This will become evident as you read the upcoming chapters on the industry and the engagement-specific chapters. Consulting engagements such as the practice review offer the opportunity to analyze processes and staffing of a medical practice that ultimately affect the income levels of the physicians. Understanding the basics of those functions will be discussed in depth in the chapters in Section 2 covering the medical practice review.

Universal functions will become more formal as the group adds physician positions. The addition of physicians, physician extenders, ancillary, and specialty services is the driving force behind the number of support staff and the level of education and training required to provide those services. As groups grow in numbers and locations, the need for advanced top-level management also grows. Although many groups are contracting with professional healthcare administrators, there is a trend towards employing full-time physician chief executive officers or part-time medical directors.

Chapter 2

Medical Office Revenue: How and Where It Is Generated and Captured

Industry Snapshot: *Medical office revenue, simply stated, is generated from the delivery of healthcare services. But in order to be paid for what they do, physicians must properly identify the service provided (current procedural terminology— CPT code), document the need for the service, that is, medical necessity (diagnosis— ICD-9-CM code), bill the appropriate site of service (hospital, office, and so on), and bill timely (denials may result from not billing services within a specified time). Billing and collecting for healthcare services requires specialized coding knowledge and technical capabilities (hardware and software).*

* * * *

The CPA consultant should have an understanding of the various sources of revenue and the effect each source has on billing and collections. Revenue results from a physician treating patients in his or her medical office. Office revenue may be generated by one-on-one interaction with the physician or through the use of a physician extender (nurse practitioner or physician assistant). Diagnostic revenues (laboratory, radiology) may also be generated in the office setting. Revenue is likewise produced by the physician when he or she consults with patients in the hospital or visits patients in long-term care facilities. Ambulatory surgery centers and independent diagnostic centers may also be a source of revenue for physician services.

The location and type of service has a direct impact on physician revenue. Whether fee for service or capitated contract, services must be coded and billed correctly.

In 1998, Medicare lowered reimbursement to physicians on services performed in a facility (hospital) versus in the physician office. This change resulted in a increase in reimbursement for services performed in the physician office and a decline in reimbursement for certain specialties with a high facility (hospital) service mix (such as surgeons). The location of service delivery directly impacts Medicare reimbursement. If an incorrect site of service is billed, reimbursement will be reduced.

TYPES OF SERVICE AND REVENUE IN THE MEDICAL OFFICE

In order to analyze profitability of the medical practice, you will need to understand the nature of services provided as well as the impact that location or site has on revenue. Services must be accurately identified in order to receive appropriate reimbursement from third-party payers.

Office revenues are generated by physicians and staff as a result of providing the treatment, diagnosis, therapeutic, and/or preventive care to patients seen in the physician's office or clinic setting. The two major financial categories of revenues are fee-for-service charges and prepaid or capitated revenues. Fee-for-service reimbursement is based on the service

provided (defined by the CPT code billed). The fee reimbursed is either based on a "usual, reasonable, customary" amount for the service provided or, in the case of a managed care agreement, upon an agreed-upon fee between the provider and the third-party payer. Capitated reimbursement is based on a "per member per month" (PMPM) amount and depends upon the number of patients assigned to the provider irrespective of the services provided. In some cases, the provider may "carve out" certain services that would be reimbursed in addition to the PMPM fee. An example would be chemotherapy services which are typically reimbursed based on fee for service even in a capitated arrangement.

The type of service provided in the office setting typically falls under the evaluation and management category of the CPT coding system. Current procedural terminology (CPT) coding was developed by the American Medical Association so that there would be a uniform method for healthcare providers and medical suppliers to report professional services, procedures, and supplies. CPT associates each service or procedure with a corresponding five-digit code. CPT was first published in 1966 and is updated annually. Chapter 4, "How Services and Diagnoses Are Coded—Reimbursement and Regulatory Considerations," explains what you need to know about the CPT coding system.

Evaluation and management (E/M) involves the taking of history and physicals, review of systems, and medical decision making. E/M visits are further classified as new patient, established patient visits, or consultations with five levels of service within each classification. E/M visits are often the most time-consuming service with reimbursement, in many cases, having no direct relationship to the consumption of time. With the exception of the lowest level of established patient visit codes (99211), each of the services identified in these classifications requires face-to-face contact between patient and physician or other licensed provider (such as nurse practitioner).

Revenues are affected by an individual physician's ability to provide appropriate healthcare within a reasonable time frame. The physician who takes an hour to see routine follow-up patients with a low medical decision complexity is not likely to realize the highest income of the group. Likewise, physicians who consistently show up late for clinics or spend unnecessary time visiting with patients or staff will not be able to handle their clinic schedules efficiently, resulting in long wait times for visits and patient dissatisfaction. Office revenues may also include ancillary services such as X-rays, laboratory services, injections, EKGs, echography, ultrasound, and physical therapy. These services may be ordered and scheduled prior to the patient visit or they may be ordered by the physician during the course of the visit, such as when a chest X-ray is ordered for a patient complaining of coughing and congestion.

Medical practices may also generate revenues from providing minor surgical procedures in the office. These services are often referred to as "starred" procedures because they are designated in CPT by an asterisk (*).

Fee for Service versus Capitated (Prepaid) Revenues

Each service, drug, or supply classified by an HCPCS (Healthcare Common Procedure Coding System) code is assigned a fee or charge based on the usual and customary fee schedule of the practice. Assisting physicians with establishing fees is a common consulting engagement. Specific steps to follow in this type of engagement are included in Section 2, "Medical Practice Review."

In a fee-for-service environment, patients are charged a fee for the services provided according to the fee schedule. The establishment of fees in the physician practice is far from an exact science. In many cases, fees are set based on what is "reasonable and customary" for the location and the specialty. The recommended alternative would be to use the relative value scale as a means to set fees. For example, fees for services might be established at 125 percent of the Medicare relative value scale. Since many of the managed care organizations likewise set reimbursement at a percentage of Medicare, this approach should result in a more reasonable determination that should align fees with expected reimbursement. In this environment, volume will obviously affect revenues since providers are reimbursed an amount based on the service provided.

Under a capitated (prepaid) plan, however, physicians are paid an established fee per patient paid monthly regardless of the number of visits if any. Capitated fees are established by actuaries representing the health plan as a PMPM amount. Health plans will negotiate these rates with employers and providers. Members of the plans will choose a healthcare provider from a roster of participating physicians and hospitals. The physician will be paid a fixed amount per patient assigned on a monthly basis whether or not the patient receives treatment. If the patient is seen by the physician, the patient will typically be responsible for a visit co-pay (such as $15 to $25). (See Chapter 5, "How the Prevalence of Managed Care Affects Providers.") Charges should be captured for all patients. Capitated plan performance will be measured by the practice to determine the financial viability of the arrangement by a "fee for service equivalent charge," or what the reimbursement would have been if the patient were being billed under the normal fee schedule for services.

CAPTURING THE CHARGE

Most simplistically, physician revenue is derived from providing treatment to patients. When the information regarding patients who receive treatment does not make it to the billing system to be recorded and billed, the practice suffers financially. The practice must have a system of checks and balances to ensure that the documentation for services provided is translated into a fee, entered into the billing system, and billed.

When fees are reimbursed on a fee-for-service basis it is obvious that the practice must accurately record and bill for all services rendered. If services are rendered and then not billed due to poor office controls, the practice has no opportunity to be reimbursed for that service. Office staff should prepare an encounter form, routing slip, or superbill. Superbills or encounter forms should be generated from the appointment system each afternoon for the next day's patients. Forms should be standard and prenumbered as assigned by the computer system or preprinted. The forms should include space for patient data (address, insurance coverage, personal information, aged account balances, and so on).

Appointment schedules for the next working day should be printed each afternoon and distributed to the front desk, nursing staff, physicians, and administrative personnel. Charts should be pulled each afternoon for the next day's clinic and superbills attached to the chart at that time. Any patients with balances past 90 days old should be directed to financial counseling with the office manager prior to the encounter. (See Tool 2-A.1 and Tool 2-A.2 for sample encounter forms.)

Tool 2-A.1 and 2-A.2: Sample Encounter Forms (*Toolkit CD-ROM*)

Patients should be asked to sign in at the time of visit. The sign in sheet should indicate the doctor to be seen (if a group practice), the time of arrival, and the time of appointment. Sign in sheets should specify the method of payment (cash, check, or credit card). The sign in sheet (see Tool 2-B, "Sign In Sheet") serves the following important purposes:

1. *Controls log for capturing charge sheets.* As you will see in Section 2, "Medical Practice Review," the sign in sheet is vital for determining daily revenue and reviewing services performed versus revenue captured for those services.
2. *Measures waiting time from time of arrival to actual time of visit.* Time management is essential to the generation of revenue both in a fee-for-service and capitated payer environment. Long wait times are a symptom of poor time management which may lead to lost revenue and certainly contributes to patient dissatisfaction.

Tool 2-B: Sign In Sheet (*Toolkit CD-ROM*)

Reception staff will retrieve the prepared chart for patients as they sign in. Patient demographic information should be verified, or updated at this time. Each chart should be reviewed for last date of visit—anyone not seen within the last year should have a new registration form attached to the chart along with the fee ticket. Registration forms, which are filled in the patient's chart, provide the demographic information on patients in addition to authorization for release of information, assignment of benefits, and payment responsibility. Demographic information includes patient's address, telephone number, social security number, employer, and insurance information, and contains authorization for release of information and assignment of benefits. (See Tool 2-C, "Patient Registration Form.") This information should be verbally confirmed for every visit with new forms completed when any changes are required. Staff should obtain a copy of all insurance cards and a copy of the patient's driver's license.

Tool 2-C: Patient Registration Form (*Toolkit CD-ROM*)

Superbills or any other billing information should not be filed in the medical record as financial matters should not affect medical treatment decisions.

The importance of the registration process for capturing revenue in today's environment cannot be stressed enough. Most co-pays will be $15 to $ 25. If these are not collected at the time of service, the expense of collecting increases and the likelihood of collecting in the future decreases.

All insurance co-pays should be collected at registration. Co-pay amounts are usually printed on the face of the patient's insurance card; however, this is not always the case. We recommend that the practice develop an insurance matrix that provides the front desk with the information needed to determine co-pays as well as referral and authorization requirements. Receptionists (check-in and check-out) must be educated on the contractual arrangements of the practice in order to avoid collecting co-pays or other amounts from those patients who are covered under agreements that restrict their payments.

Once the demographic information is obtained, co-pays are collected, and referrals are obtained, the chart is placed on a designated counter by the receptionist for clinical staff to retrieve when the physician is ready to see that patient. Generally, the physician's nurse or medical assistant will pick up the chart, call the patient, and take the patient to the exam room to prepare for the examination.

The superbill is usually completed by the physician or nursing assistant at the end of the patient examination. The physician or the nursing staff will identify the services provided and assign the diagnosis code on each encounter form. This form will be taken to the check-out desk (by the patient or the patient escorted by nursing staff) where the cashier will apply fees and, if not collected at registration, request any co-pays and deductibles. Tickets should be duplicate forms, one copy for office use and one given to the patient upon check-out.

Add-ons and walk-in patients should have computer fee tickets generated *at check-in* as they are registered. The patient will then be provided with a copy of the completed encounter form at check-out. No-shows should be marked on the fee tickets as such and entered on the patient account and in the patient chart.

Encounter forms become hard copy documentation for entering charges on patient accounts. Charges should be entered daily by charge data entry staff preferably in a batch environment. Each batch should have a "batch ticket" attached which contains the hash totals with which to balance it. (See Tool 2-D, "Batch Ticket.")

Tool 2-D: Batch Ticket (*Toolkit CD-ROM*)

Two major hash totals are charges and CPT codes. This will insure that the total charges and the correct CPT code have been entered into the account. Along with the hash totals, the charge entry staff should reconcile the charge tickets posted with the day's appointments. Many systems have a "missing ticket" feature that will match the tickets printed against the tickets input on patient accounts. If this system is not available, the daily appointment schedule may be compared to the end-of-day report to verify charge capture.

After posting, the charge entry staff should log all batches onto a "batch control log" which totals the daily and month-to-date transactions.

If not computerized, the practice should employ the use of "pegboard" systems that include day sheets and ledger cards. Day sheets should be balanced at the end of the clinic day.

Capturing Hospital Revenue for the Office-Based Practice

While primary care physicians with a subspecialty such as OB/GYN will see a high number of patients in their offices, they derive a higher percentage of revenues from surgical services provided in the hospital setting. Internal medicine physicians average five to 10 hospital patients per week. Typically, once a patient is diagnosed and admitted to a hospital, the internal medicine physician will call upon a specialist who subsequently accepts the responsibility for treatment of the patient while hospitalized.

Any provider who has a significant portion of revenue generated in the hospital needs a good system for capturing that revenue, yet capturing charges for services provided outside the office setting poses a challenge to office staff.

When physicians perform services in the hospital medical record documentation is the property of the hospital record. Therefore, the office staff must rely on the physician to provide the names of patients and type of service (consult vs. hospital visit).

Here is one method we recommend: Each practice should establish a hospital/nursing home census log. Charge entry staff should obtain daily hospital census information from the respective facility, and enter information into a log. Methods for capturing the actual charge will vary by the type of practice and the individual physician's organizational skills.

Sample surgical practice method: Hospital charge tickets are generated by charge entry staff on the date of admission or per the surgical appointment schedule. These tickets are then held in a tickler file by the coding staff by date of admission or service. Once the physician has dictated the operative report, a copy should be forwarded by the transcriptionist/medical records to the coding staff. At that time the ticket should be coded per the report by the coding staff with CPT and ICD-9 codes. Tickets should be batched and entered daily. Charges should be posted by the charge entry staff no later than 24 hours from date of service. Actual filing of claims or submission of statements by insurance staff usually does not occur until date of discharge. Most physicians do not want to bill their patients while they are still hospitalized.

The hospital log should be used as a control to account by the charge entry staff for all hospital patient visits. Although administrative staff has access to the surgical schedule, they don't have access to the daily visit medical record. Physicians must provide staff with a daily or weekly list of patients seen in the hospital and identify the type of visit (consultation at what level, subsequent hospital visit, emergency room visit, and so on). Many groups utilize an index card preprinted with the CPT codes most often used, the days of the week, and a line for the patient's name and site of service. Physicians turn the cards in to administrative staff on a daily or weekly basis for coding and charge entry.

Capturing Revenue for the Hospital-Based Practice

Hospital-based practices include radiologists, anesthesiologists, and pathologists, (referred to collectively as RAPs) and emergency room (ER) physicians. These hospital-based physicians are unique in that they generate revenue in a facility that they don't own or operate. They generate revenues primarily from providing services at hospitals, ambulatory surgery centers, or outpatient diagnostic centers. These physicians are more likely to utilize medical billing companies to outsource their accounts receivable functions.

Capturing data for charge input requires coordination of efforts between the physician's billing office and facility personnel. Typically the facility will provide the billing staff, physician, or physician representative with face sheets (patient demographic data), ordering physician requisitions or orders, and medical record documentation which supports the service provided. The ordering or referring physician orders will contain a description of the diagnosis and service to be provided. Billing staff should obtain this information on a daily basis. Billing office staffing levels will be determined by the volume of services and number of physicians in the group.

The most common billing responsibilities are summarized in Table 2-1, "Billing Office Job Duties."

TABLE 2-1 BILLING OFFICE JOB DUTIES

Bookkeeper	Handles accounts payable, payroll and prepares monthly management reports.
Charge entry	Posts charges.
Coder	Codes charge input data.
Courier	Handles pick ups and deliveries daily.
Mail attendant	Sorts and distributes mail, sorts, batches and charge data.
Officer manager (Business office manager)	Supervises all staff involved in the patient accounting functions, managed care contracting, credit balances, collection activities, oversees daily and monthly balancing activities.
Patient representative	Handles patient phone calls, insurance follow-up, self pay, and workers' compensation follow-up.
Payments entry	Posts payments and adjustments.

One method of assuring that all charges are captured is to obtain the daily log from the facility and compare to patient charges entered for that day. Charges, payments, and adjustments should be filed by date of service.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AND ITS IMPACT ON MEDICAL INFORMATION

The practitioner should also be aware of the Privacy Rule contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Most healthcare providers that are covered by the Privacy Rule were supposed to have complied by April 14, 2003. The HIPAA Privacy Rule creates national standards to protect individuals' medical records and other personal health information.

- It gives patients more control over their health information.
- It sets boundaries on the use and release of health records.
- It establishes appropriate safeguards that healthcare providers and others must achieve to protect the privacy of health information.
- It holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights.

The general rule states that a covered entity (health plan, healthcare clearinghouse, or healthcare provider who transmits any health information in electronic form) may not use or disclose protected health information except as required by or permitted by the rule, and then, only the minimum necessary information to carry out the reason for the use or disclosure. Permitted disclosures that do not require consent include disclosures to the patient and disclosures required for treatment, or for payment.

Incidental uses and disclosures that are permitted include:

- Use of sign in sheets (don't include reason for visit)
- Calling patient names in the waiting room
- Charts at the bedside (as long as reasonable safeguards are in place)
- Physicians discussing treatment options with other physicians at nursing stations (as long as reasonable efforts are made to avoid being overheard)

HIPAA has affected the accessibility of medical information in the practice; however, the confidentiality of patients' medical records and information is not a new concept. Following the basic steps illustrated in Table 2-2, "10 Components of Privacy Compliance," and taking reasonable steps to maintain confidentiality and protect information should go a long way towards compliance.

TABLE 2-2 10 COMPONENTS OF PRIVACY COMPLIANCE

1. Identify a privacy officer and form a compliance team responsible for the development and implementation of policies and procedures, notices and forms, training programs, and monitoring and sanctions.
2. Inventory compliance issues (gap analysis): Analyze issues related to physical, technical, and administrative safeguards; develop role-specific job descriptions based on a minimum necessary standard of disclosure of information.
3. Develop policies and procedures to manage protected health information.
4. Develop a privacy notice which is posted, and distributed at first point of patient contact.

TABLE 2-2 10 COMPONENTS OF PRIVACY COMPLIANCE *(continued)*

5. Obtain acknowledgment of receipt of the privacy notice. Practitioners must make a good faith effort to receive it; if the patient refuses to sign or fails to receive the notice, a notation must be documented in the record.
6. Develop mechanisms to track disclosures requiring patient authorization.
7. Develop mechanisms to escalate denials and amendments.
8. Train staff, administration, and providers.
9. Develop a re-evaluation strategy and a renewal process.
10. Identify business associates and obtain agreements.

SUMMARY

The appropriate coding and capture of services provided in a medical practice are essential to the creation of revenue and the maintenance of a healthy practice. In this chapter we have provided an overview of how revenue is generated and captured. Subsequent chapters will address the specifics of coding, managed care, Medicare, and medical practice operations and how each facet interacts in the overall generation of income.

Chapter 3

How to Use Resource-Based Relative Value Scale (RBRVS) Units as a Practice Management Tool

The Medicare RBRVS fee schedule represents "the first major change in the way physicians are paid since they stopped accepting chickens and pigs."

—Rep. Pete Stark (D-Calif.), then-Chairman, House Ways and Means Health Subcommittee

Industry Snapshot: *Establishing a reasonable fee structure is a constant challenge for physician practices. In the 1950s, physicians in the California Medical Society initiated a relative value study for the purpose of establishing a possible methodology to determine physician fees. The California Study was published in 1956 and included the codes and nomenclature that have since become the norm for medical practices.*

Despite its usefulness, the relative value concept was not initially favored by the government and was viewed as a form of potential price fixing. In 1979, the United States brought an antitrust suit against the American Society of Anesthesiologists for promulgating a relative value study. The court, however, upheld the study as a lawful methodology to determine fees.

In the mid-1980s, the Health Care Financing Administration (HCFA) contracted with Harvard University's School of Public Health to conduct a relative value study. The purpose of the study was to establish the amount of physician work involved in performing a particular service or procedure. Initially, 3,200 physicians in various specialties were surveyed to rate approximately 20 current procedural terminology (CPT) codes particular to the respective physician's specialty as to the time, technical skill, and mental and physical effort needed to perform the particular service. The responses were then extrapolated over the universe of 7,000 CPT codes to arrive at the physician work unit.

The first phase of implementing the Medicare Fee Schedule based on a resource-based relative value scale (RBRVS) began on January 1, 1992. Prior to 1992, Medicare provided each physician or practice with an annual Medicare Profile. The Profile represented the reimbursement for the physician and/or practice based on the "usual, reasonable, and customary fees" charged by similar specialties in the practice area. As physician fees increased each year, the Medicare Profile likewise increased. Conversely, RBRVS bases physician reimbursement on the "resources" expended to provide the service versus the fee charged by the physician, thus more equitably reimbursing physicians across specialties and geographic areas. The goal of RBRVS was to establish a logical system to reimburse physicians and ultimately reduce costs. As expected, there were some flaws in the methodology used to calculate the RBRVS, but the RBRVS Update Committee (RUC), created by the American Medical Association (AMA), HCFA, and medical specialty societies just prior to the initial release of the RBRVS, has been monitoring the system to keep the RBRVS up-to-date and reliable. The RUC created the Practice Expense Advisory Committee (PEAC) to monitor the practice expense relative value unit (RVU) components of the RBRVS in 1998. The RBRVS is still being updated by the RUC, along with the PEAC, to help maintain the RBRVS original goals.

* * * *

In addition to providing a systematic methodology for determining reimbursement, relative value units (RVUs) can also serve as a useful management tool. In this chapter we look at some specific uses for RVUs in cost accounting and productivity tracking, managed care contracting, and physician compensation formulas.

THREE COMPONENTS OF RELATIVE VALUE UNITS

The resource-based relative value scale (RBRVS) unit is composed of three components:

1. *Work component.* The work component represents the time and difficulty incurred in performing a service or procedure.
2. *Practice expense component.* The practice expense component represents the overhead costs (direct and indirect) incurred to provide a service or procedures.
3. *Malpractice insurance component.* The malpractice insurance component represents the malpractice insurance cost incurred in providing a service or procedure.

In determining reimbursement, each of the above components is adjusted by a geographic practice cost index (GPCI—pronounced "gypsy") factor. The GPCI is applied to the calculation based on the cost of living for a specific area. The sum of each of the components is then multiplied by a conversion factor to determine the reimbursement for a particular CPT code.

The RBRVS formula is as follows:

$$\text{Payment} = [\text{Work (RVUw} \times \text{GPCIw)} + \text{Practice Expense (RVUpe} \times \text{GPCIpe)} + \text{Malpractice (RVUm} \times \text{GPCIm)}] \times \text{Conversion Factor}$$

EXAMPLE
CPT CODE 99213 (LEVEL 3, ESTABLISHED VISIT); 2003 FEE SCHEDULE REIMBURSEMENT FOR TENNESSEE

	RVU		GPCI		
Work	.67	×	.9751	=	.653
Nonfacility practice expense	.69	×	.9001	=	.621
Malpractice	.03	×	.5923	=	.018
			Total		1.292
Conversion factor			× $36.7856		
	Payment				$47.53

Analyzing Physician Productivity With the Work RVU Component

The work unit was initially determined through the Harvard study and represents the "average" work done by a physician of "average" efficiency in performing a service. Currently, the work component composes approximately 54.5 percent of the total RVU components. The work component is a global unit of professional service and encompasses:

- Intra services (direct professional interaction)
- Pre-services
- Post services

The physician work component is computed based on an estimate of the following factors and their respective utilization in performing a service or procedure:

- The *time* required to perform the service
- The *mental effort* and *judgment* required to perform the service
- The *technical skill* required to perform the service
- The *physical effort* required to perform the service
- The *stress* involved in delivering care

Work RVUs are reviewed annually by the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services [CMS]) with the majority of the review process directed toward the development of RVUs for new procedures. The annual review process does, however, include an analysis of selected existing procedures. For instance, the initial development of the work RVU was based on a survey of physicians for selected CPT codes that was then extrapolated over a universe. In the extrapolation process, certain inaccuracies occurred. Based on a five-year review from 1992 to 1997, work RVUs for approximately 300 CPT codes were increased while the work RVUs for 120 CPT codes were decreased.

Any proposed changes to the work RVUs are published in the *Federal Register* (www.gpoaccess.gov/fr/index.html) with a 60- to 90-day comment period available. Medicare also publishes the RBRVS and updates at its fee schedule Web page posted at www.cms.gov/physicians/pfs/. For updates on current RVUs, visit the HCFA (now CMS) Web site at http://cms.hhs.gov/physicians/pfs/. See www.cms.hhs.gov/providerupdate/ for "The CMS Quarterly Provider Update." The American Medical Association specialty societies have been very active in the review and comment on proposed revisions.

When assisting physician clients in evaluating the applicability of utilizing work RVUs as a means to measure productivity, it may be helpful to review the work RVUs for selected CPT codes. For example the work RVU for a 99213 (level III established patient visit) is .67. Conversely, the work RVU for the repair of a ruptured abdominal aortic aneurysm (CPT code 35082) is 36.35. In other words, the aneurysm repair requires 54 times more time, mental effort and judgment, technical skill, physical effort, and stress than does a mid-level office visit. Allowing the physician group to evaluate the applicability of similar examples may assist them in their acceptance of the work RVU as a management tool.

For the most part the work component of the RVU is a fair indicator of the time, mental effort, technical skill, physical effort, and stress involved in delivering care. By reviewing the work component of RVUs for selected CPT codes you can assist the physician client measuring both productivity and cost.

You will use the work RVU as a means to measure productivity by work performed rather than fees generated. In medical practices where the fee structure is not determined based on RVUs this may be significant. For example, assume that the fee schedule has been

determined without regard to RVUs and the compensation model is built based on charge volume. The fee schedule, in this scenario, may distort the basis for compensation positively or negatively based on the fee per CPT code:

EXAMPLE

	Fees Generated Year XX	%	RVUs Generated Year XX	%
Dr. A	$450,000	43%	6,700	45%
Dr. B	$600,000	57%	8,300	55%

The same distortion may occur in physician compensation models that are based on collected fees. Using the work RVU as a basis, versus collections, removes any bias that may occur due to a difference in payer mix.

Practice Expense Component

The practice expense component represents the cost incurred in providing a service or procedure. Currently, the practice expense component composes approximately 42 percent of the total RVU.

CMS converted from a charge-based to a resource-based practice expense component, which was fully implemented in 2001. The result of this conversion is a decrease in the practice expense component for services performed in a facility (for example, hospital). In 1998, practice expense reimbursement was lowered for all services except for those services performed at least 75 percent in a physician office setting. With the conversion complete, the effect is an increase in reimbursement for physician office visits and a decline in reimbursement for certain specialties with a high facility service mix. The specialties negatively affected by the shift include anesthesiologists, orthopedic surgeons, thoracic, general, and vascular surgeons, cardiologists, gastroenterologists, and neurosurgeons. An unsuccessful lawsuit was filed in late 1998 by 11 of the specialties negatively affected by the resource-based shift.

The resource-based practice expense RVU includes both direct and indirect costs. Direct costs represent the costs incurred in providing the service (such as clinical personnel expense and medical supplies). Indirect costs represent the general and administrative costs incurred in providing care (such as rent and business support).

Malpractice Expense Component

The malpractice expense component (approximately 3 percent to 4 percent of the RBRVS payment) represents an estimate of the national average malpractice premium for each specialty. The Balanced Budget Amendment (BBA 97) required that malpractice RVUs be resource-based by January 1, 2000.

USING RVUS IN DETERMINING FEES, COSTS, AND PHYSICIAN COMPENSATION

The review above of the individual components of the RVU point out the areas of controversy in the RBRVS system which result from the computation for practice expense, malpractice, and the blended conversion factor. The changes made to these areas have negatively affected reimbursement for hospital-based specialists and have resulted in a negative connotation for the RVU system.

For the most part the work component of the RVU is a fair indicator of the time, mental effort, technical skill, physical effort, and stress involved in delivering care. By reviewing the work component of RVUs for selected CPT codes you can assist the physician client measuring both productivity and cost.

You will use the work RVU as a means to measure productivity by work performed rather than fees generated. In medical practices where the fee structure is not determined based on RVUs this may be significant. For example, assume that the fee schedule has been determined without regard to RVUs and the compensation model is built based on charge volume. The fee schedule, in this scenario, may distort the basis for compensation positively or negatively based on the fee per CPT code.

The same distortion may occur in physician compensation models based on collected fees. Using the work RVU as a basis, versus collections, removes any bias that may occur due to a difference in payer mix.

Physician compensation based on RVUs has the following advantages:

- Minimizes subjectivity
- Can be based solely on physician work
- Dissolves distinctions between payer types
- Acknowledges and rewards different practice patterns

You can also use the work RVU to measure the profit or cost per procedure. By doing this analysis you can better assist the practice in managed care and discounted fee for service negotiations.

In order to perform a cost study using RVUs the following tools are needed:

- A report of production frequency by CPT code. This report is typically available from most practice billing systems. More sophisticated systems may be able to provide a report based on RVUs versus dollars.
- Current RBRVS. This information is provided annually in the *Federal Register* at www.gpoaccess.gov/fr/index.html.
- Financial statements
- Spreadsheet software

The first step in the process is to convert production to RVUs, if the medical billing system does not provide this information. If you are using a spreadsheet program you multiply the frequency that the CPT code is performed by the work RVU for the CPT code.

EXAMPLE

CPT code 99213 is performed 1,000 times for the calendar year. The work RVU for 99213 equals .67. The computation for the conversion of 99213 to work RVUs is: 1,000 x .67 = 670 work RVUs.

Do this calculation for each CPT code to convert the units performed to work RVUs. Then you can determine the total RVUs generated during the period. To arrive at a cost per RVU for the practice, divide total practice expense for the period by total RVUs. Practice expense should include the base salaries for the physicians.

EXAMPLE

Total RVUs = 155,000

Total expense = $6,000,000

Cost per RVU = $38.70

You can then use the cost per RVU to determine the profitability of various services or procedures.

EXAMPLE

A medical practice wants to determine the profitability of mid-level established office visits (99213):

Fee billed	$65.00
Average collection percentage	x 70%
Collected fee	45.50
Cost to provide 99213 (.67 x $38.70)	25.93
Net profit per visit	$19.57

You can use the information regarding the profit margin or cost to provide certain procedures when helping a client negotiate managed care contracts. This system could still be used; however, in an instance where the physician (for example, pediatrician) sees no Medicare patients, it is important to take into consideration the managed care contracts. Many of these contracts may pay as much as 40 percent more than the Medicare program. The Medicare RBRVS is the best basis for evaluating a fee schedule, but this model may underestimate net profit per visit if the practice primarily sees patients with commercial payers. In addition, it is important to note that managed care contracts should be monitored frequently to maximize reimbursement. The physician may not have a set fee schedule with a commercial payer; however he or she may be getting reimbursed 100 percent of the allowable charge, indicating that the fee may be set too low.

SUMMARY

Since RVUs provide the basis for Medicare reimbursement and are used as a benchmark for most managed care reimbursement, it is important for the CPA consultant to have an understanding of the components. As this chapter reflects, RVUs may be effective in tracking productivity, analyzing cost, and allocating physician compensation, as well as anticipating reimbursement.

Chapter 4

How Services and Diagnoses Are Coded—Reimbursement and Regulatory Considerations

Industry Snapshot: *Current procedural terminology (CPT) first appeared in 1966 as a means to provide a uniform language that would accurately describe medical, surgical, and diagnostic services. Introduced and published by the American Medical Association (AMA), CPT codes assign numeric digits to the description of specific medical services and procedures. The coding provides:*

- *Standard terminology to describe services and procedures documented in the medical record*
- *A means to communicate accurate information on procedures and services for insurance reimbursement*
- *The basis for a computer-oriented system to evaluate operative procedures*
- *Basic information for actuarial and statistical purposes*

The first edition of physicians' Current Procedural Terminology*, published by the AMA, contained primarily surgical procedures, with only limited sections on medicine, radiology, and laboratory procedures. The second edition, published in 1970, presented an expanded system of terms and codes to designate diagnostic and therapeutic procedures in surgery, medicine, and the specialties. In the second edition the initial four-digit codes were replaced with the currently used five-digit codes. In 1977, the fourth edition included significant updates in medical technology and a system of periodic updating was introduced to keep pace with the changes in the medical environment.*

In 1983, CPT was adopted as part of the Health Care Financing Administration's (HCFA's) Healthcare Common Procedure Coding System (HCPCS). Subsequent to these adoptions, HCFA mandated the use of HCPCS to report services for Part B of the Medicare Program (physician's services component of the Medicare system).

A CPT Editorial Panel composed of 16 physicians has the daunting task of revising, updating, and modifying CPT codes. Through the panel's quarterly meetings, 400 to 700 revisions are made to the coding system each year.

New codes are generally effective on January 1 of each year for federal programs. Annual updates are prepared by the AMA in the late fall of each year preceding implementation. Other third-party payers, however, may not implement the new codes on the same date. Medical practices should confirm effective dates prior to submitting new or revised codes. The CPT codes included in this chapter represent 2003 codes.

* * * *

WHAT THE CPA CONSULTANT SHOULD KNOW ABOUT CODING: CPT, ICD-9, AND HCFA

To begin with, we will give you an overview of the three different coding systems, beginning with CPT. CPT descriptive terms and identifying codes provide the basis for identifying and billing for services provided in the physician office.

CPT Coding

The CPT system is the most widely accepted nomenclature for the reporting of physician procedures and services under government and private health insurance programs.

The challenge for the physician is to choose the code that most accurately identifies the service, supply, or circumstance performed. With over 7,000 codes to choose from, confusion and miscoding can occur, resulting in inappropriate reimbursement for the physician. Since coding errors can subject the physician and the medical practice to fraud and abuse implications, it is imperative that the utmost care is taken in the coding of services.

EXAMPLE

A physician incorrectly bills a new patient visit as a consultation, although the criteria for a consultation are not met (no documentation of a referral for opinion by another physician, no report back to the referring physician regarding the outcome of the consultation). The reimbursement is greater for a consultation than a new office visit (45 percent greater for a level II visit); the physician has incorrectly billed for the service provided and will be incorrectly reimbursed.

CPT codes are published annually by the AMA and other commercial vendors. Generally, the CPT code book is divided into the following sections, each of which are discussed later in this chapter:

- Evaluation and management services
- Anesthesia
- Surgery
- Radiology
- Laboratory
- Medicine services

ICD-9 Coding

In addition to providing a CPT code for the service rendered, physicians or providers must also report the condition or disease of the patient to third-party payers. They do this by using codes from the International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM). Think of CPT codes as telling "what" was done and ICD-9 codes as telling "why" it was done. The ICD-9 coding system was initially developed by the World Health Organization as a classification system for the reporting of mortality and morbidity statistics by physicians. The ICD-9-CM ("C"linical "M"odifications) is a United States adaptation and is maintained and updated under the supervision of the National Center for Health Statistics. Changes to ICD-9-CM are released annually on October 1.

Why is it important for you to have a grounding in the ICD-9 system? Third-party payers require diagnosis codes to report patient conditions or diseases. Beginning April 1, 1989, physicians were required to use ICD-9-CM coding for Medicare reimbursement.

The provider lists diagnosis codes on the HCFA 1500 insurance claim form in Section 21, "Diagnosis or nature of illness or injury." Section 21 provides for up to four diagnosis codes. The codes are then assigned to the procedure, service, or supply codes listed in Section 24.

HCFA Coding

The Health Care Financing Administration's Healthcare Common Procedure Coding System (HCPCS) level II and level III codes were created to provide a means to bill for supplies and services not covered by a CPT code (level I). HCPCS was developed by HCFA in 1983 to:

- Meet the operational needs of Medicare and Medicaid
- Coordinate government programs by uniform application of HCFA's policies
- Allow providers and suppliers to communicate their services in a consistent manner
- Ensure the validity of profiles and fee schedules through standardized coding
- Enhance medical education and research by providing a vehicle for local, regional, and national utilization comparisons

Level II codes (HCPCS national codes) are now required for reporting most medical services and supplies provided to Medicare and Medicaid patients. The codes begin with a single letter (A through V) followed by four numeric digits. They are grouped by type of service or supply and are updated annually by the Centers for Medicare & Medicaid Services (CMS).[1]

Level III codes (local codes) are assigned and maintained by individual state Medicare carriers. Like level II codes, these codes begin with a letter (W through Z) followed by four numeric digits. The most notable difference is that the level III codes are not common to all carriers. Level III codes are assigned by the local carriers to describe new procedures that are not yet available to level II. The codes are assigned by the carrier on an as-needed basis throughout the year with written notification to the physicians and suppliers to advise when local codes are required.

HCPCS codes may also be modified. The modifiers for level II codes are two alpha digits (AA through VP). Level III modifiers may be assigned on an as-needed basis by the carrier.

THE MOST COMMONLY BILLED CPT CODES

The CPA consultant can provide assistance by helping the physician identify potential coding errors or abuses:

- It is important to emphasize that through appropriate education of the coding staff, more efficiency can be obtained in the billing process. Many practices place individuals in the coding position with very little training. Not only does this slow down the billing process extensively, but it also puts the practice at risk for criminal investigation and payer audits.

[1] In June 2001 the Health Care Financing Administration (HCFA) became the Centers for Medicare & Medicaid Services (CMS); the Web site has changed to http://cms.hhs.gov.

- Physicians also need to understand the importance of completely and accurately documenting all the procedures performed as well as the diagnosis for these procedures. Oftentimes, the charge ticket will provide a list of the most commonly used diagnosis codes based on the practice specialty. A listing of diagnosis codes can be helpful to the physician and can expedite the coding-billing process. It is, however, important for the physician to indicate the primary diagnosis (reason for the visit) versus the supporting or chronic diagnoses. Coding errors can occur if the physician checks numerous diagnosis codes and the biller incorrectly chooses the primary code. For example, denials for payment may occur if the primary diagnosis code does not agree with or support the CPT code selected for the service provided.
- It is also essential that physicians performing surgical procedures have appropriate documentation sent from the inpatient facility to the physician office, as such documentation needs to be present in the patient's chart. The physician's coding for these services should coincide with that of the hospital, that is, diagnosis code, and so on.
- In many instances a physician performs a procedure at the inpatient hospital, returns to his or her office, and tells the coding person what has taken place and expects that individual to appropriately code the service without appropriate documentation. A pocket coder and tablet carried by the physician during inpatient procedures can solve this problem.

Evaluation and Management Coding

The evaluation and management (E/M) codes and the medicine codes (90000 series) are the most commonly billed CPT codes.

Codes for E/M services are categorized by the place of service (such as office or hospital) or type of service (such as critical care or preventive medicine services). Most of the categories are further divided by the status of the medical visit (such as new or established patient).

E/M codes are divided as follows:

99201-99205 New patient office visit codes
99211-99215 Established patient office visit codes
99217-99220 Hospital observation
99221-99239 Observation or inpatient care services inpatient services
99241-99275 Consultation codes
99281-99288 Emergency room services
99289-99290 Pediatric critical care patient transport
99291-99292 Critical care services
99293-99294 Pediatric critical care
99295-99296 Neonatal intensive care
99298-99299 Intensive (non-critical) low birth weight services
99301-99333 Nursing and rest home
99341-99350 Home visit services

99354-99359 Prolonged care
99360-99360 Physician standby
99361-99373 Case management/telephone
99374-99380 Care plan oversight
99381-99397 Preventive medicine
99401-99429 Counseling/risk reduction
99431-99440 Newborn care
99450-99456 Work and disability exams
99499 Unlisted evaluation and management service

One of the first steps in coding E/M services is to decide on the type of service performed, for example, determining if the office visit is for a new versus an established patient. The CPT definition of a new patient is a "patient who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past 3 years." In other words, if a patient transfers from one family practice physician to another family practice physician in the same group, the patient visits will continue to be established visits. If however, the patient is referred from a family practice physician to a cardiologist in the same group practice, the cardiology visit will be a new patient visit.

Consultations are defined as a service provided by a physician whose opinion or advice is requested by a physician or other appropriate source. It is the requesting physician's intent (request for an opinion versus a referral for treatment) that determines whether a consult code should be billed rather than an office, hospital, or nursing home visit code. Additionally, the request for a consultation from the attending physician or other appropriate source and the need for the consultation must be documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented and communicated by a written report to the requesting physician or other appropriate source. A consultant may subsequently initiate diagnostic or therapeutic services. Because of the similarities in treatment, much confusion exists in determining if the visits are, in fact, a consultation or a referral for treatment.

A misunderstanding of the rules regarding new patient visits or consults can result in incorrect billings and potential overpayments from third-party payers (insurance companies). Education of providers and billing staff is critical. Reviews of coding documentation can assist the practice in identifying potential deficiencies in this area (see Chapter 19, "Corporate Compliance Plans").

Determining Level of Service for E/M Visits

Physicians are experiencing increased scrutiny of their E/M claims for appropriateness under Medicare. Unscrupulous practices—such as billing higher level codes—could potentially increase their revenue. The CPA consultant can assist the practice in identifying risk areas in evaluation and management coding through services such as the baseline audit discussed in Chapter 19.

Deviations in coding patterns can be identified by comparing the physician client's coding for services to that of their peers. Resources such as the *2003 E/M Bell Curve Data Book*

published by Decision Health provide data to compare the practice's utilization to national averages by specialty. Data is compiled from the CMS database for all Part B services billed during a calendar year (2003 data is based on the calendar year 2001—the most recent data available).

EXAMPLE

Family Practice Client's 2002 charge volume for CPT code 99214 (level IV established patient office visit) represents 40 percent of the total established patient charges billed. The average percentage based on CMS data indicates a norm of 17.56 percent. Family Practice Client's utilization of the higher level code for established patient office visits (99214) is clearly in excess of the norm. A recommendation by the CPA to conduct a coding review of the documentation for a sample of patients who have been billed this code would be warranted.

Medicare carrier audits around the country have focused on the review of documentation to support the level of E/M service billed. In the meantime, physicians may use either the 1995 or 1997 guidelines.

The three main components for determining the level of visit are:

- Extent of patient's history taken
- Extent of examination
- Complexity of medical decision making

Additional components (contributory components) include the extent of counseling provided, coordination of care with other providers or agencies, nature of the patient's problem, and the time required. Any or all of these items may contribute to the selection of the proper code. For example, time is the controlling factor in such E/M services as critical care and prolonged services. Time factors (as with all components) must be documented by the provider in the medical record when used to determine a level of service.

In theory, the E/M codes are based upon the amount of "work" performed during a patient visit or encounter. The amount of work is determined by the three key components. Each type of E/M service has varying levels of service depending upon the complexity of the encounter.

The following are the various levels of established office visit codes:

- 99211—Level I established visit—minimal complexity
- 99212—Level II established visit—problem-focused history and exam, straightforward medical decision making
- 99213—Level III established visit—expanded focus history and exam, medical decision making of low complexity
- 99214—Level IV established visit—detailed history and exam, medical decision making of moderate complexity
- 99215—Level V established visit—comprehensive history and exam, medical decision making of high complexity

If the code chosen does not adequately describe the service, modifiers may be attached. Modifiers are two-digit codes that are attached to the CPT code. Currently, there are 30 CPT modifiers.

The following modifiers may apply to E/M codes

- *–21 Prolonged evaluation and management services.* When the face-to-face or floor/unit service provided is prolonged or otherwise greater than that usually required for the highest level of E/M service within a given category, it may be identified by adding the –21 modifier to the E/M code.
- *–24 Unrelated evaluation and management service by the same physician during a postoperative period.* Modifier –24 may be used by a physician to indicate that an E/M service was performed during a postoperative period for a problem unrelated to the original surgical procedure.
- *–25 Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure or other service.* Modifier –25 may be applied to identify that the patient's condition required a service beyond the procedure or beyond the usual preoperative and postoperative care associated with the procedure or service performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service were provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery (see modifier –57).
- *–32 Mandated services.* Services related to mandated consultations and/or related services (that is, required by a third-party payer) may be identified by adding the modifier –32 to the basic procedure.
- *–52 Reduced services.* Under certain circumstances a service or procedure may be partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual CPT code with the addition of modifier –52 which signifies that the procedure was reduced.
- *–57 Decision for surgery.* An E/M service that resulted in the initial decision to perform the surgery may be identified by adding the modifier –57 to the appropriate level of E/M service.

Choosing the appropriate E/M code is essential for the proper reimbursement of services rendered. Upcoding (choosing a code for a level higher than the service documented) can result in overpayment liabilities and potential regulatory implications (see Chapter 6, "How Medicare Patients Affect a Medical Practice," and Chapter 19, "Corporate Compliance Plans"). If the practice undercodes services (choosing a code for a level below the services documented), revenue will be negatively affected.

Anesthesia Coding

Anesthesia coding is unique in that services are billed in units of time. Each anesthesia CPT code is assigned a base unit by the American Society of Anesthesiologists. (Note: some surgical procedures have been assigned base units.) Most payers use time units based upon 15-minute increments for the first hour and increments of 10, 12, or 15 minutes for each

subsequent hour. Typically, Medicare uses 15-minute increments while a few commercial insurers use 10-minute increments. Medicare accepts the American Society of Anesthesiologists' definition of time: "Anesthesia time involves the continuous actual presence of the anesthesiologist (or medically directed CRNA or resident) and starts when he or she begins to prepare the patient for anesthesia care in the operating room and ends when the anesthesiologist is no longer in continuous actual attendance, that is, when the patient may be safely placed under post-operative supervision."

Regulations were revised by the HCFA, as reported in the November 2, 1999 *Federal Register*, to allow anesthesiologists and CRNAs (certified registered nurse anesthetists) to "sum blocks of time around a break in continuous anesthesia care as long as there is continuous monitoring of the patient within the blocks of time." Anesthesiologists and CRNAs should report the total anesthesia time on the HCFA claim form[2] as the sum of the continuous anesthesia block times. Additionally, the medical record should accurately document the total anesthesia time.

In selecting an anesthesia code for Medicare beneficiaries the CPT code used should correspond to the major procedure billed by the surgeon. The American Society of Anesthesiologist's *Anesthesia Crosswalk* provides a conversion chart that lists surgical codes and the corresponding codes from the anesthesia section of the CPT codes.

Medicare has established a special modifier (QS) to be used when billing monitored anesthesia care (MAC). MAC is defined by HCFA as "the intraoperative monitoring of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. MAC also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g. atropine, demerol, valium) and provision of indicated postop anesthesia care."

Surgical Coding

Not only is the coding of surgical services complex, but the surgery section also contains more codes than any other section. In choosing the most appropriate CPT code for a surgical procedure, the provider must consider all aspects of the procedure performed. Was the procedure "simple" or "complex"? What approach was used to perform the procedure? For example, the closure of esophagostomy or fistula can be from a cervical approach (43420) or can be a transthoracic or transabdominal approach (43425). If a skin lesion was excised, was it benign (11400-11471) or malignant (11600-11646)? The site and size of the lesion are also necessary in order to code properly. For example, the CPT code for the excision of a malignant lesion on the trunk, arms, or legs 0.5 cm or less would be 11600. If the malignant lesion is located in the scalp, neck, hands, feet, or genitalia and was 0.5 cm or less, the CPT code would be 11620.

For starters, it will help if you familiarize yourself with the codes in your surgeon client's specialty. Surgical codes are divided into categories as shown in Table 4-1.

[2] HCFA forms are gradually being reprinted as CMS forms. During this phase-in period both the "HCFA" and "CMS" versions are acceptable for use. See http://cms.hhs.gov/forms for more information.

TABLE 4-1 SURGICAL CODES BY CATEGORY

Category	Code
Integumentary (skin) system	10021-19499
Musculoskeletal system	20000-29999
Respiratory system	30000-32999
Cardiovascular system	33010-37799
Hemic/lymphatic system	38100-38999
Mediastinum and diaphragm	39000-39599
Digestive system	40490-49999
Urinary, genital, and reproductive	50010-59899
Endocrine system	60000-60699
Nervous system	61000-64999
Eye/ocular adnexa	65091-68899
Auditory (hearing) system	69000-69990

The Global Surgical Period: What's Included and What's Not?

Fortunately, there are certain guidelines that will help you review a surgeon's coding in the Surgery section of the CPT book. Surgeons typically bill surgery procedures as one "global service." The following services, then, are included in most surgical CPT codes.

- The surgical procedure
- Local infiltration
- Metacarpal/digital block or topical anesthesia when used. The surgeon's global fee likewise includes the management of post-operative pain except in special circumstances when it is medically necessary for care to be turned over to an anesthesiologist.
- Normal, uncomplicated follow-up care. The period of time included in the code for follow-up care is typically known as the "global period."

CAUTION: The CPT guidelines include only "normal, uncomplicated" care in the follow-up or global period. Follow-up care (for non-Medicare services) due to complications (for example, drainage of an infected wound) are not included in the global period and may be billed separately.

What about pre-operative and post-operative services? These may be included in the global fee. The period of time included in the global period varies based on payer policy. In the case of major surgeries, pre-operative visits the day before or the day of the surgery are typically included within the package fee. Excepted from this rule are visits at which

the decision to perform surgery was made. A –57 modifier is attached to the visit code (hospital or office) to properly denote the service so that the visit will be excepted from the surgical package. We will discuss more surgical modifiers in the following section.

Post-operative visits by the primary surgeon within 90 days are typically considered as included with the surgical package for major surgical procedures. The surgeon should not bill separately unless the visit was due to an unrelated diagnosis or for an added course of treatment other than normal recovery from surgery. However, the surgical package does include all additional medical or surgical services required of the surgeon due to the complications that do not require additional trips to the operating room. If the physician returns to the operating room for a related procedure during a post-operative period, the modifier –78 is attached to the appropriate CPT code for the procedure. Such trips are usually billed when performed at a reduced rate. When an unrelated procedure is performed by the same physician during the post-op period, modifier –79 is used. The –79 modifier may be used, for example, to bill for a major surgery on the same day or in the post-operative period of a diagnostic biopsy.

Another item that is often included within the surgical package is "supplies." With the exception of injectables and certain other designated items, supplies used in surgical procedures are included in the allowance for the surgical procedure to which they are incidental. For the most part, Medicare makes no separate payment for supplies. An exception would be splints, casts, and other devices. Likewise, prosthetics are usually billed separately when provided.

From a billing standpoint, it is important to understand those services included in the global period and those that may be billed separately. Otherwise, the practice may neglect to bill for services that would be covered (for example, follow-up care due to complications).

Starred Surgical Procedures, Surgery CPT Modifiers, and Add-ons

One of the reasons why surgical coding is so complex is that there are so many exceptions to the "rules," that is, services or procedures excluded from the surgical package. For these, the CPT code book uses an asterisk (a starred procedure), a numerical modifier, or a "+" sign to designate an add-on.

Starred Procedures. "Starred" procedures (denoted in CPT coding by the symbol *) are procedures that typically do not have a pre-operative or post-operative global period. Most starred procedures are considered to be minor surgeries. When a starred procedure is performed, pre-op and post-op services may typically be billed in addition to the procedure. The only exception is for evaluation and management services performed on the same day as the starred procedure.

EXAMPLES

- When a starred procedure is performed at the time of an initial visit (new patient) and the procedure constitutes the major service at the visit, you would use CPT code 99025. This code signifies a new patient visit when starred surgical procedure constitutes major service at that visit, and is billed rather than the E/M code for a new visit.
- When the starred procedure is carried out at the time of an initial or established patient visit involving significant identifiable services the appropriate visit is listed with the –25 modifier in addition to the starred procedure and its follow-up care.
- When the starred procedure requires hospitalization, an appropriate hospital visit is listed in addition to the starred procedure and its follow-up care.

Surgical Code Modifiers. You often find that surgeons bill for services that are not related to the surgery. An example would be a patient visit to evaluate a painful ankle after a knee surgery. For communicating special circumstances like these, there are CPT modifiers.

If patient visits occur during the global period that are unrelated to the surgical procedure, those visits are identified by using the modifier –24 in addition to the visit code. Additionally, in order for the visit to be allowed, the diagnosis code should support the visit and should be unrelated to the surgical procedures (in this same example, knee surgery returns for ankle pain).

In some cases, surgeons may perform multiple surgical procedures during the same surgical session. Effective January 1, 1995, HCFA (now CMS) reimburses multiple surgical procedures for Medicare patients as follows:

- 100 percent of global fee for the highest valued procedure (that is, the procedure with the highest number of relative value units [RVUs])
- 50 percent of the global fee for the second through the fifth procedures

When billing multiple procedures, the procedure with the highest number of RVUs is listed first without a modifier. All other procedures included in the multiple procedure are billed with a –51 modifier.

An exception to the multiple procedure rules occurs when modifier –59 is used. Modifier –59 is used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances. This modifier is used to indicate situations where several procedures, which should be paid separately, are performed on different anatomical sites or at different sessions during the same day. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision, separate lesion, or separate injury (or site of injury) in extensive injuries not ordinarily encountered or performed on the same day by the same physician.

Surgeons may also perform bilateral procedures (for example, arthroscopy of both knees) during the same surgical sessions. Generally, the surgical CPT codes are considered to be unilateral unless the description for the code states otherwise. A bilateral procedure performed by one surgeon should be billed with the –50 modifier and will be paid according to the bilateral adjustment rules (150 percent of the unilateral procedure under Medicare).

EXAMPLE

If a patient has diagnostic arthroscopy of both knees during the same surgical session, it would be appropriate to bill CPT code 29870-RT-50 and 29870-LT-50. This denotes that both the right (RT) and left (LT) knees were included in the procedure.

If an assistant or additional surgeon is used, the CPT code is billed with an –80, –81, or –82 modifier. Co-surgery exists when a single procedure requires two surgeons of different specialties. In the case of co-surgery, each surgeon should bill the surgery code with a –62 modifier.

Add-ons. Sometimes additional surgical procedures are performed in addition to the primary procedure. For example, a surgical procedure may include multiple fingers or toes, multiple vessels in vascular surgery, and so on. In these cases, a CPT code is assigned for the primary procedure and "add-on" codes (designated by a "+" and by phrases such as "each additional") are billed for the additional procedures. Add-on codes must be billed in conjunction with a primary code and may never be billed as standalone codes.

The Most Common Surgical Coding Errors

One of the most common errors providers make in billing for surgical procedures is fragmentation or unbundling. Fragmentation occurs when a physician bills separately for a service that is encompassed in a single procedure code or global fee. In the *Medicare Correct Coding Initiative*, HCFA has identified combinations of codes that constitute unbundling. For example, CPT code 22808 (arthrodesis, anterior, for spinal deformity, with or without cast, 2 to 3 vertebral segments) is the comprehensive code and includes code 22830 (exploration of spinal fusion) which is considered to be a component code. In other words, it would be inappropriate to bill 22830 in addition to 22808, and to do so would be considered unbundling. If both codes are billed together to the same patient, on the same day, Medicare will likely deny the claim.

Additionally, the *Coding Initiative* indicates codes that are mutually exclusive. Mutually exclusive codes represent those procedures which HCFA has identified may not reasonably be performed by a physician in the same patient encounter. If mutually exclusive codes are billed simultaneously, Medicare will reimburse only the code with the lower reimbursement level. An example of mutually exclusive surgical codes are 21209 (osteoplasty, facial bones, augmentation—reduction) and 21210 (graft, bone, nasal, maxillary or malar areas).

Office Supplies. With the exception of injectables and certain other designated items, supplies used in office procedures are included in the allowance for the evaluation and management code or the surgical procedure to which they are incidental. For the most part, Medicare makes no separate payment for supplies. An exception would be splints, casts, and other devices. Likewise, prosthetics are usually billed separately when provided.

Radiology Coding

Radiology codes may represent the global charge for radiology services (professional and technical component) or may only represent the professional component (modifier –26). The global charge represents a scenario in which the physician would not only provide the service or interpretation (professional component) but would also provide the equipment

and supplies needed to perform the service (technical component). Typically, radiologists charge the global fee for radiology services provided on an outpatient basis in a diagnostic facility owned by the physicians. The professional component is typically billed for services provided in a hospital setting (inpatient and outpatient) where the equipment, supplies, and technicians are provided by the hospital.

In order to assign CPT codes accurately in radiology coding, the ordering physician must be clear about the procedure to be performed; that is, the ordering physician should specify the number of views if applicable. For example, CPT code 71110 represents an exam to view the ribs, bilateral, with a minimum of three views. CPT code 71111 is the same exam including a posteroanterior chest and a minimum of four views. If the ordering physician merely requests "X-ray of ribs, bilateral" confusion will exist as to whether 71110 or 71111 will be the most appropriate code. As with E/M and surgery, proper coding for radiology depends on good clinical documentation.

Additionally, it is important to properly document computerized axial tomography (CT or CAT) scans and magnetic resonance imaging (MRI) scans that may be performed with contrast material. For most scans, the procedure can be performed with contrast, without contrast, or without contrast followed by contrast material. Different CPT codes are provided for each type of exam depending on the extent of the use of contrast material.

Interventional radiology procedures combine the use of surgical and radiology codes. Examples of invertentional cases include angioplasty, transcatheter therapy and biopsy, and myelograms. Interventional coding requires knowledge of anatomy and specific knowledge of the requirements for appropriate billing (that is, Medicare guidelines and regulations). Coding for interventional cases should only be undertaken by individuals (preferably physicians) who are trained in the specifics of the procedure and all requirements for appropriate billing of the procedures. The *Interventional Radiology Coding User's Guide* available through the American College of Radiology provides specific guidance on coding for these complex procedures.

Additionally, radiologists may perform therapeutic radiology, primarily radiation therapy for cancer treatment. It is not uncommon for radiologists to bill consultation codes prior to the provision of radiation therapy services. Radiation therapy can be billed using daily management codes (77401 to 77416) or using the weekly (five treatment sessions) management code (77427). It is important to note, however, that Medicare requires billing under the weekly treatment code.

As with surgical codes, unbundling or fragmentation is a common error when coding radiology services.

EXAMPLE

Any abdominal procedure that has a radiological supervision and interpretation code would also include abdominal X-rays (that is, CPT codes 74000–74022) as part of the total service. These X-rays would not be billed separately. If you are reviewing coding and billing of a radiology practice, you'll need to consult the *Medicare Correct Coding Initiative.*

Pathology and Laboratory Coding

The majority of the CPT codes found in the section on pathology and laboratory coding cover clinical laboratory tests. As with the coding for radiology services, choosing the correct code for clinical lab tests requires a careful review of the coding options. In many cases, the difference between the CPT code options may be subtle.

EXAMPLE

The description for CPT code 82926 is gastric acid, free *and* total; each specimen, whereas the description for CPT code 82928 is gastric acid, free *or* total; each specimen.

In 1998, a major change occurred with respect to the coding structure for multi-channel, automated tests. Codes previously used for multi-channel tests were deleted and were replaced with component test codes. The Organ/Disease Oriented Panel codes (80048–80076) are used to bill the appropriate panel. If more tests are performed than those listed in a panel, the appropriate panel code may be billed along with any additional tests performed.

EXAMPLE

CPT code 80051 is used to denote an electrolyte panel. The panel must include the following analyses: carbon dioxide, chloride, potassium, and sodium. These are the defined components of the panel, and although each analysis has a separate CPT code (for example, carbon dioxide is 82374), when performed as part of the electrolyte panel, they are not billed separately.

Generally, Medicare will not reimburse separately for specimen collection when the effort is considered minimal. However, a separate charge for venipuncture (G0001) is a reimbursable charge in most situations.

The majority of the CPT codes applicable to surgical pathology services are included in the 88300 series of CPT codes. Many issues affect the coding of pathology services: choosing the correct surgical pathology code (88300–88309), billing for specimens from different anatomic sites, proper coding for clinical pathology services, and so on. The unit of service for pathology billing according to CPT guidelines is the specimen. A specimen is defined as "tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis." A clinical pathology consultation, according to CPT guidelines, is "a service, including a written report, rendered by the pathologist in response to a request from an attending physician in relation to a test result(s) requiring additional medical interpretive judgment. Reporting of a test result(s) without medical interpretive judgment is not considered a clinical pathology consultation."

Generally, there are two types of clinical pathology consultations. The first type (80502) occurs when a review of a patient's history and medical records is performed along with laboratory test results. In this case, the surgeon's request requires the pathologist to render a medical judgment and provide a consultation.

The second type of consultation (80500) is of limited duration requiring medical judgment, interpreting test findings, and furnishing information directly related to the condition of the patient to the attending physician.

As with surgical and radiology coding, care must be given to observe coding compliance as set forth in the Medicare Correct Coding Initiative.

EXAMPLE

CPT codes 80500 and 80502 are used to indicate that a pathologist has reviewed and interpreted, with a subsequent written report, a clinical pathology test. HCFA has identified the tests that may require these services. Additionally, these codes are not to be used with any other pathology service that includes a physician interpretation (such as surgical pathology).

Medicine Coding

The first series of CPT codes in the Medicine section are for immunization injections. Beginning in 1999, two codes are provided for the administration of immunizations: 90471 is used for the first injection and 90472 is used for each additional administration along with the appropriate code for the vaccines. Additionally, there are CPT codes that describe the vaccine used in the injection (90476–90749).

Medicare, however, requires the use of a "G" code to bill for the administration of the vaccine while the vaccine product is billed using the appropriate CPT code. Medicare administration codes are as follows:

- G0008—Administration of influenza virus vaccine
- G0009—Administration of pneumococcal vaccine
- G0010—Administration of hepatitis B vaccine

Therapeutic injection codes are likewise included in the medicine section. Although Medicare does not reimburse the injection code when the injection is provided with a visit, the medication may be billed using an HCPCS code (J code).

Psychiatry codes encompass CPT codes 90804 through 90911 in the medicine section. Psychiatric codes are appropriately selected based on:

- The type of psychotherapy (interactive using nonverbal techniques versus insight oriented, behavior modifying, and/or supportive using verbal techniques)
- The place of service (office versus hospital inpatient)
- Face-to-face time spent with the patient during psychotherapy
- Whether evaluation and management services are furnished on the same day as psychotherapy

Dialysis service codes are included in the medicine section. Included in the dialysis section are CPT codes 90918 through 90921 which represent the monthly capitation payment (MCP) amount for end stage renal disease (ESRD). The monthly capitation payment for outpatient maintenance dialysis is generally defined as a comprehensive monthly payment

that covers all physician services associated with the continuing medical management of a maintenance dialysis patient. Services that may be reimbursed outside of the MCP include:

- Surgical services (such as temporary hemodialysis catheter placement)
- Complete evaluation for a renal transplant
- Training for patient to perform home hemodialysis
- Interpretation of tests that have a professional component
- Nonrenal-related physician's services

Ophthalmology diagnostic and treatment services have extensive CPT code descriptions. Ophthalmologists have the option of billing eye examinations using codes 92002, 92004, 92012, or 92014 or using the appropriate E/M code. Contact lens services are not part of the general ophthalmological service and may be billed separately. Fittings for spectacles, however, are treated by CMS as included in the payment for the spectacles and are not reimbursed separately.

Otorhinolaryngologic services (92502–92548) include medical diagnostic evaluation. However, otoscopy, rhinoscopy, and tuning fork test are included in the allowance for E/M codes.

Audiologic function tests represent testing of both ears. Modifier –52 is to be used if a test is applied to only one ear. Reimbursement for audiology services varies among payers (including Medicare). Audiology services are represented by CPT codes 92551 through 92597.

Cardiovascular services (92950–92998) include non-invasive and invasive diagnostic testing (including intracardiac testing) as well as therapeutic services (such as electrophysiologic procedures). Care must be used in choosing CPT codes for cardiac care as some procedures routinely performed as part of a comprehensive service are included in the comprehensive service and are not to be billed separately.

Cardiography codes are included in the medicine section (93000–93350). In many cases, reimbursement for these codes is dependent on the patient's diagnosis. Medicare has specific screens for designated diagnosis. If one of the designated diagnoses is not billed with the procedure, reimbursement for the procedure will be denied.

Cardiac catheterization codes (93501–93581) represent diagnostic medical procedures which include the introduction, positioning, and repositioning of catheters, recording of intracardiac and intravascular pressure, obtaining blood samples for measurement of blood gasses or dilution curves, and cardiac output measurements (Fick or other method, with or without rest and exercise, and/or studies) with or without electrode catheter placement, final evaluation, and report of procedure. When selective injection procedures are performed without a preceding catheterization, these services should be reported using codes in the vascular section (36011–36015 and 36215–36218).

Non-invasive vascular studies are likewise dependent on diagnosis codes for reimbursement. Vascular studies include patient care required to perform the studies, supervision of the studies, and interpretation of study results with copies for patient records of hard copy output with analysis of all data, including bi-directional vascular flow or imaging when provided. The use of a simple hand-held or other doppler device that does

not produce hard copy output or that produces a record that does not permit analysis of bi-directional vascular flow is considered to be part of the physical exam and is not reported separately.

Pulmonary services (94010–94799) include laboratory procedures and interpretation of results. If a separate identifiable E/M service is performed, the appropriate E/M service should be billed in addition to the pulmonary code.

Allergy and clinical immunology include:

- Allergy sensitivity tests
- Immunotherapy (desensitization, hyposensitization)
- Other therapy (for example, physical therapy)

Neurology and neuromuscular procedures are represented by CPT codes 95805 to 96117. Included in the neurology section are codes for electroencephalograms (EEGs) and sleep studies. Sleep testing has been identified by many payers as a potentially overutilized procedure. The CPT manual guidelines for sleep studies are very precise and should be reviewed carefully before billing for these services.

Chemotherapy procedures are represented by CPT codes 96400–96549. If significant separately identifiable E/M services are provided in addition to the chemotherapy services, the appropriate E/M code should be billed in addition to the chemotherapy service.

The remaining sections of the medicine section include miscellaneous codes for photodynamic therapy, special dermatological procedures, physical medicine (physical therapy), special services and reports, and qualifying circumstances for anesthesia. With the exception of the codes for physical therapy, Medicare will not reimburse for most of these miscellaneous codes.

MATCHING THE "WHY" TO THE "WHAT": ICD-9 CODING

The Centers for Medicare & Medicaid Services (CMS), formerly HCFA, provides specific guidelines to assist in standardizing diagnosis coding:

- Each service, procedure, or supply should be identified with an ICD-9-CM code to describe the diagnosis, symptom, complaint, condition, or problem.
- The primary diagnosis—the most important reason for the care provider—should be coded first, followed by the secondary diagnosis, tertiary diagnosis, and so on. Any co-existing conditions that affect the treatment of the patient for that visit or procedure should be coded. However, diagnoses that are no longer applicable should not be included.
- Services or visits for circumstances other than disease or injury (for example, follow-up care after chemotherapy) should be identified with a "V" code.
- All codes should be assigned to the highest level of specificity. The numerical code should be extended to the fourth or fifth digit when applicable.
- A chronic diagnosis should be coded if it is applicable to the patient's treatment.

- If only ancillary services are provided (such as physical therapy), code the service with the appropriate "V" code first and then the condition.
- For surgical procedures, code the diagnosis applicable to the procedure. If at the time the claim is filed the postoperative diagnosis is different from the preoperative diagnosis, the postoperative diagnosis should be used.

The American Medical Association publishes the ICD-9-CM codes on an annual basis. (See http://www.ama-assn.org for more information on ordering their coding catalog.) Other medical publishers, such as St. Anthony's, also issue ICD-9-CM reference guides.

The CPA consultant should always ensure that the physician practice is utilizing the most up-to-date reference tool since changes are made annually.

In order to accurately locate codes in the ICD-9-CM publication, the following guidelines should be considered:

1. The coder must identify the significant observations in the physician's diagnosis statement.

   Example: If the physician states that the patient has a previous diagnosis of chronic obstructive pulmonary disease (COPD) and the patient is complaining of shortness of breath, the significant observations are "chronic obstructive pulmonary disease" and "shortness of breath."

2. The significant observations are then located in the "Index to Diseases." The ICD-9-CM code for COPD is located under the main heading of "Disease—lung." The diagnosis code assigned to COPD is 496; however, there are several subcodes listed.

   Example: If the physician notes had indicated COPD with bronchitis (chronic) the diagnosis code would be 491.20. *Note:* It is very important to code to the highest level of diagnostic specificity. Based on the information provided in the physician's notes, it would be applicable to use code 496.

   Shortness of breath is found in the index under the main heading, "Short, shortening, shortness" and the subheading "breath." There are no additional headings listed in the index for shortness of breath.

3. Once the code is located in the index, the "Tabular List" should be cross-referenced to verify the code chosen. Codes should not be chosen directly from the index. The tabular list includes notes that help clarify what is included in the diagnosis code selected as well as what conditions are excluded. Additionally, fourth and fifth digits are included that assist the coder in assigning a diagnosis to the highest level of specificity.

   Example: The ICD-9-CM code for shortness of breath is 786.05, a five-digit code listed under the main heading of 786.0, "Dyspnea and respiratory abnormalities."

4. Only code the reason for the visit or procedure (or chronic diseases contributing to the encounter). For example, COPD is a chronic disease contributing to the reason for the visit, shortness of breath. However, the patient may also be treated for high cholesterol. Since high cholesterol is not a contributing factor to the reason for the visit, it would not be included as a contributing diagnosis.

5. Codes should be assigned based on the signs, symptoms, or conditions that necessitated the visit or procedure. In other words, you should only code what you know as fact. Care should be given not to assign suspected or "rule out" codes.

   Example: Assume the physician in the above example ordered a chest X-ray to "rule out" bronchitis. It would be inappropriate to assign the ICD-9-CM code for bronchitis to the chest X-ray since it has not been identified as a diagnosis and is simply suspected at the time the X-ray is ordered. The appropriate diagnosis would be shortness of breath since this is the symptom that precipitated the ordering of the chest X-ray.

6. The first diagnostic code referenced on the HCFA 1500 claim form should describe the most important reason for the care provided and, thus, becomes the primary diagnosis. In some cases, a single diagnosis code will describe the reason for care.

7. However, if additional facts are required to substantiate the care provided, the ICD-9-CM codes for those conditions are listed in order of their importance.

8. Selecting the proper ICD-9-CM code provides the basis for determining the "medical necessity" of the service or procedure performed. In order for a service to be reimbursable by Medicare it must meet the test of being medically necessary. Section 1862(a)(1)(A) of Title XVIII of the Social Security Act states that no Medicare payment shall be made for items or services which are not "reasonable and necessary for the diagnosis or treatment of illness or to improve the functioning of a malformed body member." To be covered by Medicare, the patient's condition must include appropriate clinical indications for the service ordered or performed and the service provided should have a significant likelihood of making a material contribution to the treatment of the patient.

   Local Medical Review Policies (LMRPs) are issued by the local Medicare carriers on an as-needed basis to clarify the diagnostic codes that will be considered to establish medical necessity for a certain procedure code (CPT code). LMRPs are published on the CMS Web site at and can be found at http://www.cms.hhs.gov/mcd. *Note:* The Web sites may not include the latest versions as individual contractors update codes on an as-needed basis. Medicare contractors' draft Local Medical Review Policies may be viewed at www.DraftLMRP.net during the comment period allowed for by law.

   Example: If the chest X-ray ordered in the previous example was linked incorrectly to the patient's existing condition of high cholesterol rather than the reason for the exam, shortness of breath, the fee for the X-ray would most likely be denied as not medically necessary. Most states have LMRPs for chest X-rays which require some respiratory symptom or condition as justification for reimbursement of the exam.

"V" Codes

"V" codes are identified in the ICD-9-CM codes as "Supplementary Classification of Factors Influencing Health Status and Contact with Health Services." They are typically used when a patient is being treated for something other than a current illness or injury. Physical exams and mammograms are two examples.

- Use of the "V" code is applicable when a person who is not currently ill receives health services for some specific purpose, such as organ donation or well care.

- Use of the "V" code can occur when a person with a known disease or injury, whether it is current or resolving, encounters the healthcare system for a specific treatment of that disease or injury, such as dialysis for renal disease.
- The "V" codes may also be applicable for persons when a problem is present but is not in itself a current illness. Examples of these circumstances are a personal history of certain diseases or conditions, such as history of tobacco use.

"E" Codes

The "E" codes are supplementary and are used to describe external causes of injuries and poisonings. "E" codes permit the classification of environmental events, circumstances, and conditions as the cause of injury, for example, motor vehicle accidents. They are never reported by themselves and should only be used as an additional code to provide a more detailed analysis.

SUMMARY

Proper coding (both CPT and ICD-9) is critical to obtain appropriate reimbursement. The codes are used by payers to define the "what" and "why" for the service provided. Inappropriate or incorrect coding results in inappropriate reimbursement. If extensive, the physician client may be subject to regulatory penalties and even criminal charges.

Chapter 5

How the Prevalence of Managed Care Affects Providers

Industry Snapshot: *In 1986, indemnity plans—fee for services based on usual, reasonable, and customary fees—constituted 76 percent of total health insurance coverage. By 2000, the percentage dropped dramatically with indemnity plans only accounting for 11 percent of the payer maze. Interestingly, the median gross collection percentage for multispecialty practices in 1986 was 84.9 percent, whereas the percentage in 2001 declined to 67.08 percent.*[1] *The shift from indemnity to managed care plans occurred as a result of industry efforts to curb rising healthcare costs. The result for the medical industry was a decline in reimbursement as exemplified by the statistics from the* Cost Survey.

With the risks attached to managed care contracting (financial stability of the managed care organization, reduction in reimbursement), the CPA consultant may question the validity of managed care contracting for medical clients. The reality is that the majority of patients are covered by some type of managed care product. To capture the managed care patient base, the physician must be willing to accept the managed care contractor's terms and agreements. To properly advise medical clients, the CPA consultant must have an understanding of the managed care plans that contract with providers in their area of service.

As you've seen above, the biggest influence in the healthcare industry today is the shift from indemnity plans to managed care plans which usually offer payment on a capitated or discounted fee-for-service basis, a fixed dollar amount per patient per month. Managed care (including health maintenance organizations [HMOs], preferred provider organizations [PPOs], and point-of-service plans) now covers approximately 90 percent of all insured workers, over 50 percent of Medicaid recipients, and 16 percent of Medicare beneficiaries (Medicare+Choice). And there are currently over 1,600 managed care companies.

Yet, consumer disgruntlement with the managed care system has spawned a number of managed care variations.

* * * *

This chapter shows you how to navigate the managed care maze in order to provide managed care contract analyses and managed care reimbursement consulting for your medical practice clients.

WHAT MANAGED CARE IS *NOT*

Before we begin our discussion of managed care, it helps to define plans that fall outside the managed care rubric. These are indemnity plans and government plans.

- *Indemnity plans.* Traditionally referred to as "commercial" insurance, these plans reimburse for services provided on a fee-for-service basis. Reimbursement is typically based on the concept of "usual, reasonable, and customary." If the physician's fee exceeds the amount established by the carrier as reasonable and

[1] *Source:* Medical Group Management Association *Cost Survey: 2002 Report Based on 2001 Data.*

customary, the patient will be responsible for the remainder. In an indemnity plan, there are no restrictions on access to providers and no inherent cost controls, with the exception of the usual, reasonable, and customary restrictions.

- *Government plans.* Medicaid, Medicare, and CHAMPUS are the primary government programs. Medicaid provides coverage for individuals whose incomes fall below a certain level, while Medicare provides coverage for individuals who are age 65 or older or who become disabled. The Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) provides health insurance benefits to military personnel (active and retired) and their dependents.

The Medicaid program is jointly administered by the federal and state governments and may have a different name dependent upon the respective state (for example, Tenncare in Tennessee). While Medicaid payers are all subject to the same federal guidelines, each state has its own guidelines for claims submission and publishes its own handbook outlining specific policies for that state. States have considerable flexibility in structuring the Medicaid program, including determining provider payment rates and certification standards, and developing alternative healthcare delivery programs. Numerous states have structured eligibility and coverage under Medicaid through the use of demonstration waivers granted under Section 1115 of the Social Security Act. Hence, these states are using the waivers to reform healthcare by expanding coverage without increasing the amount of federal government spending. Since 1993, the following states have been approved under the waiver program: Arkansas, Delaware, Florida, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Vermont, and Wisconsin. As with Medicare, participation with Medicaid requires that the provider accept the Medicaid fee amount for services rendered.

> **Practice Tip:** The Medicaid program provides each recipient with an eligibility card that indicates coverage dates. The practice should copy and examine the card to confirm coverage on the date of service. Coverage can change monthly and must be verified frequently. The card also contains the recipient's identification number which must be included on the claim form.

MANAGED CARE

Managed care (including health maintenance organization [HMOs], preferred provider organizations [PPOs], and point-of-service [POS] plans) now covers approximately 90 percent of all insured workers, over 50 percent of the Medicaid recipients, and 16 percent of Medicare beneficiaries (Medicare+Choice).

HMOs are the most common form of managed care. Staff model plans, also called group models, are HMOs that own the facilities and employ the personnel to provide care to their enrollees for a fixed amount. POS plans allow HMO participants to obtain out-of-network care. Typically, network providers are eligible for incentives to keep patients within the network. Out-of-network costs are measured and may affect reimbursement to network providers.

The ABCs of HMOs

HMOs are the most common form of managed care with about 80 million Americans currently participating in them. Of course, with the consumer backlash against managed care and HMOs in particular, some HMOs are trying to call themselves by a different name. For instance, Kaiser Permanente, the biggest nonprofit HMO, has eschewed the managed care label and prefers to be known as an "integrated financing and delivery system." Whatever you call them, staff model or group model HMOs are ones that own the facilities and employ the personnel to provide care to their enrollees for fixed amounts. In order to receive their health benefits, HMO enrollees must stay "in network" and only visit providers employed by the HMO. In response to consumer concerns about lack of choice in their healthcare providers, POS plans were developed. These offer the option of obtaining care outside the network at a slightly higher cost to the enrollee. We'll discuss POS plans in more detail later.

The traditional HMO model reimburses the physician on a capitated basis based on the number of enrollees assigned to the physician. The capitated payment is actuarially computed on a "per member, per month" basis. The physician agrees to provide an array of services to a base of patients at a fixed reimbursement amount (capitated payment). The payment is made regardless of whether the patient receives services.

Assessing potential financial risk is probably the most difficult task when evaluating an HMO capitated contract. One method to assess risk is to anticipate utilization, quantify the utilization using the practice fee schedule, and compare the results to the capitated payment. The HMO should be able to provide information on anticipated use based on past experience. Once the contractual commitment is made, the practice should continue to track and compare the capitated payments to the fee-for-service equivalent charges on an ongoing basis to monitor financial risk.

Additionally, the practice must consider the risk of dealing with a financially strapped HMO. Physician groups can expect to experience delinquent payments from a troubled HMO or health insurer. Consequently, it is important to periodically monitor the financial condition of the HMOs with whom the practice maintains a relationship. Services such as Weiss Ratings, Inc. track the financial health of over 700 HMOs and issue ratings based on their analysts' review of publicly available information supplemented by data collected directly from the companies.

Weiss Ratings reported improvements in profitability of HMOs in 2000, 2001, and 2002 primarily due to hefty premium increases, insurer consolidation, and elimination of unprofitable subsidiaries. Even with improvements in overall profitability, physicians should be attuned to the financial health of the specific HMOs with which they have relationships.

Consider the case of Universal Care of Tennessee, Inc., a TennCare managed care company. Effective June 1, 2003, TennCare unilaterally terminated its managed care contract as the result of concerns about a range of management issues. Issues included questions about the company's net worth, delays in claims processing, and unauthorized transfers of funds to an affiliated company. Universal Care's 95,000 enrollees are to be transferred to TennCare Select, Tennessee's "safety net" plan which is managed by Blue Cross/Blue Shield. Going forward, patients should receive care and doctors should be paid. However, many physicians had balances due on services previously provided to Universal patients. Partial payment may be forthcoming but is not guaranteed.

The general instability in the HMO industry affects consumer coverage. HMOs are changing benefit structures, raising premiums, revising or terminating provider contracts, and withdrawing from unprofitable markets (such as Medicare) or unprofitable regions.

Preferred Provider Organizations

PPOs typically contract on behalf of employer groups with hospitals and physician providers at a discounted rate. The physicians participating in the preferred provider network generally are called either preferred or participating providers. Typically there is an incentive to the patient to use a preferred provider. If the patient chooses to visit a nonparticipating provider, the patient may be responsible for a higher co-pay or deductible amount. Physicians agree to the PPO's discounted fee reimbursement in anticipation of receiving greater patient volume or to minimize the possibility that patients will change to a participating provider.

In addition to the agreed discount, the physician may also be subject to a PPO "withhold." The "withhold" is an amount deducted from the physician's payment in addition to the contractual discount. The intent of the "withhold" is to control physician behavior. All amounts withheld from participating providers are pooled and the individual physician may be reimbursed a portion of his or her withhold if certain goals are met. The goals are typically related to the physician's utilization of services or the profitability of the plan. The withhold is typically computed as a percentage of the discounted fee.

EXAMPLE

A physician's typical fee for a service is $500. The physician contracts with a PPO for which the allowed fee for the service reflects a 20 percent discount. Additionally, the PPO deducts 10 percent for the "withhold pool." The physician would be reimbursed as follows:

$500 × 80% = $400, the allowed fee

$400 – $40 (10% withhold) = $360, the reimbursed amount

In many cases, the PPOs have not effectively tracked or reported the ultimate determination of withhold amounts. Physician practices typically write the withhold amount off as a contractual adjustment and do not track this potential reimbursable portion.

Practice Tip: Practices should track the withhold amounts from managed care payers and require an annual accounting of the disposition of the withhold amount from each managed care payer.

The practice should carefully review any contract before signing and may choose to enlist a healthcare attorney and a CPA consultant to assist in the review. On an annual basis, a financial analysis should be conducted to ensure that the contract is reimbursing for services as agreed in the contract and that the arrangement is financially viable for the practice.

SUMMARY

The CPA consultant can provide assistance to the physician client in evaluating the profitability of managed care contracts. Obviously, careful review of contracts prior to execution is recommended. The practice must be mindful of the financial condition of the managed care company and exercise remedies to cancel contracts, if necessary, before losses are incurred. The CPA can also assist the practice in evaluating the managed care payer's compliance to agreed-upon reimbursement amounts as explained in Chapter 21, "Managed Care Contract Review."

Chapter 6

How Medicare Patients Affect a Medical Practice

Industry Snapshot: *The ever-evolving relationship between physicians and the Medicare payment system has been tenuous. Decreases in reimbursement, changes in reimbursement methodology, and increasing fraud and abuse scrutiny have contributed to increasing tension between physicians and the Medicare system in recent years. As the American public ages and the need for health services increases, physician practices must work within the complicated Medicare system to provide needed care to patients while maintaining their own financial health.*

* * * *

With the exception of pediatrics, most medical practices provide services to Medicare patients. In order to be properly reimbursed by Medicare, the medical practice must understand and bill in compliance with Medicare regulations. CPA consultants must likewise be aware of the regulations and the pitfalls (including fraud and abuse implications) for not billing in compliance with those regulations so that they can provide advice and guidance to their clients.

MEDICARE: THREE PROGRAMS

In 1965 Congress enacted two new programs of medical care as part of the Social Security Amendments and in 1997 it enacted a third. Combined, the three programs are known as "Health Insurance for the Aged and Disabled." Title XVIII of the Social Security Act contains the basic law governing the Medicare programs. Amendments have been made to the law almost every year since 1980. On December 8, 2003, President Bush signed into law the $400 billion Medicare Prescription Drug and Modernization Act of 2003. Beginning in 2006, all Medicare beneficiaries will have access to a prescription drug benefit for the first time in the history of the program. Additionally, this legislation creates equity in the way rural areas are funded under Medicare to improve reliable access to physicians, hospitals, ambulance companies, laboratories, hospices, and home health agencies in rural America.

The first component of the Medicare program is typically referred to as "basic Medicare" or "Medicare Part A." The Part A program is largely financed through the hospital insurance taxes that are imposed by the Internal Revenue Code and included in the Social Security tax. Benefits provided under this program cover inpatient hospital and home healthcare as well as inpatient care at other institutions (for example psychiatric hospitals).

The second component of the programs is a supplementary program covering the costs of physicians' services and other items and services not covered under the basic program. Known as "Part B," this program is financed through contributions from the federal government and monthly premium payments ($54.00 per month in 2002) from enrollees.

A third program (Part C) was created under the Balanced Budget Act of 1997 and is called "Medicare+Choice." Medicare+Choice provides managed care options for beneficiaries who are entitled to Part A benefits and who are enrolled in Part B. As of January 1, 1999, beneficiaries may choose to continue to receive their health benefits through the traditional Medicare "fee for service" program or may select a certified Medicare+Choice managed care plan.

Since Part A benefits do not typically apply to physician practices, this chapter will focus on the Part B and Part C programs. It will provide a thorough review of plan basics along with applicable regulations and current issues in Medicare fraud and abuse enforcement.

The Secretary of Health and Human Services (HHS) contracts with carriers (usually private insurance companies) which handle claims review and payment, beneficiary and physician inquiries, medical and utilization review, and administrative hearings.

Who Is Eligible for Medicare?

Enrollment in Part B is available to anyone who is entitled to Part A benefits. (Entitlement for Medicare Part A automatically begins at age 65 for individuals who are eligible for monthly Social Security retirement or survivor benefits or railroad retirement benefits.) For further review of eligibility requirements, visit the Medicare Web site at www.medicare.gov. Additionally, individuals over the age of 65 who are resident aliens or citizens of the United States may enroll in Part B even if they are not eligible for Part A benefits.

Each beneficiary entitled to Part A or Part B benefits is issued a Health Insurance Card (Form HCFA-1966). The card provides the beneficiary's name, identification number, sex, extent of entitlement, and effective date(s) of entitlement.

> **Practice Tip:** The practice should copy and examine the card to confirm coverage on the date of service. Coverage can change monthly and must be verified frequently.

If an individual who is eligible for Medicare Part B benefits continues employment after age 65, Medicare benefits are excluded to the extent that benefits are provided by an employer group health plan. In the event that a working senior enrolls in the Medicare program at 65, the Medicare benefits will be secondary to the benefits provided by the employer's health plan.

Many retired Medicare beneficiaries acquire separate health coverage to provide benefits for costs not covered by Medicare (such as co-insurance amounts and prescription drugs). These plans (Medigap Plans) are secondary to Medicare in coverage. The claims for Medigap plans (without drug coverage) rose by 11.2 percent from 1996 to 1998, twice as fast as expected according to the American Academy of Actuaries. In lieu of secondary coverage (Medigap plans), actuaries have found that many healthier seniors signed up for managed care plans (Medicare+Choice) that made it unnecessary for them to buy supplemental coverage.

What Do Medicare Beneficiaries Pay?

Medicare beneficiaries enrolled in Part B are responsible for an annual $100 *deductible* amount and a 20 percent *co-insurance* or co-payment amount. The $100 annual deductible amount and the co-insurance amount apply only to services covered by Medicare. If the service is not covered or denied as not medically necessary, no deductible or co-insurance is required and the beneficiary is not responsible. Unless the provider has obtained an advance beneficiary notice (ABN) from the patient explaining that the service may be disallowed by Medicare and the patient agrees to assume payment responsibility, the entire amount must be written off by the provider.

Medicare pays for clinical diagnostic laboratory tests (exclusive of tests provided in a hospital or similar institutional facility) according to a fee schedule established by the HHS. The laboratory or physician providing lab services must accept assignment and Medicare reimburses the tests at 100 percent of the fee schedule. The deductible amount does not apply and the patient beneficiary is not assigned a 20 percent co-insurance amount.

Additionally, no deductible is required in the case of screening mammograms, screening pap smears, or screening pelvic exams, and both the deductible and the co-insurance amounts are waived for pneumococcal and influenza vaccines.

When the deductible or co-insurance amount is applicable the physician must make a good faith effort to collect. Routine waivers of deductibles or co-insurance are deemed to be violations of Medicare regulations and, accordingly, could result in sanctions.

Medicare patients may obtain secondary supplemental insurance to provide coverage for deductibles and co-insurance (Medigap insurance). Indigent Medicare patients may qualify for Medicaid coverage in addition to Medicare coverage. Medicaid coverage is extended to "categorically needy" Medicare beneficiaries whose income is less than certain federal poverty guideline standards. For those patients, Medicaid provides secondary coverage for Medicare premiums, deductibles, and co-insurance.

In certain cases, Medicare may be the secondary payer (MSP—Medicare secondary payer). For the first 15 years of the program, Medicare was primary payer for all services to Medicare beneficiaries, with the sole exception of services covered under worker's compensation. Beginning in 1981, Congress enacted a series of amendments to require employee group health plans (EGHPs) to pay primary to Medicare for service provided to plan beneficiaries (working aged) who were also entitled to Medicare. EGHPs must pay primary to Medicare for services provided to beneficiaries who are 65 or older and entitled to employer health benefits through their own (or their spouses') "current employment status" with an employer of 20 or more employees.

In cases where there is a coordination of benefits (Medigap, Medicaid, MSP), overpayments may occur. Failure to properly address credit balances and retaining even relatively small overpayments can result in financial exposure and potential civil and criminal liability. Medicare overpayments must be researched and refunded, if appropriate, within 60 days from identification (January 25, 2002, *Federal Register*, restatement of the 1998 rule). Remedies from noncompliance may include both civil and administrative monetary penalties.

What Services Are Covered—And What Aren't?

If a service is not covered by Medicare or is deemed by Medicare not to be medically necessary for the treatment of the patient, the physician will receive no payment for that service from Medicare. Unless the physician has obtained an advance beneficiary notice (ABN), from the patient, the physician is likewise barred from seeking payment from the patient for disallowed services. In order for the CPA consultant to advise and assist the medical client in the area of Medicare reimbursement, it is imperative that the consultant have an understanding of what constitutes a covered service.

Part B covers reasonable and medically necessary physician services. Physician services are defined as professional services performed by physicians for a patient, including diagnosis, therapy, surgery, consultation, and home, office, and institutional services. Physician services do not include services provided by interns or residents in training. These services are covered under Part A.

According to Medicare regulations a "physician service" occurs when the physician examines the patient or is able to visualize some aspect of the patient's condition without using a third party's judgment. An example of direct visualization would include X-rays that, even if transmitted via teleradiology, would constitute a covered service.

It's important for medical practice consultants to know that services provided "incident to" a physician's professional services are likewise covered by Part B. In order for the services of a nonphysician to be covered under the "incident to" rules, the services must be provided as part of a continuing course of treatment (that is, for established versus new patients), in the physician office, and must be performed under the direct supervision of the physician. The physician doesn't have to be in the same room with the nonphysician provider but must be in the office suite and immediately available to provide assistance and direction. There is no "incident" to reimbursement for facility (such as hospital or nursing home) services.

Current procedural terminology (CPT) code 99211 (level I established office visit) is the code available for office or other outpatient visits for the evaluation and management of established patients, may not require the service of a physician, and may be performed by clinical personnel such as nurses and medical technicians. An example would be a blood pressure check for an established patient being treated for hypertension. This service may be provided by a clinical employee (for example LPN) and billed "incident" to the physician. Therefore, the CPA consultant should be aware that the "incident to" rules regarding direct supervision must be met. The physician cannot be making hospital rounds while the LPN provides these services and then bill for the services. In order to be a covered service, the physician must be present in the office suite. At one time, the services of healthcare practitioners such as physician assistants and nurse practitioners were *only* covered under Medicare as "incident" to providers. Under current regulations these practitioners may elect to bill incident to or may bill separately as independent providers. Billing as independent providers exempts the nonphysician practitioners from meeting the requirements of the incident to rules. As an independent provider, the nonphysician practitioner can treat new patients and can perform hospital and nursing home visits (services not covered under the incident to rules). The trade-off is that nonphysician practitioners who choose to bill separately are reimbursed at a reduced amount. For

example, nurse practitioners and physician assistants are paid at 85 percent of the physician fee schedule. Certified nurse midwives are paid at 65 percent of the fee schedule amount.

Covered services under Part B include those services identified as "Medical and other health services." Medical and other health services include:

- Physician services (discussed above)
- Services and supplies (including drugs and biologicals that cannot be self-administered) furnished "incident to" a physician's professional services of the type that are commonly furnished in physician's offices and that commonly either are rendered without charge or are included in the physician's fee
- Hospital services "incident to" physician's services rendered to outpatients and partial hospitalization (mental health) services incident to such services
- Diagnostic services that are furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital
- Outpatient physical, occupational, and speech therapy services
- Rural and community health clinic services
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies
- Antigens prepared by a physician for a particular patient
- Physician assistant, nurse practitioner, clinical psychologist, and clinical social worker services furnished to enrollees pursuant to a contract with a health maintenance organization, including services and supplies furnished as "incident to" such service, if those services and supplies otherwise would be covered if furnished by a physician or as incident to a physician's services
- Blood clotting factors for hemophilia patients
- Immunosuppressant therapy drugs furnished to an individual who receives an organ transplant
- Physician assistant, nurse practitioner, and clinical nurse specialist services
- Certified nurse-midwife services
- Qualified psychologist services
- Clinical social worker services
- Prostrate cancer screening tests
- Colorectal cancer screening tests
- Oral anti-cancer drugs
- Diabetes outpatient self-management training services
- Oral anti-emetic drugs in conjunction with chemotherapy treatments
- Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
- X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations

- Durable medical equipment
- Ambulance service, if the use of other methods of transportation is contraindicated by the individual's condition
- Prosthetic devices that replace all or part of an internal body organ (including colostomy bags and supplies) and replacement of such devices
- Leg, arm, back, and neck braces and artificial legs, arms, and eyes and replacements if required because the patient's physical condition changes
- Pneumococcal, influenza, and hepatitis B vaccines, if reasonable and necessary to prevent illness
- Certified registered nurse anesthetist (CRNA) services on a basis other than as incident to a physician's services
- Therapeutic shoes for individuals with severe diabetic conditions
- Mammography screening services
- Screening pap smears and screening pelvic exams
- Bone density measurement tests

How Medicare Determines If Services Will Be Covered

In order to be covered by Medicare, services must be "reasonable and necessary" for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. A medically reasonable and necessary service is generally defined as:

1. Safe and effective
2. Not experimental: The *Medicare Carrier's Manual* specifically excludes certain procedures that are considered to be medically unproven or experimental, such as acupuncture. Generally, diagnostic services furnished as screening or ruling out potential illnesses are not reasonable and necessary and thus are not covered. Certain screening tests (such as mammograms, glaucoma screening, pelvic exams, and screening colonoscopies) are specifically covered. Each of the covered screening exams has specific coverage requirements. For example, coverage for glaucoma screenings is limited to patients who have diabetes mellitus or a family history of glaucoma, or who otherwise are determined to be at high risk for glaucoma. The provider must be aware of the specific requirements for each screening service in order to properly bill and be reimbursed.
3. Appropriate (including setting, standard of practice, qualified personnel)
4. Meets (but does not exceed) the patient's need

Coverage determinations are set both nationally and locally. National coverage policies apply to all contractors. Local carrier coverage policies (Local Medical Review Policies—LMRP) are published in the local carrier's bulletins and are available on the Centers for Medicare & Medicaid Services (CMS)-sponsored Web site (http:www.cms.hhs.gov/mcd).

If the physician believes that a service or procedure will be denied as not reasonable or necessary, the physician may request that the patient sign a statement acknowledging that the service or procedure will most likely be denied and accepting responsibility for payment. These statements are commonly referred to as advance beneficiary notices or ABNs. In order to be valid, the statement must be specific and individualized so it gives the

patient a clear idea of why Medicare won't pay. ABNs which do not address a specific service (or services for an extended course of treatment) are not valid. (See Tool 6-A, "Advance Beneficiary Notice (ABN).") Additionally, the notice must obtained in advance, that is, before the service is provided.

Tool 6-A: Advance Beneficiary Notice (ABN) ***(Toolkit CD-ROM)***

WHAT MEDICARE PAYS PROVIDERS

Beginning in 1996, physicians were required to enroll in the Medicare program. In order to enroll, the physician completes either Form 8551 (individual healthcare practitioners) or 855R (individual healthcare practitioners to reassign Medicare benefits). All 855 forms can be downloaded in Adobe PDF format at http://cms.hhs.gov/providers/enrollment/forms/default.asp. This Web site also has links to the contact information for each Medicare carrier, fiscal intermediary, and CMS regional office.

In 2001, CMS began requiring carriers to process 90 percent of enrollment applications within 60 days and 99 percent within 120 days. Physicians are not eligible to receive reimbursement for Medicare services until they are enrolled and have received their Medicare locally assigned provider number and unique provider identification number (UPIN). Medicare has typically allowed physicians in the application process to begin treating Medicare patients and retroactively bill the program once the number is assigned (limitation of 12 months prior to assignment of the provider/UPIN number). It is improper and fraudulent to bill for services under another physician's name and provider number while the performing physician's application is pending.

Practice Tip: CPA consultants can provide assistance to physician clients in preparing and assembling information necessary to complete the 855 form.

Physicians providing services under Medicare Part B are reimbursed based on the national fee schedule payment system. Fully implemented in 1996, the national physician fee schedule payment system marks the most important change for physicians since the inception of the Medicare program in 1965. The fee schedule establishes the allowed amount of Medicare reimbursement for each covered CPT code. The rationale behind the development of the fee schedule was to provide a basis for determining the reimbursement for physician services and to slow the rise in spending for those services.

The Medicare fee schedule is based on the resource-based relative value scale (RBRVS) which we discussed in detail in Chapter 3. Under RBRVS, physician reimbursement is based on the amount of work, practice expense, and malpractice expense incurred in providing a service. Prior to the fee schedule, physicians were reimbursed based on charge histories that varied widely.

SHOULD PRACTITIONERS PARTICIPATE IN MEDICARE?

The participating provider program was established by the Deficit Reduction Act of 1984. Under this program, physicians and providers are encouraged to sign a participating provider agreement with Medicare binding them to accept assignment for all services provided to Medicare patients. When a provider accepts assignment under Part B, the payment for services is remitted to the provider and the provider accepts the Medicare-approved charge as payment in full. No additional payment can be collected from the beneficiary (except the co-insurance and deductible).

A physician may elect to be nonparticipating in which case the physician or provider may elect assignment on a case-by-case basis. The reimbursement amount, however, for assigned claims by nonparticipating physicians is 95 percent of the amount paid to participating physicians and providers. If the nonparticipating physician or provider does not elect assignment, payment is made to the Medicare beneficiary and the provider must, in turn, collect the Medicare-reimbursed amount from the beneficiary.

The benefit of being a nonparticipating physician is that the Medicare fee schedule amount (Medicare limiting charge) is slightly greater than the reimbursement for a participating physician (115 percent of the Medicare nonparticipating physician reimbursement). The physician may not, however, bill the patient an amount above the limiting charge. Consequently, nonparticipating physicians must maintain at least two fee schedules (one for Medicare patients and one for all other patients).

EXAMPLE

CPT Code 99213 (mid-level established office visit)—Tennessee rates:

Nonparticipating physician limiting charge—$51.92

Participating physician reimbursement—$47.53

Nonparticipating physician reimbursement—$45.15

If the nonparticipating physician files the claim and does not accept assignment, Medicare will reimburse the patient $36.12 (80 percent of $45.15) and the nonparticipating physician may bill and collect from the patient the limiting charge amount ($51.92). If, however, the nonparticipating physician chooses to accept assignment, the physician will be reimbursed $36.12 by Medicare and may only collect from the patient the co-insurance amount of $9.03 (20 percent of $45.15). The Secretary of HHS is required to monitor the actual charges of nonparticipating physicians to assure that these charges do not exceed the physicians' limiting charge. Failure by a physician to comply with the actual charge limitation rules can cause the physician to be fined or excluded from participation in the Medicare program.

Payment for clinical diagnostic tests performed by clinical laboratories, hospital laboratories, and laboratories in physician offices (with the exception of rural health clinics) are made on an assignment-only basis. Lab services are reimbursed at 100 percent of the fee schedule amount and no deductible or co-insurance is required. Nonphysician practitioners (such as physician assistants and nurse practitioners) are required to accept assignment for all Medicare claims.

Participation in the Medicare program is elected on an annual basis prior to the beginning of the year. Once the year begins the physician or provider cannot elect in or out of the program. Incentives to participate include:

- The establishment and free distribution of participating physician and provider directories
- Carrier toll-free telephone lines through which beneficiaries may obtain the names, addresses, specialties, and telephone numbers of participating physicians and suppliers
- Electronic transmission of claims to carriers
- Higher payment rates on assigned claims
- Direct payment for the Medicare carrier

RURAL HEALTH CLINICS

In 1977, the Congress passed legislation that established criteria for the establishment of federally certified rural health clinics. The law was designed to support and encourage access to healthcare by rural residents. CMS determines if the location of the clinic meets Medicare eligibility criteria of being in a designated medically underserved area.

Healthcare provision to rural populations through rural health clinic certification allows access in areas that otherwise would not have sustainable healthcare. Services may be provided by physicians, nurse practitioners, physician assistants, and include primary care as well as other medically needed services.

Rural health clinics receive cost-based reimbursement from Medicare and Medicaid and are regulated and audited by a federal survey process. Rural health clinics may provide an option for rural providers who are adversely affected by decreases in fee-for-service revenue.

A NEW OPTION FOR PATIENTS: MEDICARE+CHOICE

Just as physicians have a choice about how they will participate in Medicare, so do beneficiaries. Those who choose Medicare+Choice (Part C of the Medicare program) receive their health benefits from managed care organizations. Medicare+Choice was created in an attempt to reduce spending for physician services. Medicare beneficiaries who choose the option of coverage through Medicare+Choice benefit from a reduction in out-of-pocket costs and the elimination of the need for Medigap plans. Additionally, some Medicare+Choice plans provide benefits not included in the current Medicare program, such as prescription drugs, eyeglasses, hearing aids, and dental care. Of course, by using this option beneficiaries limit their choice of providers. Under the fee-for-service arrangement, beneficiaries can choose any physician, hospital, or other healthcare provider and the providers are paid based on the services they provide.

Unfortunately, a number of managed care organizations have reduced their participation in Medicare. Reduced reimbursement coupled with comprehensive new compliance responsibilities under new Medicare+Choice program rules have made it difficult for managed care companies to cover the costs of quality care and provide services that are not

currently available with traditional Medicare (for example, prescription drugs). Medicare beneficiaries who have been notified that their coverage has been cancelled have the option of enrolling in another Medicare HMO or in the original Medicare fee-for-service program.

The CPA consultant can offer assistance to the medical practice by assisting in the review of Medicare+Choice contracts to determine the financial viability for the practice. Additionally, since patients may move between Medicare+Choice plans and between Medicare+Choice and traditional Medicare, it is always important to verify coverage on a frequent basis.

PREVENTING AND SPOTTING MEDICARE FRAUD AND ABUSE

Most physicians are aware of the government's attitude toward healthcare fraud and abuse. Funding for enforcement in all agencies (Office of Inspector General [OIG], FBI, and HCFA [now CMS]) was projected to approximately double between fiscal years 1997 and 2002. The government has made its position clear—healthcare fraud is a priority and will be pursued vigorously. The CPA consultant must be aware of these implications while advising medical practice clients.

The annual HHS/OIG (Department of Health and Human Services Office of Inspector General) Work Plan sets forth the projects to be addressed during the fiscal year by the Office of Audit Services, the Office of Evaluation and Inspections, the Office of Investigations, and the Office of Counsel to the Inspector General. Project areas that are perceived as critical to the mission of the OIG (protecting HHS programs against fraud, waste, and abuse) are outlined in the Work Plan.

The Work Plan as of fiscal year 2003 includes the following areas for physician practices:

- Consultations
- Coding of Medicare physician services
- Coding of evaluation and management services
- Coding of physician evaluation dialysis
- "Long distance" physician claims
- Bone density screening
- Billing for chiropractic care
- Cataract surgery comanagement
- Financial arrangements between physicians and ambulatory surgical centers
- Services and supplies incident to physicians' services
- Reassignment of benefits
- Medicare payments to nonphysician practitioners

The Work Plan can be found in its entirety at http://oig.hhs.gov. Additionally, Fraud Alerts and Advisories are issued periodically by HHS/OIG to identify relationships or conduct which the OIG believes merit recognition as constituting potentially fraudulent activity. The Alerts provide an indication as to what activities will be prioritized for investigation.

The OIG posts new Fraud Alerts and Advisories on its Web site at http://oig.hhs.gov/fraud.html.

The Medicare statutes generally authorize payment only for medical care that is "medically necessary" and of a quality that meets generally accepted professional standards. The statutes impose criminal and civil liability for submission to the government of false or fraudulent claims for payment.

The OIG reported that for fiscal year 1999, it estimated that approximately $13.5 billion of improper payments were made. The estimate was based on a statistical sampling of Medicare fee-for-service claims. The reasons for improper payment ranged from "inadvertent mistakes to outright fraud and abuse." The OIG attributed approximately 32 percent of these improper payments to lack of medical necessity and 40 percent to inadequate documentation. Inadequate documentation may mean that there was no documentation in the patient chart that the service billed was provided or that the documentation was not sufficient for the service billed.

EXAMPLE

In order to bill a 99213 (level III established office visit), the physician must document in the patient medical record at least two of these three components:

1. An expanded problem-focused history was obtained from the patient (chief complaint, brief history of the present illness, and a problem-focused system review)
2. An expanded problem-focused exam (limited exam of the affected body area or organ system and other symptomatic or related organ systems)
3. That the medical decision making was of low complexity (limited number of diagnoses or management options, limited amount and/or complexity of data to be reviewed [lab tests, X-rays, and so on], low risk of complications and/or morbidity)

Failure to properly document these items could create a denial for insufficient documentation in the event of a Medicare audit. These are documentation requirements that should be reviewed by the CPA consultant when performing a coding compliance review (see Chapter 19, "Corporate Compliance Plans").

Liability for healthcare fraud is usually predicated on showing that the physician or provider actions meet the following conditions:

1. The provider submitted (or caused to be submitted) a claim for payment to the federal government
2. The claim was false or fraudulent
3. The person acted knowingly

In determining whether a claim is false, "Guidance on the Use of the False Claims Act in Civil Health Care Matters" (June 3, 1998) directs U.S. Attorneys to:

1. Examine the statute, regulations, and interpretive guidance to determine whether the claims are false
2. Verify the accuracy of the data relating to billing
3. Conduct an appropriate investigation, including interviewing witnesses, and subpoenaing documents (such as medical records, internal billing guidelines, and internal reviews of claims to Medicare)

The term "knowingly" is defined in the Civil False Claims Act (amended in 1986) to mean a person who:

1. Has actual knowledge of the information
2. Acts in deliberate ignorance of the truth or falsity of the information
3. Acts in reckless disregard of the truth or falsity of the information and no proof of specific intent to defraud is required

In the "Guidance on the Use of the False Claims Act in Civil Health Care Matters," U.S. Attorneys are directed to consider the following factors in determining whether a false claim was submitted "knowingly":

1. Notice of billing rules. Was the provider on actual or constructive notice of the policy including guidance from the local intermediary or carrier received personally?
2. Clarity of the rules. Was it reasonable to conclude that the billing rules were understood?
3. Magnitude of the error. Was the error rate so high or the type of error so pervasive that it would suggest reckless disregard or deliberate ignorance?
4. Compliance. Was a compliance plan in place or were other procedures in effect to assure accurate billing? (See Chapter 19, "Corporate Compliance Plans.")
5. History of past billing. Were provider errors previously identified in billing and refunded to the Medicare program? Were prior audits conducted that disclosed errors that continue to be made?

The 1986 amendments to the Civil False Claims Act were clearly designed to establish a reduced intent requirement. The language included in the Act in respect to reckless disregard is intended to be above mere negligence and less than specific intent. In all cases there is an affirmative duty prior to submitting claims to make those inquiries that are reasonable and prudent under the circumstances. As Senate Report 99-345 states:

> The Committee is firm in its intention that the act not punish honest mistakes or incorrect claims submitted through mere negligence. But the Committee does believe the Civil False Claims Act should recognize that those doing business with the Government have an obligation to make a limited inquiry to ensure the claims they submit are accurate.

Criminal Statutes Against Healthcare Fraud

The following criminal statutes are utilized by the Department of Justice in prosecuting healthcare fraud.

Federal Anti-Kickback Statute (42 U.S.C. Sec. 1320a-7b(b))

This statute makes it a crime for anyone to knowingly and willfully solicit, receive, offer, or pay any remuneration directly or indirectly (including bribes, rebates, kickbacks, cash, or in-kind payments) in return for referring an individual for services under any federal health program or in return for purchasing, leasing, or ordering any good, facility, service, or item paid under a federal healthcare program. Each offense is punishable by a fine up to $25,000 or imprisonment for up to five years, or both.

False Statements in Connection with Federal Healthcare Programs (42 U.S.C. Sec. 1320a-7b(a))

This statute makes it a crime (1) to knowingly and willfully make a false statement or representation of a material fact in any application for payment, (2) to knowingly and willfully make a false statement or representation in determining rights to payment, or (3) to fail to disclose or to conceal facts known that affect the initial or continued right to payment. Each offense is punishable by a fine up to $25,000 or imprisonment up to five years or both.

Federal Healthcare Crimes Involving Healthcare Benefit Programs

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established four specific federal healthcare offenses that relate to healthcare benefit plans:

1. Healthcare fraud: Under 18 U.S.C. Sec. 1347, whoever knowingly and willfully executes or attempts to execute a scheme or artifice to defraud any healthcare benefit plan; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program, in connection with the delivery of or payment for healthcare benefits, items, or services may be fined, imprisoned for not more than 10 years, or both.
2. Theft or embezzlement in connection with healthcare: Under 18 U.S.C. Sec. 669, it is a crime for anyone to knowingly and willfully embezzle, steal, or convert the moneys, funds, securities, premiums, credits, property, or assets of a healthcare benefit program. The penalty is a fine or imprisonment up to 10 years, or both.
3. Obstruction of criminal investigation of healthcare offenses: Under 18 U.S.C. Sec. 1518 it is a crime punishable by fine or imprisonment up to 5 years or both to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a federal healthcare offense to a criminal investigator.
4. False statements relating to healthcare matters: Under 18 U.S.C. Sec. 1035, it is a crime punishable by fine or imprisonment up to five years or both for anyone in connection with the delivery of or payment for healthcare benefits to knowingly and willfully falsify, conceal, or cover up by any trick, scheme, or device a material fact or to make any materially false, fictitious, or fraudulent statements or representations or to make or use any materially false writing or document.

General Criminal Statutes

The following criminal statutes are generally applicable to healthcare fraud:

1. False statements (18 U.S.C. Sec. 1001): Applies to any false statement submitted directly or indirectly to the federal government (such as Medicare claim forms).
2. False claims (18 U.S.C. Sec. 287): Applies to any false claim for payment submitted to the federal government (such as claims for procedures not performed or claims for unnecessary services or procedures).
3. Mail fraud (18 U.S.C. Sec. 1341 and Wire Fraud, 18 U.S.C. Sec. 1343): Applies to use of the mails (U.S. Postal Service) or wire (interstate telephone transmissions) in furtherance of a scheme or artiface to defraud.
4. Conspiracy (18 U.S.C. Sec. 371) and Conspiracy to Defraud the Government with Respect to Claims (18 U.S.C. Sec. 286): Applies to agreements between two or more people to violate the law.

In addition to the criminal statutes applicable to healthcare, there are three principal civil statutes. The civil false claims statutes are available to the Department of Justice and the OIG in seeking civil damages or exclusion from federal healthcare programs for false or fraudulent claims.

The Civil False Claims Act (31 U.S.C. Sec. 3729-3731)

The primary statutory authority used by U.S. Attorneys to conduct civil investigations of healthcare fraud is the Civil False Claims Act. It provides for triple damages and a civil penalty of not less than $5,500 or more than $11,000 for the presentation of false or fraudulent claims for payment or for making or using a false record or statement to obtain reimbursement on a false claim. The statute also provides for private persons to file "qui tam" actions of behalf of the United States. If the government proceeds with the action the qui tam relator is entitled to between 15 percent and 25 percent of the recovery or settlement.

Program Fraud Civil Remedies Act (31 U.S.C. Sec. 3801-3812)

Under this Act, any person who presents a claim that the person knows or has reason to know is false, fictitious, or fraudulent or is supported by any written statement that asserts a material fact that is false or omits a material fact is subject to a civil penalty of not more than $5,000 for each claim and the recovery of damages of not more than twice the amount of the claim.

Civil Monetary Penalties (42 U.S.C. Sec. 1320a-7a) and Exclusion Authority (42 U.S.C. Sec. 1320a-7)

The Civil Monetary Penalties Law allows the OIG to begin administrative proceedings to impose civil monetary penalties and assessments of damages for improperly filing claims, for payments to induce the reduction or limitation of services, and other abuses. The OIG may seek civil monetary penalties for the following offenses:

—Presenting a claim that the person knows or should know is false ("should know" is defined in the Act to include "acting in deliberate ignorance or in reckless disregard of the truth or falsity of the information and no proof of specific intent to defraud is required").

—Presenting a claim for a service not provided as claimed
—Engaging in a pattern or practice of upcoding
—Presenting claims for physician's services not performed by a physician
—Violation of the anti-kickback law
—Contracting (by employment or otherwise) with someone who has been excluded for participation in a federal healthcare program
—Payments by hospitals to physicians as an inducement to reduce or limit services to patients

Penalties may range from $2,000 to $50,000 for each improper act and assessments in lieu of damages up to three times the amounts claimed or remuneration offered, paid, or received.

Additionally, the Secretary of HHS, acting through the OIG, has the authority to exclude from participation in federal healthcare programs persons or entities who are convicted of certain crimes, including program-related crimes, patient abuse, felony convictions for healthcare fraud, and felony convictions relating to controlled substances.

CLAIMS APPEALS PROCESS

An initial determination must exist to start the appeal process. To obtain an initial determination, a claim is submitted for reimbursement and Medicare's decision on that claim becomes the initial determination. A common form of initial determination is the Explanation of Medical Benefits (EOMB) sent by the carrier to the beneficiary (patient) or the provider (if the physician is participating or benefits have been assigned).

If the physician receives an adverse initial determination or other challenge to payment or coverage, the first step should be to negotiate with the contractor. The willingness of contractors to negotiate varies from region to region. A negotiated settlement is the most expeditious, cost-effective avenue to settle a dispute over a submitted claim denial.

If the carrier changes an initial Part B determination in a post-payment audit, the provider or beneficiary has the right to the following forms of appeal:

- Carrier fair hearing—amount in controversy is greater than $100
- Review—amount in controversy is less than $100

Additionally, if the carrier does not act upon a request for payment within 60 days (from date of claim filing), a carrier fair hearing can be requested on the delayed claims.

The Part B appeal process consists of five steps:

1. Request for review: The request must be made in writing and must be made within six months of the initial determination. A decision should be issued within 45 days of the receipt of request for review.
2. Carrier fair hearing: For disputed amounts greater than $100, the physician may request a fair hearing. The request must be made within six months from the review determination and must be in writing. The physician may appear in person, submit a written argument, or have a telephone hearing. Carrier fair hearings are bound by CMS's interpretations of the law. The fair hearing will be scheduled so that a decision is rendered within 120 days after receipt of the request.

3. Administrative law judge (ALJ): In order to request an ALJ hearing, the amount in dispute must be greater than $500. The request for an ALJ hearing must be made in writing within 60 days of receipt of the reconsideration determination or review determination. ALJs are not bound by CMS's interpretations.
4. Medicare Appeals Council: A Medicare Appeals Council hearing must be requested in writing within 60 days of the receipt of notice of the ALJ decision. The Appeals Council can decline to review an ALJ decision in which case the physician may appeal to federal court or the case may be remanded to the ALJ for further consideration or action.
5. Federal Court: In order to appeal to federal court, the amount in dispute must be greater than $1,000. The request must be filed within 60 days of the Medicare Appeals Council's decision.

Practice Tip: If a physician is audited by Medicare and appeals the decision, the assistance of legal counsel (attorney with healthcare reimbursement expertise) is recommended. The CPA consultant may assist the physician or may provide litigation support services to the attorney in reviewing the audit report and gathering and analyzing information to assist in the rebuttal.

FURTHER SOURCES OF INFORMATION

The CPA consultant can provide a valuable service to the medical client by assisting the client in being aware of and complying with Medicare regulations. This is not an easy task since there are over 100,000 pages of Medicare regulations. However, it is imperative to be aware of the basics and to be familiar with Local Medical Review Policies and those illustrated in Table 6-1, "Medicare and Medicaid Resources."

TABLE 6-1 MEDICARE AND MEDICAID RESOURCES

Online Medicare training is available at the CMS Web site (see below).

Topics available are extensive and include:

a. ICD-9-CM Coding
b. Medicare Fraud and Abuse
c. Front Office Management
d. Medicare Secondary Payer
e. HCFA-1500
f. HCFA-1450-UB92

TABLE 6-1 MEDICARE AND MEDICAID RESOURCES *(continued)*

Centers for Medicare & Medicaid Services (CMS)	www.cms.gov
Federal Register	www.access.gpo.gov/su_docs
Office of Inspector General	www.dhhs.gov/progorg/oig
Local Medical Review Policies	www.lmrp.net
CCH Medicare and Medicaid Guide	www.cch.com
Medicare *Part B News*	www.partbnews.com
St. Anthony Publishing/ Medicode/CHIPS (Igenix)	www.ingenixoline.com
OIG Compliance Program Guidance for Individual and Small Group Physician Practices	http://oig.hhs.gov/fraud/complianceguidance
American Medical Association	www.ama-assn.org

SUMMARY

Inadequate knowledge of the regulations pertaining to Medicare billing can result in reduced reimbursement, at a minimum, and if proven false or fraudulent can result in civil and/or criminal implications. If a practice provides treatment to Medicare patients, they must invest in the resources and education to provide the most up-to-date information. Carelessness or lack of appropriate information can result in serious penalties.

Section 2

Medical Practice Review

Chapter 7

How to Define the Medical Practice Engagement

The medical practice review process is typically initiated when the medical practice perceives a need to improve operations and hence, the bottom line. For example, a comprehensive medical practice review—what we call a "fiscal physical"—may be appropriate for a practice experiencing a general decline in net income and an overall feeling of chaos in practice operations. The "symptoms" may be scheduling complaints from patients, long wait times for appointments, and incorrect billings.

The comprehensive medical practice review is a service through which the CPA consultant reviews and provides input on all operational aspects of the practice. It is typically not limited in scope and, depending upon the practice size and specialty, might include:

- Review of job descriptions and organizational flow
- Review of all forms and reports used by the practice
- Review of physical layout of office in relation to operational flow
- Review of internal controls
- Review of procedures for accounts payable
- Overhead analysis
- Documentation and review of policies and procedures regarding the capture of income and billing for services
- Documentation and review of procedures for third-party reimbursement, tracking, and handling denials
- Review of procedures for collections and payment posting
- Review of fee schedule
- Review of coding and documentation
- Review of policies and procedures regarding the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A limited review may be appropriate if the practice has identified a perceived area of weakness.

EXAMPLE

A limited review of billing and collections would be appropriate for a practice with a decline in the collection percentage. In a limited review of billing and collections you might:

1. Review procedures for posting charges. Are charge tickets posted timely (within one day from day of service)?
2. Review procedures for billing third-party payers. Are claim forms submitted daily?
3. Review a sample of explanations of benefits to determine if there are consistent denials from third-party payers (such as problems with timely filing or medical necessity).
4. Review procedures for collecting from patients at the time of service. Are co-pays routinely collected (preferably when the patient registers for the visit)?

Based on the information collected, the practice would be provided a written summary of the findings along with recommendations to improve billing and collections.

HOW TO DETERMINE THE TERMS OF THE ENGAGEMENT

At the outset, you need to come to an understanding with the client as to the terms of the engagement. What follows, then, are the aspects of the engagement you need to address and which will form the basis for the engagement letter.

Identifying the Client

In most cases the client will be the medical practice. However, in some instances the practice attorney may engage you in order to preserve confidentiality. In other instances, the client may be a third party requesting an independent evaluation of the operations of the practice.

EXAMPLE

A hospital may request a comprehensive review of a practice it plans to acquire to determine deficiencies in operations that may need to be addressed (such as coding discrepancies) prior to the transfer.

Defining the Problem and Expected Outcome

Just as the client should define the problem, the client should also establish the anticipated outcome from the engagement. However, you must guide the client and provide a much-needed "reality check." For instance, assume the client is concerned about practice collections and anticipates that the consultant recommendations will enable the practice to achieve a 90 percent gross collection percentage. You need to explain that this is an unrealistic expectation. Or, what if the client assumes that the billing system is the cause of collection deficiencies? He or she will naturally anticipate that the result of the practice review will be a recommendation for a specific change to a new billing system. Yet, if you intend to provide an overall evaluation of operations and do not plan to research and recommend a new billing system, you need to discuss that limitation with the client.

The engagement letter formalizes the agreements reached through the pre-engagement discussions with the client. The engagement letter encompasses all aspects of the proposal (definition of the problem, description of the process, time frame, staff assigned, limitation of results, and anticipated fee). A clear pre-engagement understanding forms the framework for a successful project. If you do not listen and communicate carefully with the client at this stage, the review may not achieve the desired outcome for the client and may result in a nonprofitable engagement for you.

Assume, for example, that you visit your physician and he or she begins an examination and commences diagnostic tests without ever inquiring as to your medical problem. The physician may, by luck, be able to adequately treat your ailment, however, much time will be wasted and, in the end, you may not feel that you were treated properly.

To continue the medical analogy, the clients need to tell us "where it hurts." Too often, consultants rush in and begin testing without allowing the clients to voice their concerns.

Describing the Process

You will need to provide the client with an overview of the entire practice review process and your requirements as you go through the process. Details of the process are discussed in the remaining chapters in this section. For instance, tell the client you will need a work area for conducting an on-site review to interview a representative group of physicians and employees. Additionally, the client should understand that you will request a sample of practice data (see Tool 7-A, "Data Information Request and Survey") to be revised and tested (see Chapter 9, "How to Analyze and Test Data to Improve Medical Office Operations").

Tool 7-A: Data Information Request and Survey *(Toolkit CD-ROM)*

If the client is reluctant to allow you to interview employees, you should carefully evaluate whether to accept the engagement. Likewise, if access to data is restricted, the results of the review may be rendered worthless.

Setting the Time Frame

The client and the consultant should agree on dates both to begin and complete the engagement. The site visit should be planned to coincide with the schedule of the client. If the on-site review commences prior to the client providing availability of staff and access to data, the engagement time may be inefficient. Since medical office operations are dynamic and ever changing, the report should be delivered expeditiously in order to enhance its effectiveness and applicability.

Providing the Names and Qualifications of Individuals Involved in the Project

The client should be provided with the names and qualifications of the staff that will be participating.

Setting an Anticipated Fee

The client typically will request that the consultant provide a range of fees for the project. Estimating a reasonable fee for the engagement may be the most difficult component. Not only must you establish a fee that is perceived as fair and reasonable to the client but you must also maintain an appropriate rate realization and profit on the engagement.

Establishing an appropriate fee is dependent on proper planning and supervision during the engagement. The in-charge consultant should plan the engagement process and determine the staff to be assigned, estimate the hours needed to accomplish each step of the process, and base the price on the hourly rate of the staff assigned to each phase of the process.

Additionally, the agreement should provide that if an unanticipated need arises (that is, not covered by the scope of the practice review—such as tax or entity planning), the client will be billed separately for that service. The client will receive a "change order" and must agree to be responsible for the cost of the add-on service in addition to the fee for the practice review.

EXAMPLE

While you are conducting a practice review for Family Doctors, the physicians ask you to review their most recent corporate return for tax planning recommendations and observations. The engagement letter should provide that additional services (such as tax planning) performed outside the scope of the review will be billed separately.

Since protected health information (PHI) will be accessed (for example, for review of coding), the engagement letter should include a business associate agreement (see Tool 7-B for a sample) in conformity with HIPAA regulations.

Tool 7-B: Business Associate Agreement *(Toolkit CD-ROM)*

HIPAA mandates that all covered entities put in place administrative, technical, and physical safeguards to ensure the privacy of the protected health information they maintain on their clients. Under the regulation, a covered entity is defined as a healthcare provider (physician offices, surgical centers, hospitals, and so on), a third-party payer (insurance companies), or a clearinghouse (financial intermediaries). At times, these covered entities might solicit the services of an external party to perform duties on their behalf that requires the explicit release of protected health information to these outside businesses. For example, a physician's office might hire a medical transcription service to record the physician notes. Since the transcription service is not a covered entity, it is not bound by HIPAA regulations, but clearly the protected health information is at risk. In these cases, HIPAA requires that the covered entity execute a contract, called a business associate agreement, with the outside party that they release information to—therewith known as a business associate. This contract binds the business associate to safeguard the protected health information in the same way that the covered entity is required to under HIPAA.

The engagement letter formalizes the agreements reached through the pre-engagement discussions with the client. The engagement letter encompasses all aspects of the proposal (definition of the problem, description of the process, time frame, staff assigned, limitation of results, and anticipated fee). Tool 7-C contains an engagement letter for a comprehensive review and Tool 7-D contains an engagement letter for a limited review.

Tool 7-C: Engagement Letter—Comprehensive Review ***(Toolkit CD-ROM)***

Tool 7-D: Engagement Letter—Limited Review ***(Toolkit CD-ROM)***

SUMMARY

Defining and documenting the engagement is an integral part of the consulting process. Ill-defined engagements may result in dissatisfied clients and, at the very least, in time incurred on the engagement that may not be able to be billed. Accurately defining the problem and expected outcome along with the anticipated fee is the key to a successful and profitable engagement.

Chapter 8

How to Form Your Preliminary "Diagnosis": Gathering Data and Interviewing Employees

You can only assess a medical practice's strengths and weaknesses properly by making sure you are looking at the right information, talking to the right people, and asking the right questions. A scan of a billing system report, indicating charges by current procedural terminology (CPT) code, may reveal, for instance, that office visits are consistently being charged at the highest level.

In your interview with the employee responsible for coding, you can then focus on trying to get answers for why this is occurring. Hence, your interview will be more productive. Then, you can verify your own assumptions and your interview findings by testing a sample of the billing data (which we show you how to do in Chapter 9).

In this chapter, we focus on the data gathering process. You'll discover which reports to request and what areas the data will help you evaluate. Then you'll learn which employees to interview, what to ask them, and how to use both the data you've gathered—from reports, employee questionnaires, and the interview itself—to come up with a list of areas to troubleshoot when you test the data.

THE MOST USEFUL REPORTS AND DATA

Here is a list of the data most commonly used in conducting a medical practice review. The list includes management reports, which should be available from the practice billing system, financial reports, and benchmarking data. You will want to obtain management reports and financial statements for the current period and perhaps the prior three years so that trends can be reviewed.

1. Financial statements
2. Billing system report indicating charges by CPT code
3. Billing system report indicating charges by provider, location, and specialty
4. Billing system report indicating charges by payer class
5. Billing system report indicating aged accounts receivable by payer class
6. Billing system adjustment report
7. Billing system report—day end summary
8. Benchmarking data (such as the Medical Group Management Association Cost Survey; http://www.mgma.com)

THE MEDICAL PRACTICE INTERVIEW

Interviews are an integral part of the practice review. Relying on data solely to develop assumptions and recommendations would be shortsighted and risky. The numbers only tell part of the story. As with a golf score card, the numbers will tell if you won or lost, but not how to improve your swing. The interviews will help you see the inner workings of the office and how everything comes together, from patient visits to charge capture and claim processing. These interviews also help you get a better understanding of job responsibilities, making it easier to get the necessary information to form appropriate recommendations on improving operations.

EXAMPLE

A review of the charge and payment report may indicate a below-average collection percentage. Without any input from the staff, the consultant might recommend that the practice send claim forms to payers on a daily basis. Interviews with insurance staff, however, may confirm that claims are going out daily and that the real issue is lack of staff for follow-up.

Using Tailored Questionnaires Prior to the Interview

Tool 24-A, "Sample Internal Control Questionnaire" (on the *Toolkit CD-ROM*), is a sample questionnaire that serves as an example for the type of questions for the interview process. Although questionnaires are helpful to ensure that all necessary areas are covered, the interview should not be restricted by the questionnaire. Interviewing is a fluid process.

Employees to Interview

Request a list of all employees, with job titles, and dates of hire, prior to scheduling the interviews. At a minimum, you should interview a supervisor or manager in each department along with a rank-and-file employee. In addition, you should ensure that a representative employee from each office function will be interviewed. Since the clinical functions interface with the business office functions in the areas of charge capture and coding, it is important you interview employees in both areas. It is likewise beneficial to include both long-term and short-term employees so you can obtain both perspectives.

An example of selected interviewees may include:

- *Administrative*—Administrator/office manager
  —Bookkeeper
- *Front office*—Front office supervisor
  —Receptionist
  —Scheduler
- *Billing and insurance*—Billing and insurance supervisor
  —Charge input clerk
  —Payment poster
  —Coding employee
  —Claims filing clerk
  —Claims follow-up
  —Patient statements and collections clerk

- *Medical records*—Medical records supervisor
  —File clerk
- *Clinical*—Clinical supervisor
  —RN, LPN, or med-tech

Not only is it important to interview a supervisor and employee in each department, representing each job function, it is likewise beneficial to interview employees within each department or location, if the practice maintains multiple locations or departments.

Additionally, you should interview a representative sample of physicians. In smaller practices (fewer than five physicians), it would be advisable to interview each physician. For practices with more than five physicians, you may interview a selected sample (such as by department or specialty, location, or administrative responsibility). If the practice is of sufficient size to be governed by an executive board and committees, you should interview the board members and committee chairpersons.

Scheduling the Interviews

You will need to schedule interviews so that the physicians and employees can set aside sufficient time from their routines to meet with the CPA consultants. Interviews of all employees with the exception of practice leaders should be scheduled at 30-minute intervals with perhaps a 10-minute break between each interview. For interviews with the administrator or physician CEO you'll need to schedule at least one hour; these interviews should be scheduled first to assist in setting the stage for all other interviews.

It is important to "manage the interview" so the engagement stays within budget. Having the feedback from the questionnaire will certainly help you do that as it allows you to focus on problem areas. You should advise the interviewee at the beginning of your meeting of the time allocated and, in general, the areas you plan to cover. Keep in mind that while the employee should be encouraged to offer opinions and observations freely, the interview is not a therapy session. If not properly managed, the interview may not only exceed the budget but may also not provide you with the appropriate information.

The interviews should be conducted in a location that will provide some degree of privacy. If possible, however, the interview should be conducted in the employee's work area. This will allow you to obtain samples of forms, memos, and so on used by the employee while the interview is going on. Additionally, you'll have the opportunity to observe the employee in his or her work environment.

Interviewing Techniques

The interviewer must actively listen in order to direct and reassess questions based on the interviewee's responses. Active listening requires the interviewer to:

1. *Use appropriate body language.* Make eye contact with the interviewee and respond appropriately by nodding your head or other expressions to indicate an understanding of the interviewee's comments. You do not have to become a "bobbing head doll"; however, body language can encourage openness and responsiveness.

2. *Stay in present time.* Give your full concentration to the interviewee. If you allow your mind to wander and do not pay attention, the lack of attentiveness will be evident to the interviewee. This may affect responsiveness and cause you to miss important information.
3. *Take notes.* As much as possible, all responses should be documented. Obviously, information committed to mental storage may be forgotten or distorted. Reviewing and compiling interview notes are an integral component of the review process. Additionally, taking notes indicates a high level of interest in the responses to questions and will encourage the interviewee to be open and informative.

Every employee has an opinion. The following general questions should be asked of each interviewee regardless of position or job responsibility:

1. *What are your job responsibilities?* Each employee should be asked to verbalize his or her basic job duties. Ask the employee to describe a typical work day. Interestingly, you may discover that the employee's actual duties do not correspond to his or her formal job description; they may not even agree with the employer's perception of their duties.
2. *What do you think works well in the practice?* Ask about the employee's perception of those procedures that allow the office to operate efficiently. For example, a billing employee may feel that the computer system enables them to perform their duties efficiently.
3. *What do you see that could use improvement?* Ask the employee to name at least one thing that, if changed, would allow them to perform their job more efficiently. For example, if the billing software is cumbersome and outdated, the billing employee may feel it impedes his or her efficiency.

The information obtained through interviews will assist the consultant in the testing function. For example, if bank deposits are only made once a week, the consultant may need to increase the testing regarding cash receipts. Likewise, if charges are posted weekly, the consultant may want to expand testing to insure that all charges are captured.

Of equal importance during the interview phase is the general observation of office operations. Based on the work routines identified in the interviews combined with observations of workflow, the consultant should be able to flowchart the paperwork flow from check-in to payment at the conclusion of the interview phase.

OBSERVATIONAL SKILLS

Another data gathering skill that is overlooked is observation. Seeing is believing. People may not feel free to comment in their interview, but may reveal important information just by doing their jobs in your presence. Considering the following questions when you are on-site will be important in the overall assessment of office efficiency:

1. Are the employees routinely interrupted? If so, the organizational structure may not allow for the handling of duties at the most efficient level. Likewise, employees make lack the training to efficiently handle their duties, thus, requiring too much assistance.

2. Do employees appear to be frantic and constantly putting out fires? All too often medical offices resemble a battleground, constantly under attack and responding to routine bombings. If the office is frantic, this is a sign of poor procedures and a general lack of organization and appropriate supervision.
3. Is there excessive loitering and chatting? If the employees appear to have too much free time, this may be an indication of overstaffing. It may also be a symptom of poor supervision—there may be plenty of work to be done; however no one feels inclined to do it.
4. Does the office layout appear to discourage efficiency? The consultant does not have to be an engineer to recognize major layout inefficiencies. For instance, if patients are attempting to check in and out at the same window, collection efforts and charge capture may both be impaired. If the check-in and out window is overly busy, the patient will not be inclined to wait to pay and may be encouraged to leave the practice with their charge ticket in hand.

In some practices, business office space is sacrificed for clinical space. If the business office is too small or departments are inconveniently located in relation to one another, the inefficiencies incurred can create financial implications.

SUMMARY

As in the physician-patient relationship, in order for the consultant to properly diagnose and recommend treatment, data gathering and interviews must occur. In the process of formulating a diagnosis both (data gathering and interviews) are equally important. The consultant must be aware of the obvious issues provided through the data and the not-so-obvious issues that may be determined through interviews and observations. Accumulating data during this segment of the engagement (reports, notes of interviews, and observations) is essential for appropriate analysis.

Chapter 9

How to Analyze and Test Data to Improve Medical Office Operations

Once you have gathered the data and completed on-site interviews, you are ready to test specific areas of the data. You will use sampling techniques (typically nonstatistical sampling) in the testing process. Based on the information obtained in the interviews, you can expand testing in certain areas. For instance, if you find that the cashier is only making bank deposits once a week, you can expand your testing for controls over cash receipts.

The areas to be tested include the following and you will find how-to guidelines on analyzing each of them in the sections that follow:

- Charge data (capture and compliance)
- Collection data and cash controls
- Insurance (filing and follow-up)
- Practice overhead
- Human resources

In order to efficiently analyze the data gathered and provide recommendations, the consultant should consider performing a SWOT analysis. In the context of the medical practice review, the acronym stands for *S*ituations, *W*eapons, *O*bjectives, and *T*actics.

EXAMPLE

Situation—A review of a sample of patients on the daily office schedule to billed charges indicates that approximately 5 percent of office visits are not posted to the billing system.

Weapons—The billing system has the ability to print charge tickets and numerical sequence and will likewise prepare a missing ticket report.

Objective—Establish a system to ensure all office visit charges are captured.

Tactics—Print charge tickets in numerical sequence, prepare a missing ticket report daily, and investigate discrepancies, batch charge tickets, and post daily.

TESTING FOR ACCURATE CHARGE CAPTURE: HOW TO ENSURE THAT ALL SERVICES PROVIDED ARE BILLED AND CODED IN COMPLIANCE WITH FEDERAL REGULATIONS

The goal for posting medical office charges is that the information be posted in a timely and accurate manner, in compliance with all applicable federal regulations. Correctly recording charge data is essential to the financial success of the practice. Poor procedures and inefficiencies can result in financial losses and regulatory implications.

Office Charges

Office charges are going to make up the majority of the sample at most physician offices. These charges are made up of all outpatient nonfacility charges. Nonfacility charges are typically those procedures performed in a physician office. Charges are initially recorded on the charge ticket/encounter form/superbill and then entered into the billing system by a staff member.

Data Required for Testing

You'll need the following information:

1. Charge ticket
2. Daily reports of charges billed
3. Office appointment schedule and registration

To test for inefficiencies in charge capture, trace a sample of the registration or appointment schedule to the charges posted for the day as summarized in the billing report's day end summary (see Tool 9-A, "Service Date to Date of Posting Form").

Tool 9-A: Service Date to Date of Posting Form *(Toolkit CD-ROM)*

If the patient was registered and no corresponding charge was posted, the consultant should retrieve the chart to ascertain that services were provided. If services were in fact provided and no charges were posted, this would be an indication of a weakness in the system. Are prenumbered charge tickets used? Is the missing ticket report generated daily and researched for discrepancies? To insure that all office charges are captured, it is important that the practice utilize prenumbered charge tickets and that all ticket numbers are accounted for prior to posting. Many billing systems will assign ticket numbers as the charge ticket is generated. In the posting process, a missing ticket report can be generated to identify any charge tickets that went astray. All charge tickets should be accounted for in numerical sequence and batch totaled before posting. A summary ticket identifying the charge ticket numbers included in the batch along with the batch totals (total charges, a hash total of current procedural terminology [CPT] code) should be attached to each batch and should be reconciled with the total posted to the billing system.

Practice Tip: Not only do unposted charges represent lost revenue, this may likewise be an indication of embezzlement. If a patient charge is recorded on the system, either a payment or adjustment must be posted to clear the account. Conversely, if the charge is never posted, any payment received may be "pocketed" with no paper trail on the billing system.

Not only must charges be reconciled with services rendered, but they also must be posted in a timely manner. In order to test for prompt charge capture, the CPA should reconcile a representative sample of daily charge posting summaries to the batch summary and any time lag from date of service to date of posting. (See Tool 9-A, "Service Date to Date of Posting Form.") There should never be more than a one-day lag from time of service to date of posting. Most third-party payers maintain timely filing limits for reimbursement. If the claim form is not submitted within the timely filing period from date of service (in some cases 60 days), the claim will be denied.

Not posting charges in a timely manner can also create a ripple effect in the billing process. Even if the primary insurance claim form is filed within the time limits, secondary insurance claims (which are not filed until primary insurance remits) will be delayed. Additionally, the collection of any self-pay portion due from the patient (such as co-insurance) will also be delayed, creating collection difficulties.

Hospital Charges

Hospital charges are the facility charges, or those charges incurred by a physician for a patient based in a hospital setting. This charge can be anything from a procedure to an inpatient consultation.

Data Required for Testing

You'll need the following information:

1. Hospital log (surgical log, hospital census)
2. Daily reports of charge entry

While the prenumbering of charge tickets provides internal control for the capture of office services and procedures these controls are not present in the hospital setting. The office staff is typically at the mercy of the physician to report services provided outside of the office. As noted in Chapter 2, "Medical Office Revenue: How and Where It Is Generated and Captured," in some practices physicians are provided index cards with the patient census on which they can indicate patients seen in the hospital. Physicians can carry these cards in their pockets and turn them in to the office staff for billing purposes on a daily basis.

In the case of a surgical practice, the office staff typically relies on the hospital documentation (face sheets) and operative reports provided by the physicians to bill for services rendered. In anesthesia and radiology practices, the billing office likewise relies on hospital documentation to establish demographic data (name, date of birth, address, insurance coverage, and so on) and bill for services based on the anesthesia and radiology reports prepared by the physician. In the process of gathering data and interviewing employees you will have found out how hospital visits or services are recorded and you will use a sample of these printouts along with the applicable billing report to conduct your test.

To test the capture of hospital services you will trace either the doctors' records or the hospital census to the billing system. In the case of surgical practices you will compare the surgery log or schedule maintained by the practice to charges posted on the billing system.

To ensure that anesthesia charges are captured the anesthesia or surgery schedule can be compared to charges posted on the billing system. Hospital employees typically schedule in-patient and outpatient radiology services. You should request a copy of the hospital schedule for radiology and trace a sample to the billing records.

Compliance

Section 5, "Limited Medical Practice Engagement Opportunities," addresses the procedures involved in designing a corporate compliance plan. With the publication of the Office of Inspector General's (OIG) Model Physician Compliance Plan in the *Federal Register* on June 12, 2000, all medical practices should be encouraged to implement a compliance program.

An integral component of the compliance plan is the baseline audit, which assists the practice in identifying areas of potential weakness in billing processes. The CPA consultant, with appropriate training and resources, can assist the medical practice by providing an independent baseline audit. However, as discussed in Section 5, the CPA consultant should be engaged by legal counsel for the medical practice, thus protecting client confidentiality.

In the context of the practice review, the consultant must carefully weigh the extent to which coding compliance will be included as a component of the review and whether the extent of compliance work creates a need for the engagement to be performed through the practice's attorney. (See Tool 9-B, "Sample Chart Audit Worksheet.")

Tool 9-B: Sample Chart Audit Worksheet *(Toolkit CD-ROM)*

IDENTIFYING PROBLEM PAYERS

Problem payers can be those insurance payers who do not pay in ample time after the charge is submitted, or deny payments causing the practice to resubmit the payment. They can also be paying below the agreed-upon contracted rates.

Data Required for Testing

As a first step identifying problem payers, you should obtain an aging of accounts receivable by payer class (that is, managed care, Medicare, Medicaid, and so on). First you will compare the aging totals to prior years and to the median for the specialty.[1]

[1] Medians are published annually by the Medical Group Management Association (MGMA) in the MGMA *Cost Survey*, Aging of Accounts Receivable by Payor Class, Median Operational Statistics by Specialty.

EXAMPLE
XYZ PRACTICE ACCOUNTS RECEIVABLE AGING

Days	2002	2003	Median
0-30	35.60%	32.90%	43.90%
31-60	21.00%	19.80%	15.45%
61-90	10.30%	9.70%	8.38%
Over 90	34.30%	40.10%	22.69%

Assume that the above aging data is obtained from the XYZ Practice. What do you notice? The "over 90" is above the median in both 2002 and 2003 and, furthermore, increased by 17 percent from 2002 to 2003. You may have also noted that the 61-90 day category was over the median in both 2002 and 2003. It appears that a consistent delay in payments from the 31-60 day category is contributing to the increase in the over-90-day category. If the cause of the inefficiency is not identified and remedied, the over-90-day category will most likely continue to increase.

One way to get to the bottom of this problem is to use the detailed report prepared by payer class. This will assist you in identifying potential payer problems. For instance, the aging may reflect an excessive amount of Blue Cross accounts in excess of 90 days. This information will allow the consultant to focus review activities on specific payers.

EVALUATING EFFECTIVENESS OF COLLECTION POLICIES AND PROCEDURES

Data Required for Testing

You will need the gross collection percentage for the current year and three prior years. It is helpful to identify the gross collection percentage for the practice and compare the percentage with prior years and with the median percentage for the specialty.

> *CAUTION:* It is important to use the gross collection percentage (collections divided by gross charges) versus the net collection percentage (collections divided by charges net of adjustments). Although some adjustments are purely contractual (allowed fee as opposed to billed fee), other adjustments may occur due to denied claims and uncollectible accounts.

EXAMPLE
XYZ SURGICAL PRACTICE GROSS COLLECTION PERCENTAGE

2002: 50.50%

2003: 49.5%

Median: 65.75%

This example reflects gross collection percentage that is certainly less than the median for the specialty in both years reviewed. Yet when evaluating collection efficiency in light of the gross collection percentage, it is dangerous to look only at the benchmark figures. You should also consider two internal factors that can affect the gross collection percentage for a practice:

1. *Practice fee schedule.* Is the practice above or below the average fee range for the most performed services? Several publications exist which compile average fees by locality. These publications provide fee ranges for each CPT code. Assume, for example, that the practice is currently charging $50 for a mid-level established office visit (99213) and the range for that service is $56-$71. Obviously, the lower-than-average fee should positively affect the gross collection percentage. Conversely, if the fee for the same service is $90, the gross collection percentage might well be lower than the median.

   In some instances a practice may utilize multiple fee schedules (that is, one for Medicare patients representing the Medicare fee schedule and one for all other patients). If the practice bills the "allowed" fee for services rendered there should be no contractual adjustment. Consequently, the gross collection percentage should be higher than the median.

2. *Practice payer mix.* What percent of practice charges are Medicare, Medicaid, and so on? If the median Medicare practice mix for the specialty is 25 percent and the practice has 35 percent in Medicare revenue, the gross collection percentage may be affected.

SETTING AN INDIVIDUAL TARGET GROSS COLLECTION PERCENTAGE

A weighted average should be established using the MGMA benchmarks and current collection percentages gathered from the practice explanation of benefits (EOB) analysis to establish a target collection percentage. This percentage, being weighted by the above factors, should be easy to reach and maintain by the physician practice.

Data Required for Testing

You will need reports on volume of charges by CPT code, charges by payer class, and gross collection percentages by payer class.

1. Identify the top 20 procedures performed by the practice based on charge volume. In order to obtain this data, the practice should provide a report, indicating the volume of charges by CPT code. Typically, the top 20 CPT codes will account for 80 percent of total charges.

2. Establish the practice payer mix. For example, what percent of the practice gross charges are for Medicare patients? To obtain this information, the practice should provide a report indicating group charges by payer class.
3. Review the reimbursement for the top 20 procedures by each of the major pay classes to estimate the collection percentage by pay class.

   In the above example, assume that Medicare constitutes 25 percent of gross practice charges and the overall allowed fee on the top 20 CPT codes equates to a Medicare collection percentage of 55 percent. The Medicare portion of the target collection computation would be as follows:

% of Practice	×	Collection %	=	Target collection component
25%	×	55%	=	13.75%

A similar exercise would be performed with other major pay classes with the total computation as follows:

TARGET COLLECTION PERCENTAGE FOR XYZ SURGICAL PRACTICE

Payer	% of Practice	× Collection %	= Target Component
Medicare	25%	55%	13.75%
Medicaid	5%	40%	2.00%
Aetna	20%	57%	11.40%
Blue Cross	25%	60%	15.00%
Other insurance	20%	65%	13.00%
Self-pay	5%	30%	1.50%
		Target collection %	56.65%

The median collection percentage for a general surgery practice[2] is 46.49 percent and the median percentage of Medicare patients is 30 percent, whereas XYZ Surgical Practice has a Medicare payer mix of 25 percent. Maintaining a Medicare payer mix below the median positively affects the XYZ Surgical Group's gross collection percentage. Additionally, the fee schedule for XYZ Practice may be lower than the average for the top 20 CPT codes.

Based on the above analysis, if the consultant had recommended the median collection percentage as a target for the practice, the bar would have been set too low. Conversely, if the practice maintained a high mix of Medicare patients and an above average fee schedule, using the median as a collection goal may have established unrealistic expectations for the practice.

[2] *Source:* The Medical Group Management Association: *Cost Survey 2002 Report Based on 2001 Data.*

EXAMPLE
DAYS IN ACCOUNTS RECEIVABLE

XYZ Practice	20XX	75.36 days
XYZ Practice	20XY	80.54 days
Median		71.97 days

In this example, the days in receivables have increased from 20XX to 20XY and in both years have exceeded the median. A slow turnaround on receivables is an indicator of collection inefficiencies. Conversely, if days in receivable are low and the gross collection percentage is low, the practice may be adjusting accounts inappropriately.

TESTING FOR CASH CONTROLS

Data Required for Testing

You will need the following information:

1. Daily bank deposit slips
2. Daily report of payments posted
3. Sample of charge tickets for office visits

Cash control testing should include tracing a sample of payments posted to the billing system to actual bank deposits. Total payments posted for the day should equal the total bank deposit for the day. You should investigate any discrepancies.

Collecting the patient responsibility portion of the fee (co-pays) at the time of service is an important component of an efficient collection system. A review of a sample of office visits should be conducted in which the actual fee collected from patients at the time of service is compared with the amount due. If the percentage of co-pays due is excessive, the practice racks up hefty expenses trying to collect them. It is not financially reasonable for a practice to send statements for $10 and $15 co-pays. All patients with co-payment agreements should pay their co-pay amount at the time of service, preferably at check-in.

Cash controls are imperative in a medical practice. Bank deposits must be made daily, intact. Additionally, payments received should be posted daily to the billing system. If a lockbox is not utilized by the practice, an employee (other than the employee posting the payment) should copy the checks and the explanation of benefits received in the mail for posting purposes. The daily batch should be totaled and a bank deposit prepared. The amount posted to the billing system should be reconciled with the amount deposited and the batch total.

GUARDING AGAINST LAG TIMES AND DENIALS FOR THIRD-PARTY REIMBURSEMENT

Data Required for Testing

You will need the following information:

1. Insurance pending log
2. Explanations of benefits from payers

To evaluate the efficiency of the processes for third-party reimbursement, you should first review the turnaround time from date of service to date of payment as illustrated in Tool 9-C, "Sample Insurance Claims Filing Analysis Worksheet."

Tool 9-C: Sample Insurance Claims Filing Analysis Worksheet ***(Toolkit CD-ROM)***

If the billing system provides information as to the date the claim was filed, this data can also be used to evaluate insurance turnaround. The average time lag from date of service to date of payment should not exceed 30 to 40 days. If the turnaround time is greater than 30 to 40 days, you should review the following:

1. Are charges posted on a timely basis? If the physician turns in his or her documentation for hospitalized patient services on a monthly basis instead of weekly, an excessive time lag may be created.
2. Are claims filed on a timely basis? Is the practice filing claims weekly instead of daily?
3. Are secondary claims filed on a *timely* basis? Claims for reimbursement from secondary payers are not filed until the primary insurance has been paid. If there are delays in filing the primary claim or delays in posting the primary payment, the filing of the secondary claims may be delayed.

Practice Tip: Most payers have maximum timely filing deadlines. For some payers, the timely filing deadline is 60 days. If the claim form is not submitted within 60 days from the date of service, it will be denied.

Uncovering Filing Errors and Noncompliance Denials

Filing errors or noncompliance denials are common reasons for lags between date of service and date of payment. If in your review you find that claims are denied for filing errors or noncompliance you should review a sample of the "Explanation of Benefits" forms from Medicare and other payers.

Causes of denial for filing errors typically include:

- *Billing an incorrect insurance company.* If the practice has denials for "wrong payer billed," the practice may not be updating insurance information from patients on a routine basis (should be each visit). A patient's insurance coverage may change due to a change made by their employer or a change in their employment. A request to update patient demographic information on a routine basis may eliminate errors in billing wrong payers or sending statements to incorrect addresses.
- *Timely filing.* If the practice has claims denied for timely filing, the procedures regarding charge capture must be reviewed and revised. As mentioned previously, office charges should be posted daily and hospital charges should be posted, at a minimum, on a weekly basis. Timely filing denials are a clear indicator of office inefficiency.

Noncompliance denials may include the following:

- *Lack of proper authorization.* These denials typically result from the lack of pre-certification for a surgical procedure or hospitalization or the lack of a referral from a primary care provider. If the practice has significant denials for lack of authorization, you should review and recommend revisions for the procedures related to pre-certification and the referral process. The practice will need to take steps to insure that appropriate authorization is obtained prior to the commencement of treatment. In the case of referrals, the specialist should require the referral number as a matter of routing prior to the visit. Likewise, procedures or hospitalizations should not be scheduled prior to the obtaining of necessary pre-certifications.
- *Not medically necessary.* In order for a service to be approved for payment, the service must be medically necessary. One criterion for determining medical appropriateness is the "reasonable and necessary" rule. Section 1862(a)(1)(A) of Title XVIII of the Social Security Act states that no Medicare payment shall be made for items or services which are not "reasonable and necessary for the diagnosis or treatment of illness or to improve the functioning of a malformed body member." To be covered by Medicare (and most payers) the patient's condition must include appropriate clinical indications for the service ordered or performed and the service provided should have a significant likelihood of making a material contribution to the treatment of the patient.

  Prepayment medical necessity denials typically occur when the diagnosis does not support the CPT code billed. An oversimplified example would be if a patient was billed for an X-ray of the foot with a diagnosis of headache. Medicare carriers issue Local Medical Review Policies (LMRPs) on a periodic basis that set forth the diagnoses that will support medical necessity for certain procedures. If the service covered by the LMRP is billed with a diagnosis other than one provided, the service will most likely be denied as not medically necessary.
- *Unbundling.* As noted in Chapter 4, "How Services and Diagnoses Are Coded—Reimbursement and Regulatory Considerations," certain codes are determined to be mutually exclusive of other codes and if billed together the least expensive code will be allowed and the other "unbundled" codes will be denied. These codes are updated quarterly as part of the National Correct Coding Initiative.

- *Noncovered service.* Certain CPT codes may be excluded from coverage based on the contract or payer.

The amount denied versus the amount billed should be computed and analyzed. Likewise, the reasons for the denials should be summarized and analyzed.

You should also request a review of any pending correspondence regarding denials. Document and summarize the date of correspondence, date of service, and reason for denial. If there are consistent lag times between the date the denial was received and the date correspondence was sent back to the insurer, you should recommend that correspondence regarding denials be handled within five days. The problem could result from the fact that no one is designated to follow up on unpaid claims. Follow-up on unpaid claims and denials should be a primary responsibility of designated staff (number assigned will depend on the size of the medical office).

REVIEWING OVERHEAD EXPENSES TO KEEP PRACTICE COSTS DOWN

Data Required for Testing

You will need the following information:

1. Financial statements (comparative)
2. Benchmarking information (obtained, for example, from the yearly edition of the MGMA's *Cost Survey*)

Since Medicare, Medicaid, and managed care typically constitute 75 percent of group practice revenues, physician practices to some degree have lost control of the "top line" (collections). In order to maintain profitability, practices must do more than ever before to control their expenses. In order to do that, however, they need to review expenses in every category—from staff salaries to rent and supplies.

As part of the medical practice review, you should review expense items as a percentage of collections as illustrated in Tool 9-D, "Sample Practice Overhead Analysis." Overhead items should be compared to prior years to establish trends and also to benchmarks. You can obtain benchmarks for expense items in the yearly edition of the MGMA's *Cost Survey.*

Tool 9-D: Sample Practice Overhead Analysis *(Toolkit CD-ROM)*

You will start out by reviewing total overhead percent against the benchmark percent for your client's specialty. For example, one benchmark median percentage for total overhead for a nonhospital-owned family practice is 59.43 percent of collections.[3] If the practice is above the median, this may be an indication of excessive cost and you will want to review

[3] *Source:* MGMA's *Cost Survey 2002 Report Based on 2001 Data.*

individual categories to find the root causes. However, even if you don't find that the total overhead exceeds the median, it is still a good idea to review expense categories against data from prior years so you can see if certain expenses have increased.

Personnel

The largest expense item in most medical practices is personnel (exclusive of physicians). It would be typical for employee salary expense to vary according to volume. However, the percentage (salary expense as a percent of collections) should not vary substantially. If the percentage is increasing and is in excess of the median, perhaps the practice is overstaffed. On the other hand, if the percentage is too low, the practice may be understaffed. The consultant should analyze full-time equivalents (FTEs) by department (benchmarks are included in the MGMA's yearly *Cost Survey*) and also perform a review of job descriptions. Additionally, the consultant should review the wage structure of the practice to determine if employees are compensated in line with the average of other practices based on duties, experience, and so on. Annual salary surveys are typically conducted by local and state MGMA chapters and may be helpful in reviewing wage structure.

Rent

Rent should likewise be reviewed. If the percentage is above the median, the consultant should assist the practice in evaluating the use of space. Does the practice have unused clinical space (such as exam rooms)? Does each physician have a private office? Is the waiting area too large for the patient volume?

If rent is below the median, the practice may be sacrificing efficiency. For example, is the administrative space adequate to provide an efficient work environment? If there are too few exam rooms, does that impede the ability to treat patients promptly?

Medical and Office Supplies

Supplies are obviously a variable expense and the dollar amount should increase proportionate to volume. However, supply expense as a percent of collections should not vary excessively. If the percentage is above the median and the trend is increasing, the consultant should examine the procedure for ordering and authorizing the purchase of supplies. In specialties where substantial stock may be maintained of items used in treatment, such as orthopedics, ophthalmology, and oncology, the practice may benefit from an inventory system to insure that items are properly ordered and billed.

HUMAN RESOURCES—REVIEW OF WORKFLOW AND ORGANIZATIONAL STRUCTURE FOR OPERATIONAL EFFICIENCY

Employee salary expense is typically the largest expense category for the medical practice. The consultant should perform the tests and analyses included in the review of overhead to evaluate staffing. In addition, a review of organizational workflow and authority should be conducted. Does the practice have a recognized leader (office manager, administrator)? Does the practice manager have the authority to lead? If the physician group consistently circumvents the authority of the manager, his or her effectiveness will be diminished.

The employees must have a clear understanding of their job duties and must also understand how their jobs affect the workflow of the entire practice. If the practice organization is inefficient, overall profitability may be impaired. Additionally, employees may become discontent if the practice operates in a constant state of crisis. Employee turnover can be costly in terms of retraining and continuity.

SUMMARY

Analysis of the data provides the consultant with the information necessary to formulate recommendations and prepare the report. It is important that all data be viewed and considered as a whole in formulating conclusions. For example, if the collection percentage is below par, are the fees high? Are there problems with insurance reimbursement? Components of testing and analysis cannot be considered in a vacuum. Doing so may lead to incomplete and incorrect assumptions.

Chapter 10

How to Present Your Findings and Develop an Implementation Plan

The medical practice report is a compilation of the consultant's observations, findings, and recommendations. The report is the vehicle through which the consultant has the opportunity to verbalize and present the results and benefits of the engagement. As such, the report should be well organized and informative.

DEVELOPING SEQUENCE OF FINDINGS

In the course of analysis, the consultant should develop a list of findings. This list and the related recommendations for improvement or correction will provide an outline for the report.

1. The first step is prioritizing, that is, reviewing your findings for materiality to determine if they should be included in the written report. Clearly the biggest issues will make up the bulk of the report, such as breakdowns in charge collections or employee fraud, but there are going to be smaller problems that may not be necessary to put in the report. For example, in the course of interviews, an employee may have advised you that the printer used to prepare patient statements is too loud and disturbing. A solution might be to move the printer to another location or invest in a cover for the printer. This is a recommendation that might best be communicated verbally to the practice manager and most probably does not warrant being included in the report.
2. The next step involves the grouping of related topics. For example, if you have three items that relate to patient charge entry they should be grouped together accordingly. If the report has a section dealing with posting charges, the report might follow the process from date of service to date of posting and how each employee is contributing to or breaking down the system. However, you would not want to bring up coding issues in this section as that would divert the focus because in most offices coding is not part of the job description for the employees posting the charges.
3. Finally, all findings should be evaluated for importance and impact. Remember, this is your opportunity to raise awareness and obtain consensus for your recommendations. It is advisable to order findings according to the affect on the operations of the practice. For example, assume a practice is 30 days behind on posting charges. This issue would be one of high priority since it negatively affects several operational areas of the practice (insurance filing, patient billings, collections, and so on).

Findings should be clearly presented. In order to effectuate change, the consultant must be able to communicate and sell the need for change. The CPA consultant can do this by identifying the problem itself (for example, timeliness in claim submission), the cause of the problem (lack of staff to process the amount of claims generated by the office), and the effect of the problem (money lost due to timely filing denials).

OFFERING REMEDIES

For every finding or issue addressed in the report the consultant must offer a remedy.

The recommendations must be clearly tied to the documented weaknesses and must indicate a specific course of action to improve or remedy the situation. The recommendations should be specific but must also be framed in a manner that will gain acceptance from those who will be required to carry out the implementation.

EXAMPLE

A pathology practice is 60 days behind in posting charges and generally is inefficient in all aspects of the billing and collection function. The entire process is hampered by an outdated billing system, which requires the staff to do many functions manually. The practice may be losing revenue because the staff does not have the time to respond to work denials or follow up on the accounts receivable. The billing staff realizes that problems exist and recognizes the need for direction in order to correct the situation. As the consultant, you would want to emphasize the weaknesses while praising the employees for their willingness to change. Change can be effectuated by attacking the problems, not the individuals.

INCLUDING DATA TO SUPPORT FINDINGS

Physicians are trained to make decisions based on data. The consultant must include in the report sufficient data to document the problems with the current system and the effect that the inefficiencies have on the overall system and profitability. Data summaries, to the extent that they contribute to illustrating a specific weakness, should be included in the report. For example, a schedule reflecting an aging of accounts receivable compared to prior periods and also to the median may be an effective way to communicate the nature of inefficiencies in the collection procedures.

Graphs are a helpful tool for communicating data. Physicians may relate better to financial information in graphic form versus numeric data. (See Tool 10-A, "Sample Graph for Presentation.")

Tool 10-A: Sample Graph for Presentation (*Toolkit CD-ROM*)

PRESENTING THE REPORT

The presentation of the report should be scheduled at a convenient time so that distractions can be minimized. For the physician group, this may mean an early morning or evening session or even a weekend meeting. It is important that the physicians are not hurried and can explore the data and ask questions.

The consultant should devote sufficient time to prepare for presentation. Typical to presenting at a seminar, the consultant should be prepared to present the information clearly and succinctly. Additionally, the consultant should control questions and inquiries so that the presentation does not get off track. For example, an extended discussion on one specific area may prohibit a review of the entire report based on time constraints.

Use of visuals is effective in report presentations. Directing the physicians' attention to a central focus (overheads, Power Point, and so on) assists in the presentation of data. Instead of flipping through a document, the physicians are directed visually to the information presented.

IMPLEMENTING THE REPORT

The key to a successful consulting engagement lies in the ability to implement recommendations to effectuate positive change in the organization. If the medical practice review is conducted and a report is prepared and presented, but nothing changes, the practice has received little or no benefit. As part of the report presentation, the consultant should propose a plan for implementation. The implementation plan should establish priorities. Implementation efforts should be directed initially at those areas requiring immediate change.

EXAMPLE

If the practice is 30 days in arrears on posting office charges, the first area of implementation may be to approve overtime or employ temporary staff to bring the posting current. This may be done in conjunction with establishing procedures to ensure that the posting is kept current.

The entire staff should be informed and educated on the changes that will be implemented and how they will affect individual duties and the overall organization. It is important to solicit "buy-in" from the staff so that the changes are not threatening but are seen as a way to bring positive improvements to the organization.

An implementation timetable should be established in conjunction with management and staff. Targets should be set for implementation.

EXAMPLE

If charge posting is 30 days in arrears, the target for bringing posting current may be one month (for example, at the end of July all charges will be posted and current). This will help set deadlines and cause the staff to focus on a deadline to get all charges posted.

Periodic status reports should be provided to management and the physician group regarding the implementation progress.

Keeping the practice informed not only of the changes being made but also of the positive impact of the changes should motivate the group to continue the process. For example, the implementation process may include changes to improve the collection process. Providing the physicians and management with statistics that indicate improvements in the gross collection percentage or accounts receivable aging should encourage the group to continue the implementation process.

SUMMARY

The presentation of the medical practice report is in many respects the most important step in the engagement process. The report presents in written format the consultant's observations and recommendations and must be presented in a format that encourages the medical practice to take action. Successful implementation = successful engagement.

Section 3

Physician Compensation

Chapter 11

How to Design Physician Compensation Plans

FOUR PRINCIPLES OF PHYSICIAN COMPENSATION DESIGN

Designing an effective physician compensation model requires the buy-in of the physician group. Compensation can be an influential motivator towards desired behavior. However, for the desired results to be achieved, certain basic principles must be in place. A successful plan will motivate the physicians to share resources and work together as a team.

Principle 1: The Physicians in the Group Must Trust the Formula

When change occurs, the natural response is apprehension. This is especially true in the case of compensation formulas. In many cases, the physicians may already be apprehensive as to the equality and fairness of the existing formula. However unpopular the existing formula may be, any change may be perceived as threatening.

The key to success and acceptance of change depends on the degree of physician involvement in plan design. If the physicians are not involved in the change process, buy-in will most likely not occur. Organizational planning and budgeting is an integral part of compensation design. As part of the plan design, sample formula computations should be prepared based on budgetary expectations so that the physicians can see the effects of the new formula on physician compensation. If the sample computations are not prepared, the physicians may reach philosophical decisions that do not equate to the desired financial results.

Not only do the physicians need to trust the formula, they must trust the individuals assigned the task of administering the formula. The group must have faith in the integrity and competency of those providing the computations. For instance, if there is a perceived sense of favoritism on the part of the individual administering the formula, the remaining physicians in the group are likely to be skeptical as to the equity of the compensation model as a whole.

Additionally, the physicians must trust the data used in the compensation computation. If data regarding production, collection, and expenses is continuously flawed and suspect, the physicians are unlikely to rely on the results of the model. Reviewing management reports and financial statements with the group is essential in establishing a level of understanding. The physicians must first understand and accept the validity of the existing financial reports before they can feel confident in the use of that data in a compensation formula. Underlying financial data must be consistently reliable in order to garner the trust of the physician group.

Finally, the physicians must trust each other. If there is inherent mistrust among the physician group regarding patient scheduling and workload, use of resources, or quality of care, the formula is likely to fail. The group must develop a cohesiveness and sense of equity regarding core values. Timely, reliable information is key to the establishment of trust within the physician group. Absent of hard data, physicians may draw conclusions about members' contributions to the group based on their own perceptions or the perceptions of others. Information is the key to dispel misconceptions based on observation alone.

Principle 2: The Formula Must Be Clearly Understood

All too often the classic flaw of a compensation model lies in the complexity of the model. In an attempt to achieve equity in allocation, the practice sometimes creates a plan that, for lack of a better description, "splits hairs." The model may result in numerous, complicated spreadsheets and calculations. As the formula becomes more complicated the purpose of the calculations may become lost in the computations.

Complex formulas lend themselves to error and manipulation. In order for the physicians to trust the formula, the calculations must be reliable and must bear some resemblance to the overall financial results of the practice. If the computations are too complex and there is no reconciliation to verifiable financial data (billing reports and financial statements), the results can be manipulated to shift income inappropriately.

For example, consider the situation of a practice whose normally highest earning physician's compensation declines due to not meeting certain formula components. It is often difficult (and politically incorrect) for the administrator/office manager to relay this bad news, especially if it is unexpected. A complex formula may allow for the unnoticed tweaking of certain factors in the formula calculations in order to waylay this unpleasant task.

Additionally, human nature directs us to distrust those things we do not understand. Complex formulas tend to create distrust among the physician group. If the physicians do not understand the formula, they may have the perception that they are being taken advantage of and treated unfairly. The perpetuation of complex models can result in a compensation system that no one understands, even the individuals responsible for calculating the formula.

If the formula is so complex that no one understands the calculations or the purpose of the calculations, the formula cannot be used as a tool to direct behavior. The physicians must understand the calculations and, most importantly, they must understand how their behavior affects their compensation. A general rule of thumb is to provide narrative descriptions of the underlying formula to the group with a summary report of compensation amounts. Pages and pages of spreadsheets with printing the size of an ant will rarely be understood or used.

EXAMPLE

Compensation Plan of Best Medical Group

Revenues:

Professional service revenue will be allocated 100 percent to the physician providing those services.

Ancillary service revenue will be allocated to the ancillary service pool. All costs directly associated with ancillary revenue will reduce the ancillary revenue to create a "net ancillary" service pool. The net ancillary service pool will be distributed equally among all physicians.

Expenses:

One-third of all expenses will be shared equally.

Two-thirds of all expenses will be allocated to each physician based on his or her prorata share of professional service revenue.

Principle 3: The Formula Must Be Equitable

As in the book *Animal Farm*, compensation models may be equitable; however, "some may be more equal than others." The basic premise is to establish equality in the computations. This becomes extremely important in multi-specialty practices. The allocation of overhead, for instance, must be equitable based on the utilization of resources. It would be inequitable to allocate overhead on a straight percentage basis in a practice housing both family practice and surgical specialists. The formula may not be "equal," however, equality is established through equitable allocations. (See "Determining Equitable Allocations" later in this chapter for details on equitable allocations.)

Principle 4: Group Incentives Must Be Promoted

The fourth principle may very well be the most important in maintaining a successful practice. Physician practices are in a state of transition due to changes in reimbursement, escalating costs, and increasing government regulations. Compensation can be a critical force in supporting change and moving the practice forward and should play a key role in motivating the behaviors needed to effectuate the desired change. There is no doubt that money directs behavior.

A fundamental objective of all compensation plans should be to maintain the financial viability of the group. Without careful, appropriate financial planning and budgeting, practices may set compensation in excess of financial resources, thus setting the group up for failure. Without planning and efficient management, huge losses may occur. Physician compensation models should be designed in a manner that does not jeopardize the financial stability of the group.

In the group practice setting, physician compensation must be considered in the broad context of change initiatives and used to support those initiatives. However, care should be taken not to adopt an innovative approach that does not align with the group's culture or strategic goals. In order to be effective, the compensation model must be in alignment with group goals.

Compensation can be a powerful motivator; however, it cannot influence change if the practice has no strategic objectives. The group must adopt a common philosophy and decide on its desired objectives prior to the design of a compensation plan. The desired organizational behaviors have to be established so that the compensation system can be designed to encourage those behaviors.

For instance, in a fee-for-service environment, productivity still drives revenue. In order for the practice to achieve financial success, the physicians must be productive. A compensation formula in this scenario would want to incorporate factors in the model to motivate physician productivity (such as number of visits, hours worked, and so on). All too often, in large group practices, physicians lose sight of the connection between their work effort and practice profitability. Practice consolidators (physician practice management companies [PPMCs], hospitals, and so on) have experienced the negative financial effect of physicians who cut back hours due to lack of proper incentives to be productive.

On the other hand, groups that are seeking to grow through the addition of physicians, new services, or locations, may realize a negative effect if compensation is strictly tied to individual productivity. The group must focus on overall practice profitability. In order to facilitate growth, physicians must be encouraged to share their patient load. If the sharing results in significant decreases in the existing physicians' productivity, perhaps the practice should rethink the addition of new providers.

To achieve and maintain long-term success, physician practices must reconsider how they measure value and success. Traditionally, practices have measured success in terms of productivity, cash available, or net income. Although valuable measurements, these primarily relate to short-term results.

In today's competitive environment, the successful group will continue to monitor short-term measures while incorporating other intangibles into the compensation formula. Practices must begin to examine behaviors, organization culture, and operational strategies that will promote long-term success. Factors such as patient satisfaction, outcomes, and quality of care should likewise be considered in the formula.

Defining group strategy is essential to the design of an effective compensation system. The group must decide its direction, goals, and purpose before defining its pay system. The compensation formula must mirror the group strategy and motivate individuals in the appropriate direction for the group to achieve its goals. The plan must be simple enough so that the individual members have a clear understanding of the desired behavior and the manner in which that behavior can affect their compensation.

Well-designed plans establish a true partnership between the group and the individual physician. Core values of trust and respect established between the group and the individual will contribute to the overall organization's performance and achievement of long-term objectives.

DETERMINING EQUITABLE ALLOCATIONS

An equitable formula is not necessarily based on an equal sharing of income. As a matter of fact, with the exception of radiology, anesthesiology, and pathology (practices that are typically hospital-based and work on an hours scheduled basis versus patient visits scheduled), equal compensation may actually be inequitable.

EXAMPLE

A three-physician family practice generates the following collections per physician:

Dr. A $425,000

Dr. B $450,000

Dr. C $525,000

If Drs. A, B, and C were compensated equally; Dr. C would be unfairly compensated since her revenue constitutes almost 40 percent of the total income for the practice.

In the design of compensation systems, allocation of revenue is the first step. Revenue may be assigned based on charge volume or collections, or restated in the form of relative value units (RVUs) per physician (see Chapter 3). A proper allocation of revenue is essential for a sound compensation model. Attention must likewise be directed toward the division of expenses (overhead).

With managed care and government programs (Medicare and Medicaid) controlling approximately 75 percent of group practice revenue through capitation and or discounted fee-for-service revenues, monitoring overhead is essential to maintain profitability. Accurate expense identification and allocation is likewise essential for a sound compensation formula.

In the past, the majority of practices allocated costs based on revenue, whether charges or collections defined revenue. For instance, an allocation of net income based on a production percentage defined as charges assumes that all costs are variable and increase proportionately with increases in revenue. The same would be true using any measure of production as the basis for allocating costs.

In multi-specialty practices, the variable allocation of practice costs can cause disproportionate expense assignment in the compensation model. For example, assume a pediatrician and a surgeon share office space. The pediatrician maintains a four and one-half day per week schedule and uses four exam rooms. The surgeon, on the other hand, uses two exam rooms and maintains an office schedule of three days per week. A variable sharing of practice costs could result in the following disproportionate allocation:

Monthly practice expenses:			
Rent			$ 5,000
Administrative salaries and benefits			$ 7,100
Clinical salaries and benefits			$ 3,750
Medical supplies			$ 1,100
Other			$16,000
Total			$32,950
Monthly practice collections:			
Pediatrician	$32,000	(44%)	
Surgeon	41,000	(56%)	
Total	$73,000		
Expenses allocated by collections:			
Pediatrician	($32,950 × 44%)		$14,500
Surgeon	($32,950 × 56%)		18,450

In this example, each physician is allocated expenses at the same percentage of his or her collections (45 percent). However, the surgeon who uses less of the practice resources is saddled with 27 percent more overhead dollars than the pediatrician. The pediatrician is obviously benefiting from economies of scale since the median overhead percentage for pediatricians is 58.42 percent of collections.[1] The surgeon, on the other hand, is penalized in this allocation with a 45 percent overhead amount. The median overhead percentage for general surgeons is 37.75 percent.

The example points out the discrepancies that can occur if practice costs are simply allocated based on production. Should a physician be penalized for generating a higher level of income based on charges, collections, or RVUs? Shouldn't there be some consideration for utilization of practice resources?

Calculating Practice Expenses Based on Actual Performance

In order to resolve these inaccuracies, a careful allocation of practice costs must occur. Practice expenses should be allocated based on the following categories:

- Direct
- Equal
- Utilization
- Volume

[1] *Source:* The Medical Group Management Association (MGMA) *Cost Survey: 2002 Report Based on 2001 Data*.

Direct Expenses

Direct expenses include those costs that are directly assignable to and to some degree may be controllable by the physician. Costs in this category may include continuing medical education (CME), dues and subscriptions, cellular phones, malpractice insurance, fringe benefit costs (health, life, and disability insurance), and qualified plan contributions.

In some cases practices will establish a limit or allowance on certain direct expenses such as cellular phones and CME. Obviously, some limits must be placed on these expense items, otherwise physicians may incur costs in excess of what is financially feasible for the practice. Consideration should be given as to whether these expense items will be considered operational expenses in determining net income before physician compensation or as a component of the physician compensation pool.

Other direct expenses may include the cost for a clinical employee (such as registered nurse or medical assistant) directly assigned to the physician. In practices in which each physician employs a secretary, the related salary and benefit expense may be directly allocated to each physician.

Costs of furnishing an office may be a direct allocation to the physician. Furnishings and computers should be governed by a set dollar limitation and frequency of purchases. Most office furnishings should have a five- to ten-year life, with computers being replaced every three years.

Equal Expenses

Certain practice costs do not fluctuate based on utilization or volume of services provided. These expense items may exist regardless of the number of patient encounters or the charges generated of the practice. Items that may be divided equally among the providers in the practice might include legal and accounting expense, telephone, practice manager/administrator's salary and benefits, and advertising and promotional expenses.

If the practice is single specialty or multi-specialty with similar office hours, it may be practical to divide all administrative salaries and benefits equally, as well as rent expense. If, however, the physicians maintain significantly different schedules and utilization of the office (as in the example of the pediatrician and the surgeon), administrative salaries and rent may be more appropriately allocated by utilization. A careful analysis of utilization is required. Although the physician may not be in the office suite full-time, he or she most likely will require office space on a full-time basis. Therefore, rent may contain both a fixed and a variable component. Rent should also be allocated to a Stark (ancillary) revenue center in determining net income to be allocated for those services.

For instance, if one physician uses four exam rooms and another uses two exam rooms, perhaps rent should be allocated 2/3 and 1/3 respectively. Along the same line, if one physician maintains a four-day office schedule and another maintains a two-day schedule, perhaps the receptionist's salary and other related front office expenses should be allocated similarly (2/3, 1/3).

The billing staff salary and benefits should most likely be divided equally. In our example with the pediatrician and the surgeon, if the billing office salaries were allocated based on volume, the surgeon would pay the greater expense with obviously a lower volume of actual transactions. However, the surgeon's billing might entail more coding expertise and

follow-up time. If the billing office is allocated on any basis other than equal shares we may, once again, be "splitting hairs."

Utilization

In multi-specialty practices, certain expenses should be allocated based on utilization. An equal allocation in cases of significant disproportionate use can result in an inappropriate division of practice costs. For instance, rent and certain clinical and administrative salaries may be allocated based on utilization.

Careful consideration, however, must be given to multi-office, multi-specialty practices. Assume, for instance, that a practice decides to open an office in a typically retail center (such as a shopping mall) for exposure and a walk-in clinic. The rent in this location may exceed other locations for the practice. If costs are specifically allocated to a site, the physicians at the higher cost site may be unduly penalized. In most multi-office situations, the best alternative would be to pool all costs and then assign the pooled costs based on individual utilization.

For example, if Physician A requires the use of 3 of the 27 total exam rooms maintained by the practice, he or she would be allocated 1/9 (11 percent) of the pooled space cost. In the cases of multi-location practices that maintain a central administrative/billing location, it may be advisable to divide the cost of the central office equally among the providers.

Volume

Certain expenses will vary directly with volume—volume being defined as charges, collections, RVUs, patient visits, number of surgeries, and so on. The most obvious variable expense is medical supplies. Other variable expenses may include laboratory expense and radiology (X-ray) expenses. Lab and radiology are designated health services and, therefore, costs associated with those services should be allocated to the Stark revenue center.

Variable expenses should be allocated based on volume or production. Once again, to determine if the basis for allocation of costs is reasonable and fair, we must define production. In the allocation of variable costs, production may be defined as:

- Gross charges
- Collections
- RVUs
- Number of patient visits
- Number of hours worked
- New patient visits
- Number of surgical cases
- Number of employees
- Any other basis that is determined to be reasonable and fair

The underlying theory should be a determination of cause and effect. What activity fluctuations (cause) affect an expense to the extent it will increase or decrease based on those fluctuations?

A careful allocation of practice costs is essential in establishing an equitable compensation model. However, to allocate each expense item differently on a monthly or quarterly basis may become cumbersome. Direct expenses should be maintained separately so that they can be directly allocated with each distribution. The more direct expenses that are identified, the more accurate the allocation.

Calculating Practice Expenses Based on Prior Year Performance

Up to this point, the discussion represents an allocation of costs based on actual performance during a period. Expenses may also be allocated based on a prior year performance and adjusted on a periodic basis during the current year to reflect variances. For example, assume that a cost analysis of the practice for the prior year indicated that one-third of total practice costs should be allocated equally and two-thirds should be divided based on production. These amounts could be used throughout the year and adjusted based on actual at year end. Another example would be to develop a cost conversion factor per RVU based on historical data with quarterly, semi-annual, or annual revisions.

EXAMPLE

ANALYSIS OF COST PER RVU (EXPENSE CONVERSION FACTOR)

Total operating expenses (overhead) year ended 12/31/XX	$2,120,000
Total RVUs generated for year ended 12/31/XX	# 125,000
Cost per RVU (expense conversion factor)	$ 16.96

COST ALLOCATION FOR BUDGETING PURPOSES

Physician	RVUs year ended 12/31/XX	Overhead x $16.96
Dr. A	30,000	$ 508,800
Dr. B	60,000	$1,017,600
Dr. C	45,000	$ 763,200

Total costs would then be allocated on a monthly basis to each physician based on his or her actual RVU production from the prior month. This method assumes that expenses paid in the current month are related to the services provided in the prior month. An analysis may be performed quarterly to determine if the overhead conversion factor has increased or decreased materially, which would result in a revision for the upcoming quarter.

Obviously these calculations can be determined at various levels of reporting. It may be appropriate for the group to segregate costs to revenue centers and then to physicians within that revenue center. It should be a determination of what is fair in deciding the appropriate allocation method.

Allocating Expenses in Multi-Specialty Practices

In multi-specialty practices that include both primary care and specialty physicians, most specialists accept the fact that their overhead percentage may be higher than single specialty practices. The offsetting benefit should be the advantage of captive "gatekeepers" who provide referrals to the specialists within the multi-specialty group. The specialists pay an overhead "tax" for the benefit of association with primary care "gatekeepers."

If this allocation (equal, utilization, variable) were applied to our original example (pediatrician and surgeon), the following result could be obtained:

EXAMPLE

	Pediatrician	Surgeon
Rent (2/3, 1/3)	$ 3,300	$ 1,700
Administrative salaries (1/2, 1/2)	3,550	3,550
Clinical salaries (2/3, 1/3)	2,500	1,250
Medical supplies (volume)	700	400
Other (revenue)	7,000	9,000
Total	$17,050	$15,900
Collections	$32,000	$41,000
Overhead as a percent of collections	53.3%	38.8%

The more specific allocation of expenses in this example has resulted in an overhead allocation that is comparable to the MGMA survey median (58.42 percent for pediatric, 37.75 percent for surgery) versus the previous 45 percent overhead allocation to each physician based on a percent of collection allocation across the board.

SUMMARY

In designing a plan it is important to remember:

- Model the plan before implementation to make sure it encourages the desired behavior.
- Make certain the data used in the computation is accurate.
- Communicate frequently and regularly—building consensus is essential to success.
- Review the plan frequently in light of organizational or industry changes.
- When change is indicated, do not be afraid to change gradually.

Chapter 12

Anti-Referral Laws and Physician Compensation: Stark I and Stark II Regulations

Industry Snapshot: *The Stark laws, named after U.S. Representative Pete Stark of California and known as Stark I and Stark II, are often referred to as the anti-referral laws or the physician self-referral laws. Basically, the Stark laws were implemented to discourage inappropriate ancillary referrals that result in a financial reward to the physician making the referral.*

Prior to the passage of the Stark laws, the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) conducted a study in 1989, which found that patients of referring physicians who owned or invested in independent clinical laboratories received more services than Medicare patients in general. In fact, the study reported that such physicians ordered 45 percent more services, costing the Medicare program $28 million.

A 1991 study by the Florida Health Care Cost Containment Board confirmed these findings. In addition to lab services, physician owners were overutilizing diagnostic imaging and physical therapy services. A follow-up study by the General Accounting Office (GAO) for the Ways and Means Health Subcommittee reported that physician owners had a higher referral rate for all types of imaging services than non-owners. The GAO concluded its report stating "we believe this analysis for referral for imaging services, together with our earlier analysis of referral patterns for clinical laboratory services, illustrates a broad potential for higher use and higher costs through self-referral."

The intent of the Stark laws was to remove the financial incentive for what was perceived to be unnecessary ancillary referrals. The complete regulations are available at www.cms.hhs.gov/medlearn/refphys.asp (CMS Web site).

* * * *

An understanding of Stark Regulations is imperative for the proper structure of a physician compensation plan (both small and large group practices). Running afoul of Stark can cost the practice in penalties and possible exclusion from the Medicare program. The CPA consultant should be aware of the basic principles as outlined in this chapter in order to advise physician clients on how best to comply with the regulations in their compensation planning.

STARK I REGULATIONS AND MEDICARE REIMBURSEMENT

Stark I was included in the Omnibus Budget Reconciliation Act of 1989 and prohibited a physician from referring a patient or specimens for Medicare reimbursable services to a clinical laboratory participating in the Medicare program, if the physician (or immediate family member of the physician) had a financial relationship (ownership interest or compensation arrangement) with the clinical laboratory provider. Further, clinical laboratories were prohibited from submitting claims or billing for reimbursement if the

services were rendered in connection with a prohibited referral. The Stark I regulations were published in interim form on August 17, 1995, and the final regulations became effective September 13, 1995.

STARK II REGULATIONS, FINAL RULE EXCEPTIONS, AND IMPACT ON REFERRALS

Stark II became effective January 1, 1995, and expanded the scope of the referral prohibitions to all "designated health services," adding patients in the Medicaid program. Proposed regulations were issued on January 8, 1998, and the Stark II Final Rule was released January 2001 (effective January 4, 2002). Generally, the Final Rule "prohibits a physician from making a referral to an entity for the furnishing of designated health services (DHS) for which Medicare would otherwise pay, if the physician (or immediate family member) has a financial relationship with the DHS entity." If a financial relationship exists and there is a referral of DHS, the law is implicated, unless one of the provided exceptions applies.

The Final Rule contains 27 exceptions. The most commonly used and most often criticized in the 1998 Proposed Rule is the in-office ancillary exception. The in-office ancillary exception protects physicians' referrals for most, but not all, DHS furnished in physicians' offices. Specifically, the exception does not protect the furnishing of most durable medical equipment (for example, external ambulatory infusion pumps).

Under the Final Rule, in order to qualify for the in-office ancillary services exception, service must be furnished personally by one of the following individuals:

- The referring physician
- A physician who is a member of the same group practice as the referring physician
- An individual who is supervised by the referring physician or by another physician in the group practice provided the supervision complies with all other applicable Medicare payment and coverage rules for the services

In-office ancillary services must be performed in one of three locations:

- The same building, but not necessarily the same part of the building, in which the referring physician (or another physician who is a member of the same group) furnishes substantial physician services that are unrelated to the furnishing of DHS
- A centralized building used by the group practice for some or all of the group's laboratory services
- A centralized building used by the group for some or all of the group's DHS (other than clinical laboratory)

A group practice is defined in the Final Rule as two or more physicians, legally organized, furnishing the full range of patient care services that the physician routinely furnishes, including medical care, consultation, diagnosis, and treatment, through the joint use of shared office space facilities, equipment, and personnel. Substantially all (defined as 75 percent) of the patient care services must be furnished through and billed through the group.

Designated health services (DHS) are defined in the Final Rule as the following:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Radiology and certain other imaging services (including magnetic resonance imaging [MRI], computerized axial tomography scans [CAT or CT], and ultrasound services)
- Radiation therapy services and supplies
- Durable medical equipment (crutches and walkers excluded)
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Additionally, the Final Rule clarified guidance on the following services and benefits by providing for:

- Inclusion of traditional radiology in the definition of DHS
- Exclusion of radiology procedures that are integral to a nonradiology, non-DHS service, such as imaging guidance during surgery
- Inclusion of and separate categorization of radiation therapy
- Inclusion of pathology services
- Inclusion of ultrasound, MRI, and CT
- Exclusion of nuclear medicine from DHS
- Exclusion of preventive screening (such as screening mammography)
- Exclusion of imaging services that are invasive (such as fluoroscopy and ultrasound where insertion of a needle, catheter, tube, or probe is required)
- Exclusion of cardiac catheterization and endoscopy

In the 2001 Stark Regulations, the government adopted a list of diagnostic and procedural codes to identify specific services in the areas of clinical laboratory, physical therapy, occupational therapy, radiology and certain other imaging services, and radiation therapy services by publishing specific current procedural terminology (CPT) codes (available on the CMS Web site, www.cms.gov).

EFFECT ON PHYSICIAN COMPENSATION PLANS

The Final Rule provides some useful guidance into permissible types of incentive compensation and income distribution methods. An understanding of these guidelines is imperative for CPAs who consult with physician practices regarding compensation and incentive plans.

In general, a group practice may compensate physicians with an incentive bonus or a share of the profits of the practice based on the physicians' personal productivity, including DHS personally performed by the physicians, but not based on the volume or value of referrals of DHS performed by someone else in the group practice. Within larger practices, a component of the group practice consisting of five or more physicians may also share profits, so long as they are not related to the volume or value of referrals to someone else.

EXAMPLE

If a multi-specialty group has five or more orthopedic surgeons in the practice, the orthopedic group may be defined as a component within the practice. This definition could be important if the orthopedic surgeons provided physical therapy services. Meeting the definition of component would allow the orthopedic surgeons to share the physical therapy revenues within the orthopedic group versus sharing with the entire multi-specialty practice.

Profit distributions that will not be deemed to relate directly to the volume or value of referrals (and therefore will not constitute violations of the Stark Laws) include:

- Dividing the group's profit on a per capita basis (per member or per physician)
- Bonuses based on the physician's total patient encounters or relative value units (RVUs)
- Bonuses that are based on an allocation of non-DHS services
- Bonuses that are calculated in a reasonable and verifiable manner, that is, not directly related to the volume or value of the physician's referrals of DHS

The rules for profit and productivity bonuses apply to all physicians in a group, and are not limited only to the physician members of the group. An exception exists for group practices whose revenues from DHS are less than 5 percent of the group practice's total revenues, and the allocated portion of those revenues to each physician in the group practice constitutes 5 percent or less of his or her total compensation.

PENALTIES FOR NONCOMPLIANCE

The good news is that there are no criminal penalties for noncompliance with the Stark laws. Most medical groups put themselves at risk for noncompliance by distributing bonuses that include DHS referrals. If a practice is deemed not to be in compliance with Stark either by not meeting the in-office exception or by distributing profits in a noncompliant manner, the practice may be penalized as follows:

- Civil sanctions of up to $15,000 for each bill or claim filed while the practice was in violation
- $100,000 in penalties for circumvention schemes
- Exclusion from federal programs

The penalties, combined with the risk of exclusion, should encourage practices that provide DHS to review their compensation plans to insure that their methodology for distributing profits does not violate the Stark laws. Often, CPAs are asked to review compensation and incentive plans for their physician clients based on the financial reasonableness of the plan. An unknowledgeable CPA might offer advice that would be reasonable from a solely financial standpoint but would cause the practice to be in violation of Stark.

CASE STUDY

Facts: Small-town Internal Medical Practice is a group practice composed of three physicians. The physicians merged their solo practices five years ago in order to obtain economies of scale and to be able to effectively negotiate with managed care payers. Dr. A is a pulmonary subspecialist, Dr. B is an endocrinologist, and Dr. C practices general internal medicine.

The practice provides radiology and laboratory services (both designated health services [DHS] under Stark II). The existing compensation formula is that each physician has been credited with his respective collections from all patient services, including radiology and laboratory. Dr. A and Dr. B are the highest users of radiology and laboratory based on their subspecialties.

The physicians have been pleased with their current system of compensation. They have analyzed overhead and feel they have appropriately allocated expenses between fixed and variable designations. Because of their subspecialty designations, a direct allocation of income is deemed to be a fair basis of compensation.

Objective: The physicians and their advisers were unaware of the Stark regulations as they relate to physician compensation formulas. Since the designated health services were provided in the group practice, the physicians incorrectly assumed that they were in total compliance with Stark.

The group wants to revise its compensation plan for the upcoming fiscal year to be in compliance with Stark regulations. They understand that, in order to be in compliance, the revised plan will not directly allocate DHS revenues (radiology and laboratory) to the physicians who ordered the services. Their goal is to develop a plan that will comply with Stark while maintaining, to some degree, their existing compensation levels.

Existing Plan: The existing compensation plan provides for a direct allocation of physician collections (including radiology and laboratory collections). Expenses are divided as follows: $25,000 in expenses are allocated equally to each physician (fixed expenses), and the balance of expenses is allocated based on the percentage of individual collections by physician to total group collections.

The formula produced the following results for the current year:

	E/M Collections*	Ancillary Collections	Total	Fixed Overhead	Variable Overhead	Net
Dr. A	$ 400,000	$ 50,000	$ 450,000	$25,000	$222,000	$203,000
Dr. B	375,000	85,000	460,000	25,000	228,000	207,000
Dr. C	375,000	30,000	405,000	25,000	200,000	180,000
Total	$1,150,000	$165,000	$1,315,000	$75,000	$650,000	$590,000

* E/M = Evaluation and management

Alternative I: Equal Sharing of Designated Health Services Revenues

In this first alternative all collections from DHS (radiology and laboratory) are pooled and allocated equally to each physician. Expenses are allocated in accordance with the existing formula ($25,000 equally, the balance based on a percentage of individual collections to total collections). Variable expenses are allocated based on the revised total collections (with designated health services allocated equally).

Applying the assumptions in this compensation plan to the current year's numbers resulted in the following:

	E/M Collections	Ancillary Collections	Total	Fixed Overhead	Variable Overhead	Net
Dr. A	$ 400,000	$ 55,000	$ 455,000	$25,000	$224,000	$206,000
Dr. B	375,000	55,000	430,000	25,000	213,000	192,000
Dr. C	375,000	55,000	430,000	25,000	213,000	192,000
Total	$1,150,000	$165,000	$1,315,000	$75,000	$650,000	$590,000

Dividing DHS revenues equally results in a shift in compensation from Dr. B (previously the highest compensated physician) to Dr. C (previously the lowest compensated physician).

Compensation shifts due to an equal sharing of the DHS revenue are as follows:

	Existing Formula	Alternative I	Increase (Decrease)
Dr. A	$203,000	$206,000	$ 3,000
Dr. B	207,000	192,000	(15,000)
Dr. C	180,000	192,000	12,000

The group's reaction to Alternative I is not favorable. Although the group goal is to develop a compensation model that will be in compliance with the Stark regulations, the dramatic shift in income from Dr. B to Dr. C is not acceptable. The group has even discussed splitting up if another alternative cannot be developed.

Alternative II: Allocation of Designated Health Services Based on Evaluation and Management (E/M) Revenue

The Stark regulations provide that revenues from DHS cannot be allocated, for compensation purposes, directly to the physician who ordered the services. The revenues may be pooled and allocated equally (as in Alternative I) or by some other method, as long as they are not allocated directly to the ordering physician.

A reasonable alternative may be to allocate the DHS based on the respective evaluation and management service revenues of the individual physicians. For simplicity in this example we have used collections. However, a more exact allocation would result from evaluation and management charges. In the case of multi-specialty practices (such as surgical and primary care combinations), an allocation of DHS revenue based on evaluation and management charges may provide for a reasonable allocation of income.

Reallocating radiology and laboratory revenues based on evaluation and management revenue in Alternative II results in the following distribution based on current year numbers:

	E/M Collections	Ancillary Collections	Total	Fixed Overhead	Variable Overhead	Net
Dr. A	$ 400,000	$ 57,000	$ 457,000	$25,000	$226,000	$206,000
Dr. B	375,000	54,000	429,000	25,000	212,000	192,000
Dr. C	375,000	54,000	429,000	25,000	212,000	192,000
Total	$1,150,000	$165,000	$1,315,000	$75,000	$650,000	$590,000

The results of Alternative II are identical to Alternative I. Dr. B's ordering of ancillaries is much greater than Dr. C's ordering based on his subspecialty of endocrinology. An allocation of DHS based on evaluation and management revenues may produce no change in situations where the DHS revenue is disproportionate to evaluation and management revenue based on differences in the combined specialties. The same situation might occur if the practice included an oncologist with significant in-office chemotherapy revenues.

Alternative III: Establishing a Base Salary

Neither of the first two alternatives results in a viable formula for the group. Although the group has traditionally maintained an "earn what you bring in" mentality, the establishment of a base salary may be necessary to achieve compliance and maintain the integrity of the group.

The Stark regulations allow the establishment of a base amount as long as the amount is determined in advance and does not exceed fair market value. Alternative III provides for the establishment of a base salary equal to 80 percent of the total current year compensation, determined as follows:

	Current Year Compensation	Base at 80%
Dr. A	$203,000	$163,000
Dr. B	207,000	167,000
Dr. C	180,000	145,000
Total	$590,000	$475,000

The incentive pool available for allocation (based on current year's numbers) is computed as follows:

Total collections	$1,315,000
Less: total overhead	(725,000)
Less: total physician base salaries	(475,000)
Incentive pool	$ 115,000

The incentive pool is then allocated based on each physician's respective share of evaluation and management revenue to the total as follows:

	E/M Revenue %	Share of Incentive Pool
Dr. A	34%	$ 40,000
Dr. B	33%	38,000
Dr. C	33%	38,000
Total		$115,000

Combining the incentive pool with the established base salaries results in the following total compensation per physician (based on current year numbers):

	Base Salary	Incentive	Total
Dr. A	$163,000	$ 39,000	$202,000
Dr. B	167,000	38,000	205,000
Dr. C	145,000	38,000	183,000
Total	$475,000	$115,000	$590,000

Alternative III compares to the existing formula as follows:

	Existing Formula	Alternative III
Dr. A	$203,000	$202,000
Dr. B	207,000	205,000
Dr. C	180,000	183,000

Although Alternative III requires a shift in group mentality from the "earn what you bring in" methodology, the physicians are willing to make that shift to maintain the integrity of their income. Alternative III provides a way to establish a Stark-compliant compensation formula while maintaining the group distribution goals.

The following must be considered in establishing a base compensation plan:

- The base salary should not exceed 80 percent of total expected compensation.
- The base salary should be comparative with the market based on the physician's specialty, tenure, qualifications, and so on.
- The base salary is set in advance and should not be modified during the computation year simply to accommodate the formula. If factors change (for example, a physician changes to a part-time status), then the base can be revised. The formula should incorporate standard objectives that should be achieved in order to "earn" the established base. If these objectives are not being met, the base can be revised. Otherwise, it should remain in effect until the next computation period.

The case study illustrates the fact that the practice must consider several alternatives to insure that practice goals are achieved and appropriate incentives are in place. Unfortunately, there is no existing formula that will work in all practices. Designing an effective compensation plan requires a thorough knowledge of the practice goals and objectives as well as the applicable regulations.

EXAMPLE

Family Practice, PC provides lab and radiology services. The physicians are paid a base salary and bonuses are based on the physicians' total collections, which include collections from DHS referrals. *Problem:* Since DHS revenues are included in the distribution formula, the methodology is noncompliant with Stark. *Alternative:* The practice could consider distributing the bonus based on non-Stark collections.

SUMMARY

An understanding of the Stark regulations and their impact on financial relationships of medical practices is imperative. Physician compensation consulting performed without consideration of the impact of Stark can expose the practice to serious regulatory implications.

Section 4

Valuation of Physician Practices

Chapter 13

Medical Practice Valuation Opportunities and Issues

Industry Snapshot: *Valuations of physician practices have evolved over the past 15 years both in terms of purpose and computations involved. Before the mid-1990s, valuations were performed primarily for physician buy-ins or buy-outs and marital dissolution purposes. In those cases, the values assigned consisted of equipment and furniture, usually at book value, and patient accounts receivables, discounted for contractual adjustments and uncollectible accounts. The calculation was a simple arithmetic computation.*

In the mid-1990s physician practices became a target for acquisitions by hospitals and physician practice management companies (PPMCs or PPMs). Acquisitions of practices were typically negotiated based on the fair market value of the entity including goodwill. In response, valuations of physician practices became more sophisticated, incorporating standard valuation techniques and methodologies. The shift in valuation methodology has created a need for CPA consultants who not only understand the healthcare environment but also have training in valuation practice. You must be aware of certain industry-specific areas to accurately estimate the value of any physician practice. The healthcare industry is a highly regulated one. If you ignore the influence of regulatory issues when appraising a physician practice, the final value can be rendered worthless.

* * * *

REASONS FOR PERFORMING A PHYSICIAN PRACTICE VALUATION

In recent years, providers of consulting services for medical practices have increasingly been asked for advice or to perform valuations of physician practices. Within the valuation field, there are several reasons for appraising the value of a medical practice, which include but are not limited to:

- Buy-sell agreements
- Marital dissolution
- Merger and acquisition transactions

Before you can begin a valuation engagement, you must define the standard of value. The standard of value can differ depending on the reason for the appraisal engagement.

Buy-Sell Agreements

In most group practices, the owners/shareholders of the physician practice have executed buy-sell agreements that dictate the method of appraising the value of the practice. In many such cases, the value is based on a formula method that may, or may not, be similar to fair market value. Buy-sell agreements that utilize a well-defined formula can be relatively simple to execute. However, in many cases, the agreement does not adequately

define all variables used in the formula. In other cases, some agreements only refer to the "fair market value" of the practice. Even in such cases, a well-written buy-sell agreement will define whether the value relates to the tangible assets only, or all practice assets—tangible and intangible.

Why Your Involvement Matters

Your role as consultant-appraiser is probably more vital in the initial planning and drafting of the buy-sell agreement than it is on the back end when you are requested to act as the appraiser only. Your experience and foresight can contribute significantly to the development of a proper buy-sell agreement. Your involvement in the development process can prevent the use of ambiguous terms and unrealistic formulas, and can assist physician management by ensuring that whatever form of value is included in the agreement, the final result can be adequately funded.

> *CAUTION:* If your involvement is only at the resolution or valuation stage of a buy-sell agreement, review the entire document for ambiguous terms, definitions, or formulas. Do not attempt to interpret the intention of such ambiguities. Leave that potential liability for the attorney who authored the document. Have legal counsel (of both sides) clarify the meaning of such terms and definitions. For example, if the buy-sell agreement uses a formula based on "revenue," make the parties involved stipulate whether that means gross charges, net charges, or collections.

Marital Dissolution

Valuations of physician practices for marital dissolution purposes are dictated by state laws. That is, actual law or case precedent in the state in which the case is being contested usually dictates the premise of value to be used in the appraisal. Depending on the state in which the court action takes place, the standard of value can vary. For marital dissolution purposes, some states include only the practice's tangible assets, some will additionally include "practice" goodwill, and some will include all tangible and intangible assets. It is the intangible value that is associated with the medical practice and can usually be transferred to new ownership. Practice goodwill can include patient charts, an assembled workforce, or the clinic's location. It should not be confused with the physician's "professional" goodwill, which is directly related to personal reputation of the healthcare provider. Before embarking on a valuation engagement, you need to be aware of the definition of value for divorce purposes for the appropriate jurisdiction.

Value of Appraiser Involvement

The greatest value you bring to the table is your skill in helping the parties settle the division of assets issue. Depending on the family law experience of the attorneys involved, much of your time as appraiser or expert witness can be as an "educator" to the client or the attorney. In many cases, the official "client" will need to be the litigant's attorney so as to make the attorney-client privilege apply to your work. Seek the advice of the requesting counsel as to his or her preference. Additionally, your understanding of what types of goodwill or intangibles are allowed by state law or precedent may provide as much benefit to the client as the valuation report.

CAUTION: This may go without saying, but do not allow yourself to be unduly influenced by the counsel that has retained your services. Let it be known at the beginning of the engagement that you will provide a report stating what you believe to be the value of the business. Be wary if you are pushed in one direction or another—oftentimes just to see if you will acquiesce.

Mergers and Acquisitions

As managed care products proliferate in certain areas of the country, payers for medical services are attempting to reduce the cost of providing such services to their clients who pay the insurance premiums—patients. The payers (insurers) need healthcare providers for their clients (patients). The physicians need patients to maintain their levels of revenue. Therefore, various entities such as physicians, hospitals, physician practice management companies (PPMCs), and insurance companies are forming strategic alliances to gain negotiating strength with payers, employers, and patients. Hence, the third and most common reason for an appraisal of a physician practice is for merger and acquisition transactions.

PPMCs, management service organizations (MSOs), and hospitals are forming integrated delivery systems, which join forces with physicians to provide an array of services for their patients and indirectly for the payers. To form these systems, entities are acquiring strategically located medical practices and other healthcare providers. Primary care physicians have been the principal targets of the practice acquisitions. They are considered to be the "gatekeepers" of healthcare services. They will determine which patients need the care of specialist practitioners. Based upon such future expectations, physician practice acquisitions have been transacted at prices that include substantial values for intangible assets (goodwill). Most of these strategic business combinations have been transacted at "fair market values," which was unheard of as recently as 10 to 15 years ago.

Your Vital Role in the Merger and Acquisition (M&A) Valuation

You may wear a number of hats when you take on the job of medical practice appraiser in M&As. In addition to being the appraiser of two or more practices that intend to merge, you might also become the facilitator of the entire merger process. After all, once you have appraised all of the practices intending to merge, you will know more detailed information about each practice than anyone else involved in the merger. The valuations can result in a variety of additional consulting services that help the parties involved work through their differences—both financial and cultural.

As the appraiser in an acquisition transaction, in addition to helping the parties involved determine an acquisition price for the transaction, you can also educate them on the regulatory requirements. For instance, your understanding of the regulatory requirements can assist a physician in determining which issues to pursue with more vigor than others during the negotiation process. If your client wants his cake *and* wants to eat it, you can advise him that it is okay for the acquirer to give him a cake, but he can only eat one slice per year. For example, the physician needs to understand that if he negotiates a high sale price for the practice *and* an unreasonably high ongoing compensation package that is not supported by the historical results of the practice, he may be subject to the same inurement (benefit payment) penalties as the acquirer.

EXAMPLE

Your client has a practice with a fair market value of $150,000 that has historically generated a compensation for the physician of $150,000. If he sells his practice for $250,000 and receives annual compensation of $200,000, he could potentially be subject to inurement fines or penalties for accepting amounts in excess of the fair market value of his practice and his services. What sounds like a "great deal" in a nonregulated industry could lead to potential fines in the healthcare industry.

As an appraiser for the acquirer in a transaction, your role as valuator may be to not only give the hospital or PPMC an indication of how much to offer a physician(s) for the practice, but also to provide documentation for the acquirer's legal counsel that the amount paid for the practice was not more than fair market value. Working for the acquirer in the transaction also often requires a considerable amount of educating the client on the effects of various areas of the negotiation process.

EXAMPLE

Continuing with the same example as above, the physician's practice has a fair market value of $150,000 and the physician has historically generated compensation of approximately $150,000. It is not unusual for the acquirer to come back to you as the appraiser and ask for a value of the practice based on compensation to the physician of $200,000. It is your job as the appraiser to educate the acquirer that if he agrees to pay the physician compensation of $200,000 per year, then maybe the practice only has a fair market value of $75,000.

FACTORS AFFECTING THE VALUE OF A PHYSICIAN'S PRACTICE

There are a number of factors that affect the value of a physician's practice—many of which are discussed at great length in other sections of this guide. Several of the industry factors that have had (and continue to have) an impact on the values of physician practices are as follows:

- Changes in reimbursement for physician services
- The regulatory environment
- Changes in operating environment and other considerations
- The presence of goodwill
- The movement of the patient base, payers, and organizations structured to control medical costs

Changes in Reimbursement for Services

To fully understand the impact of future changes in reimbursement, you must understand how we arrived at the industry's current position. As discussed in Chapter 5, most plans, and therefore patients, have shifted to some sort of managed care type of arrangement. The significance of this shift is that most managed care organizations follow the reimbursement trends of Medicare, which has been decreasing reimbursement for certain specialties.

A large portion of the decrease in Medicare's reimbursement level is due to the restructuring of the unit of measure used by Medicare known as resource-based relative value scale (RBRVS) units, which were discussed in Chapter 3. However, for your valuation purposes, you mainly need to know the impact the RBRVS has had on certain specialties. Estimated decreases in reimbursement for specialties in 2002 were 9 percent for anesthesiology, 8 percent for cardiac surgery, and 6 percent for thoracic surgery. Additionally, primary care specialties that have seen historical increases in Medicare reimbursement of 3 percent to 5 percent over the last several years had estimated changes that ranged from a decrease of 2 percent to an increase of 1 percent to 2 percent.

Therefore, since many of the managed care organizations structure their reimbursement levels around the changes in reimbursement from Medicare, anticipating the impact of future reimbursement trends for certain specialties can be critical. For example, multi-specialty group practices generate 25 percent of their revenue from Medicare, 44 percent from managed care organizations, and 6 percent from Medicaid. That equates to 75 percent of the total practice revenues for the group that are dictated by outside parties. Only the remaining 25 percent, composed mostly of indemnity plans and uninsured patients, pay the fee requested by the physician. This trend is only expected to continue. In the United States we now have more people over the age of 60 than we do under the age of 20, and as the aging baby boomers enroll in Medicare, physicians may see their revenues decrease.

Regulatory Environment

The regulatory agencies for acquisitions can vary and overlap (federal and state agencies and regulators), depending on the sources of revenues for medical practices (different reimbursement sources), coupled with the tax status of some of the acquirers (both for-profit and nonprofit healthcare organizations). In a crowded regulatory environment, regulators do not necessarily agree on valuation issues. The Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) is responsible for enforcement of Medicare laws. However, the IRS has enforcement authority for non-profit organizations qualifying as tax-exempt under Internal Revenue Code Section 501(c)(3). The OIG has stated in the much discussed "Thornton Letter" (a December, 1992 letter to the IRS written by D. McCarty Thornton, Chief Counsel to the Inspector General) that payments in excess of tangible values could be considered an inurement (benefit payment) to physicians. This would be in violation of anti-kickback provisions of the Medicare laws. The "Thornton Letter" is located at http://oig.hhs.gov/fraud/docs/safeharborregulations/acquisition122292.htm.

The IRS position, however, is that acquisitions must meet the Community Benefit Standard that requires the transaction to be at "arms length." In addition, tax-exempt organizations must pay fair market value or they have created private inurements or benefits to physicians. The "IRS Valuation Training for Appeals Officers" states that consideration of the cost, income, and market comparison approaches must be given when assessing a medical practice value. The preferable approach for the IRS is the income approach. However, use of an income approach, such as a discounted cash flow, tends to contradict the OIG's position of a valuation based on only tangible assets. A value based on an income approach indicates an enterprise value for the entire business—not just tangible assets as the OIG's "Thornton Letter" suggests.

The regulatory issues may be difficult to digest in one reading. As a matter of fact, they only cover the surface of the issues. However, their existence has affected and will continue to affect physician practice appraisals and their ultimate results. An appraiser of a physician practice must understand the result of such influences on any given engagement.

> *CAUTION:* The best approach for the appraiser to take is to discuss such issues with the client's legal counsel. Let the client's legal counsel (hopefully a healthcare specialist) dictate whether the valuation you are engaged to perform will include any goodwill, intangible value, or tangible assets only. Allow the client and legal counsel to determine whether they are comfortable with paying for intangible assets or tangible assets only.

Changes in the Operating Environment and Other Considerations

Several major changes have occurred in the physician practice operating environment over the last several years.

Increased Operating Expenses

The first change is the continued increase in operating expenses (overhead). Increases in operating expenses can be attributed to the increasing complexity involved in practice administration. Formerly, a 40 percent overhead rate for total operating expenses was a realistic "rule of thumb" for most medical specialties. Conversely, that meant that the physician's compensation would be approximately 60 percent of net revenues. However, the overhead rate for most specialties is now in the 55 percent to 60 percent range. That change means that only approximately 40 percent to 45 percent of net revenues are available for the physician's compensation. Some of the sources of industry data mentioned in Chapter 14, "How to Collect and Analyze Data for a Medical Practice Valuation," provide a breakdown by type of expense for the various specialties. The levels of operating expenses can vary substantially by medical specialty.

Increased Technology. Like other industries, the pace and rapid advance of available technology is a factor that has affected the operation of the physician's practice. The changes in technology have occurred not only in the accounting and medical information area of operations, but also in the medical equipment utilized by the healthcare provider to service patient needs. Just as computer hardware and software applications have evolved at a rapid pace, so too has the technology used to provide healthcare services in the physician's office. Physicians who want to stay competitive within their local markets must continue to make new investments in "patient technology." Equipment used for patient services such as cardiology, imaging, and lab is evolving at such a swift pace that it is difficult for providers to keep up with technology changes. Additionally, the investment made by practices in such equipment retains very little value over an extended period because of the frequent changes in technology.

Mid-Level Providers

Another trend that has had an impact on the operating environment of physician practices has been the use of mid-level providers or "physician extenders." With the increase in overhead mentioned above, many physician practices have found it necessary to employ mid-level providers to increase patient volume at a reduced cost. From 1995 to 2000 the

number of nurse practitioners increased by 100 percent, physician assistants by 131 percent, and midwives by 90 percent. Yet the number of physicians has increased by only 28 percent. In a recent survey executives of health plans were asked if they thought the use of physician extenders had improved the level of healthcare in America. Eighty-six percent responded that they thought it had. Yet when physicians were asked the same question, only 10 percent believed that they had improved the level of healthcare. If the practice being valued employs any mid-level providers, you must understand the additional regulatory requirements involved regarding the supervision of such employees. Furthermore, part of the value of the practice may relate to the revenue produced by the additional provider(s). Additional analysis regarding who generated the revenue (the physician or the mid-level provider) and the expenses associated with each provider may be required to determine the impact of the provider on the value.

Goodwill

Earlier in this text we discussed the issue of practice versus professional goodwill. The term "goodwill" is often used in the industry to include all aspects of the intangible value of the practice. The intangible value of a physician practice often ranges from 15 percent to 50 percent of the total value of the practice. The intangible value can include items such as the physician's professional goodwill, patient charts, assembled workforce, location, managed care contracts, and so on. Additionally, the average percentage of the total value of the practice can vary by specialty. For example, *The Goodwill Registry, Year 2003* reports the 11-year median intangible value for multi-specialty clinics is 41.42 percent, while the median for neurology is 24.93 percent. Furthermore, the volume of physician practice transactions in a specific geographic location can have an impact on the intangible value of a practice. Some areas of the country have seen much more activity in the area of practice consolidation than others. The competition for various types of healthcare providers within a given geographic area can cause the intangible value of a practice to fluctuate somewhat.

Patient Base Payers

Another major factor affecting the values of physician practices is the movement of the patient base. Fifteen years ago, the volume of a provider's patient base was determined almost completely by the physician only. In today's managed care environment, the patient base is affected to a large degree by the managed care organizations. In most cases, patients are allowed to "choose" their healthcare providers. However, if a physician does not participate with a specific managed care plan, he or she is excluded from that portion of the potential patient population. In many cases, this is not by the physician's choice. A payer can form a local network of providers in a given geographic area and exclude the remainder of the providers from its network. Patients wishing to see a physician not participating within a given network may not be reimbursed by the health plan for the physician's services. Therefore, they change to a physician who does participate so that insurance will pay for the services. A reduction in the patient census will negatively affect revenue, thus decreasing the value of the practice.

SUMMARY

The CPA consultant must be aware of the factors affecting the operations and revenue of the physician practice in performing valuation services. The primary value of the practice results from the projection of future revenues. The appraiser must not only be able to evaluate present operations in the practice, but must also be aware of future trends to be able to accurately project operations in the future.

Chapter 14

How to Collect and Analyze Data for a Medical Practice Valuation

Before performing the necessary analysis for valuing a physician practice, you must collect three types of relevant data:

- Client-specific financial and statistical data
- Physician practice industry data
- Regional economic and statistical data

CLIENT-SPECIFIC FINANCIAL AND STATISTICAL DATA

Certain items are crucial to determining a basis for the valuation opinions that will eventually result from the engagement. Although they are essential for the engagement, the clinic's financial statements and tax returns are not sufficient for forming an opinion as to the value of a physician practice. In order to perform a proper valuation analysis, the consultant must also have access to detailed client-specific information that resides outside the pure financial picture presented (statements and taxes). This necessary "full picture" information is embedded in the daily operations of the practice.

Table 14-1, "Examples of Client Data to Obtain When Performing a Valuation of a Physician Practice," lists some of the client-specific items that might be requested prior to beginning the engagement.

TABLE 14-1 EXAMPLES OF CLIENT DATA TO OBTAIN WHEN PERFORMING A VALUATION OF A PHYSICIAN PRACTICE

Financial statements—prior five years. This item is self-explanatory. The request also assumes the most current interim statements for the subject practice (if available).

Tax returns—prior five years. Forms 1120, 1065, or Schedule C (if the practice is a sole proprietorship). Encourage the client to include tax returns of any related entities (real estate partnerships, billing companies, and so on).

Charges, collections, and adjustments for the last five years. These are the three most important components of income. Items are crucial for analyzing collection percentages, and efficiencies or lack thereof in billing practices. These three items are the backbone of the practice's revenue stream and are necessary when analyzing accounts receivable, payer mix, adequacy of fees charged, and results of reimbursement trends.

Aging of accounts receivable. An aging is significant for determining the collectible portion of accounts receivable.

(continued)

TABLE 14-1 EXAMPLES OF CLIENT DATA TO OBTAIN WHEN PERFORMING A VALUATION OF A PHYSICIAN PRACTICE *(continued)*

CAUTION: Especially for smaller practices, most physician billing systems will only print an accurate accounts receivable aging as of the date requested. Many systems are not capable of printing an aging that is retrospective of a prior date. Therefore, if it is crucial that you have an aging as of March 31, the client will need to know that by that date. Otherwise, you may have to settle for an aging that is "close" to the valuation date.

List of debt obligations and possible pension accruals. If only practice assets are being appraised, it is important to know if any debts are secured by such assets.

Data regarding payer mix (preferably based on charges). What are the sources of revenue—Medicare, Medicaid, Blue Cross, HMO, capitated payers, self pay? Deviations in the practice's collection rate can be due to significant differences in the payer mix.

Total active patients. This number is often an estimate. However, many physician billing software packages will print the number of different patients seen by the physician over a stated period of time. The number of active patients can be important for calculating items such as a value for patient charts.

Average number of patient visits per day. This statistic is not necessarily intrinsic to the value of the practice. However, it is often a component of various compensation packages utilized by acquiring organizations. Therefore, it can be an important statistic for the users of the appraisal.

Average number of new patients per month. This statistic is often an indicator of the actual growth of the practice as opposed to growth through fee increases or patient utilization. Like the statistic for number of patient visits, this number is often more important for management's use than for the value of the practice. However, it is one more area that provides additional beneficial information to the users of the appraisal.

Average hospital census. How many hospital admissions is a physician responsible for? Although hospitals are not allowed to buy referrals, this is certainly an important statistic for a hospital that is acquiring the practice.

Gross charges by current procedural terminology (CPT) code (include procedure count if possible) for prior five years. This report may be one of the most important pieces of data obtained during the valuation process. Different billing software packages title this report differently. The most common title for this report is the "Production Analysis." The report indicates coding trends specific to the subject practice.

Analysis of this report can give users of the report an abundance of information that is helpful in the development of a fair and legal incentive compensation plan. The production analysis can indicate how much of the practice revenue is from ancillary services (X-ray, lab, and other diagnostic tests, and so on).

Additionally, the production analysis can also indicate coding issues that could lead to potential Medicare fraud and abuse problems.

TABLE 14-1 EXAMPLES OF CLIENT DATA TO OBTAIN WHEN PERFORMING A VALUATION OF A PHYSICIAN PRACTICE *(continued)*

Example: Dr. A reports a level of revenues that is well above the median for his area of specialty. This would usually tend to indicate a practice with a value that is higher than the norm. However, after analysis of the production report, it is determined that most office visits are being coded as a level IV or V visit. This could indicate a pattern of "up coding" by the physician. If this is the case, the acquiring entity may wish to reconsider the transaction due to the possible legal liability associated with the physician's coding practices.

Current practice fee schedule. A comparison to standard fee ranges for the geographic area can indicate potential areas for improvement to management. It can also indicate philosophical differences among practices that are anticipating a merger.

Medical specialty of physicians or mid-level providers in the practice. Information for comparison to industry standards is usually done on a specialty-by-specialty basis. For example, data for an internal medicine physician may not be comparable to industry data for an orthopedic surgeon.

Copies of curriculum vitae (CVs) for all providers. The CV is a resume of the physician's prior experience. It provides data that may be important for analysis of the prior management of the practice. Most valuations include an analysis of a company's management. Obviously, the physician(s) is an important part of the management team. In fact, sometimes he or she is the only component of management personnel.

Listing of employees, date of hire, current rate of pay, and job description. This is important information for users of the appraisal report, as it assists with determining potential adjustments necessary for two entities considering a transaction. Oftentimes, pay rates and fringe benefits can vary substantially from one entity to the next.

Example: Practice A is either merging with or being acquired by Practice B. Practice A gives its employees either no or little coverage in the area of fringe benefits. However, Practice B employees receive health insurance, a retirement plan contribution, and generous paid time off. To combine the two practices effectively, Practice A employees' compensation packages will need to be upgraded to the Practice B package, which will significantly increase the personnel costs of Practice A.

Listing of all participation agreements (such as PPOs, Medicare, and so on). Which healthcare plans does the practice participate with? Are there capitated plans for which the practice receives monthly payments? If so, how many patient lives does the practice cover and what is the per member/per month (pm/pm) payment received? This information can be analyzed in conjunction with the payer mix and can tend to explain reimbursement differences from industry standards for the specialty.

Listing of all fixed fee arrangements included in the practice (such as medical directorships or contractual relationships with industry). In many rural area primary care practices, the physician may receive a medical directorship from a local nursing home, receive payments for reading EKGs for a local hospital, or have a contract with a large industrial employer for various services. If any such directorships exist, will they be included in the appraisal?

(continued)

TABLE 14-1 EXAMPLES OF CLIENT DATA TO OBTAIN WHEN PERFORMING A VALUATION OF A PHYSICIAN PRACTICE *(continued)*

Description of billing procedures. This includes (1) software used, (2) process for posting charges and filing claims, (3) process for sending patient statements, and (4) process for increasing fees. This information can provide an additional benefit to the users of the valuation and can also assist the appraiser with identifying both weaknesses and efficiencies in the billing operations of the medical practice.

Description of medical office facilities. This includes (1) copy of lease, (2) square footage, (3) recent real estate appraisal if facility is owned (if available), and (4) mortgage balance if facility is owned. Depending on ownership of the real estate, are there normalizing adjustments that need to be made to the practice's financial statements for facility rent? If a building is included in the practice, but is not being included in the appraisal, does an adjustment need to be made to the income statement for rent?

Copies of all equipment leases. Information regarding equipment leases can assist the appraiser with identifying potential liabilities that may exist but not be recorded on the balance sheet. Historically, the financial reporting for most medical practices has been tax driven. Therefore, it is not uncommon to find capital leases that have not been capitalized. Obtaining copies of the leases can assist with identifying unknown liabilities and also potential equity in equipment that has not been capitalized.

Copy of current malpractice certificate of insurance. Does the physician have malpractice insurance to cover past acts? If not, is the other party to the anticipated transaction accepting any additional legal liability for prior acts?

List of any potential or pending claims or litigation in the last three years and a statement as to the outcome or status of the claim. Also include results of audits by Medicare or any other regulatory authorities. This information would be standard information required in the due diligence of any business combination. It is simply an added benefit to provide the users of the valuation with important information. Additionally, if there are pending claims, is there something about the claim that could potentially affect the value of the practice as a going concern? If the practice has been audited by Medicare, an unfavorable outcome of the audit can tend to indicate some potential integrity problems with management or some possible problems with the office billing personnel.

In addition to the "normal" financial data included with the valuation of any company, a significant amount of information needs to come from the subject's medical billing software. Often, the client may not even be familiar with the reports included in the document request list. It is often helpful to take a few minutes with the person most familiar with the billing software and review the list of available reports that can be generated by the billing application. You can often find reports that can provide critical practice data that the physician's staff didn't even know (or care) was available.

EXAMPLE

A necessary report for valuation purposes contains charges by CPT code. The practice may or may not review this information and consequently may not be aware of the software's ability to sort charges by procedure code.

See Tool 14-A, "Practice Valuation Questionnaire and Document Request List," which includes not only a sample document request form for a physician practice, but also an explanation of the items being requested on the form.

Tool 14-A: Practice Valuation Questionnaire and Document Request List (*Toolkit CD-ROM*)

PHYSICIAN PRACTICE INDUSTRY DATA

In order to analyze the significance of the information you obtain, you will need benchmarking or comparative data. The items listed below can serve two purposes: (1) they can be used in a comparison format when analyzing the practice's data, and (2) they can also be used as part of the analysis performed for the industry economic outlook portion of the report. Some of the industry data sources you should use in appraising a medical practice appear in Table 14-2.

TABLE 14-2 ANNUAL INDUSTRY DATA SOURCES

Medical Group Management Association (MGMA) Cost Survey. This annual survey compiles data on operating revenues and costs for physician practitioners. The data is published for multi-specialty and single-specialty practices. The survey provides excellent benchmarking data for the 19 most common specialties in addition to a plethora of data relating to multi-specialty practices. Contact the MGMA at 104 Inverness Terrace East, Englewood, CO, 80112-5306, (303) 799-1111, fax (303) 643-4427 or visit their Web site at www.mgma.com.

MGMA Physician Compensation and Production Survey. This annual survey compiles data on compensation and revenues for physicians and practitioners, sorted by specialty. It provides excellent benchmarking data for most specialties. Compensation and benefits data is reported based on demographics such as type, size, and geographic location. Production is reported based on some of the same comparisons as compensation. The survey also reports data for part-time primary care physicians and mid-level providers.

American Medical Association (AMA) Physician Marketplace Statistics. This annual survey provides data on items such as compensation, payer mix, fees, and expenses. It provides the mean, median, 25th percentile, and 75th percentile. Contact the AMA at Order Dept., P.O. Box 7046, Dover, DE, 19903-7046, (312) 464-4512, fax (312) 464-5837, or visit them at www.ama.assn.org.

(continued)

TABLE 14-2 ANNUAL INDUSTRY DATA SOURCES *(continued)*

AMA Physician Characteristics and Distribution in the U.S. This annual report provides data on trends, characteristics, and distribution of physicians. The trend information is by specialty and Metropolitan Statistical Area. The characteristics section reports individual characteristics of the population. The distribution section is for geographic data.

The Goodwill Registry. This report, published annually by The Health Care Group, Inc., is a compilation of medical and dental transactions. It provides an evaluation of intangible assets as a percentage of gross collections. All practice intangibles are summarized as "goodwill." The study is separated by specialty and year. Transactional data reported in the study include gross collections, purchase price, overhead percentage, goodwill percentage, demographics, type of transaction, and methods used in the appraisal of the practice. The report is released approximately the beginning of April each year. Contact The Health Care Group, Inc. at 140 W. Germantown Pike, Suite 200, Plymouth Meeting, PA 19462, (800) 473-0032, fax (610) 828-3658, or visit their Web site at www.healthcaregroup.com.

REGIONAL ECONOMIC AND STATISTICAL DATA

Before you can successfully appraise the value of a practice, you must be familiar with the economic environment in which the entity operates. This understanding includes not only being familiar with the factors that influence the general economy for the demographic location of the practice, but also having an understanding of the industry factors that may influence the perceived value of a specific practice. You can access most of this information for free over the Internet. Potential sources of economic data are included in Table 14-3, "Sources of Economic Data for Valuation of a Physician Practice."

TABLE 14-3 SOURCES OF ECONOMIC DATA FOR VALUATION OF A PHYSICIAN PRACTICE

Ibbotson Associates. ***Stocks, Bonds, Bills & Inflation Annual Yearbook, Valuation Edition.*** The book can be ordered on Ibbotson's Web site at www.ibbotson.com. The use of the data from Ibbotson will be explained later in the valuation engagement. However, as it pertains to an analysis of the overall economic outlook for the practice and the geographic area, it provides information on the results of the financial markets and inflation over the last 70 years.

U.S. Census Bureau. Available demographic data for most U.S. counties at www.census.gov. Census Bureau information can provide details regarding population and financial data for a specific area or region.

Local chambers of commerce. Most area chambers of commerce have Web sites on the Internet. Some sites are more informative than others. However, often it can be more useful to visit the local office at the same time a site visit is performed. Depending on the involvement of the chamber at the local level, some offices can provide an immense amount of financial and demographic information. A good chamber of commerce office will have such information readily available as part of attempting to attract new business to the area.

TABLE 14-3 SOURCES OF ECONOMIC DATA FOR VALUATION OF A PHYSICIAN PRACTICE *(continued)*

State economic development agencies. Most states have some sort of economic development agency Web site. They can be found by accessing www.nasire.org/statesearch/. Some of the information found at the state level will be a duplication of the information received from the census bureau and the chamber of commerce. However, sometimes additional information regarding industrial changes can be obtained. Local changes in the industrial component of a local economy can drastically enhance or detract from the future prospects of a physician's practice.

Regional Federal Reserve Banks. The regional federal reserve banks publish articles and statistical data by region, state, and city. The information available varies depending on the regional bank accessed. The Federal Reserve Board Web site with links to the various regional banks can be accessed at www.federalreserve.gov. The Fed offices are usually a valuable source for not only historical information but also for predictions regarding the economic outlook for the future of a given state or region.

Additionally, searches of newsgroups over the Internet using a search engine such as Google or Yahoo based on various healthcare topics can provide a wealth of information regarding economists' opinions on the national economy as it relates to healthcare and physician services. Searches of newsgroups can also provide information regarding expected changes in Medicare reimbursement and payer changes. Of course, governmental sites devoted to the healthcare industry provide a wealth of information as well.

THREE APPROACHES TO DETERMINING VALUE

There is no one-size-fits-all method for analyzing the data you have gathered and determining value. You must consider three approaches to determine the value of a business or its assets as a going concern. Going concern value is based upon the practice's earnings power and cash generation capability as it continues in business. The three basic approaches to determine value as a going concern are:

- The cost approach
- The income approach
- The market comparison approach

Cost Approach

The cost approach is generally utilized in valuations that include only specific components of the medical practice assets (for example, equipment and accounts receivable only). The cost approach tends to be less useful when appraising the full going concern value of the entire practice. Most methods within the cost approach do not include a value for all intangible assets. With this approach, each component of a business (including the liabilities) is valued separately. The values are totaled and the liabilities are subtracted to derive the total value of the practice. Estimates are made as to the fair market value of the individual assets and liabilities.

The cost approach assumes that the value of a physician's practice will not exceed the sum of its assets. You would value both tangible and intangible assets using the most appropriate method available. Upon completion of appraising all individual physician practice assets you add the amounts to reach a result. Tangible assets considered in the appraisal may include items such as accounts receivable, supply inventory, and equipment. Intangible assets may include, but are not limited to, goodwill, patient charts, assembled workforce, contracts, noncompete agreements, reputation, and going-concern value. Additionally, depending on the purpose of the valuation, real property owned by the medical practice may affect the appraisal or be included in it.

If the acquisition is for an equity interest in the practice, the corresponding liabilities associated with the business should be deducted from the value of the assets. Liabilities that may be included include debt secured by practice assets, unsecured debt, accrued liabilities such as pension contributions, and accrued payroll liabilities.

> **Practice Tip:** This method is used in conjunction with a valuation for marital dissolution purposes more commonly than anything else. Under the cost approach, it is much more difficult to obtain a value that accurately includes the full value for intangible assets. However, in various states, many of the intangible assets are excluded from the final value because they are associated with the physician's professional goodwill.

Income Approach

The income approach is generally used more often when the objective of the appraisal is the determination of the going concern value of the practice. Methods utilized under the income approach compute a business enterprise value—a value of all assets, tangible and intangible. The income approach to valuation is based on the assumption that an investor would invest in a property with similar investment characteristics, but not necessarily the same business. The computations used with the income approach generally determine the value of the business to be equal to the expected future benefits divided by a rate of return. This approach involves capitalization, which is the process of converting a benefit stream into value. The value derived is the value of the operating assets and liabilities of the entity. The non-operating assets (if any) being purchased are then added to the value as determined to obtain the value of the enterprise.

Discounted Cash Flow Method

The income approach to value is based on the theory that a physician practice is worth the future benefits derived stated in terms of present value. The most common method used under this approach for medical practice appraisals is the discounted cash flow (DCF) method. Based on an analysis of the practice, normalized after-tax cash flows are projected for a period of time until a stabilized level of operations is achieved. Some practitioners prefer to use projections for a predetermined period such as five years. However, if the stabilized level of operations is reached prior to the predetermined period, the additional years of projected cash flow have little or no affect on the value. Quite often, the reason for

using a predetermined period for the DCF when only two or three years are sufficient is due to client requests for five years of projected data to review.

The cash flows derived from the projection are discounted to arrive at a present value. The sum of the discounted values is added to a terminal value, or a value into perpetuity, to arrive at the after-tax enterprise value of the medical practice. Additionally, you must make sure that an after-tax discount rate is applied to after-tax cash flows.

> *CAUTION:* In many cases, the most difficult part of applying the DCF method in a valuation is making the normalizing adjustments to the medical practice financial statements. Items that may need consideration for adjustment include, but are not limited to, physician's compensation, facility rent, equipment leases, retirement plan contributions, charitable contributions, the physician's personal luxury auto, family members on the practice payroll, family members who actually work but are *not* on the payroll, and the inclusion or exclusion of medical directorships.

Discount Rates. An entire separate book could be written, and many have been, on the derivation of the appropriate discount rate. In short, the discount rate should reflect an investor's required rate of return for an investment based on the associated risk. Different methods are used for developing discount rates. However, the two most common are the build-up method and the capital asset pricing model (CAPM). Whichever method is used for developing the discount rate, the appraiser must have a thorough understanding so those items involving professional judgment can be substantiated and defended. No matter which method is used for arriving at a discount rate, there will be a portion of the rate that relates to the risk associated with the specific practice. The appraiser must understand which practice factors affect the risk associated with the practice being appraised. The determination of this additional level of risk is where the subjective professional judgment comes into play.

Build-Up Method

Many appraisers, especially those who work with smaller privately held companies, use a "build up" method of developing a discount rate. The build-up method includes three basic elements the sum of which determines the appropriate discount rate. The three elements include (1) the risk-free rate, (2) a general risk premium, and (3) a specific risk premium.[1] The three elements are combined in a "building block" fashion.

The first "block" is the risk-free rate, which most appraisers generally equate to the 20-year Treasury bond yield. The long-term Treasury bond yield is thought to be the closest vehicle in which an investor could invest funds with no risk. The second "building block" is the general risk premium or the equity risk premium. This premium is most commonly obtained from *Stocks, Bonds, Bills and Inflation Annual Yearbook*, published by Ibbotson Associates of Chicago (www.ibbotson.com). The equity risk premium for appraisals of physician practices generally consists of two parts - a large company premium and an additional small company premium. The large company premium reflects the return

[1] Gary R. Trugman, *Understanding Business Valuation, A Practical Guide to Valuing Small to Medium-Sized Businesses, 2nd edition* (New York: American Institute of Certified Public Accountants, Inc., 2002), p. 234.

required above the risk-free rate when investing in a diversified portfolio of large company stocks. The small company premium measures the required return for companies in the 9th and 10th decile of the New York Stock Exchange, which is generally several percentage points higher than the large company returns. The final "building block" is the specific risk premium. This premium is the portion of the method that relies the most on your professional judgment about the risk associated with the medical practice that is above and beyond the risk of a diversified portfolio of small company stocks. It takes into account the specific characteristics of the subject physician's practice and the healthcare-medical practice industry.

An example of the application of the build-up method to the discount rate for a physician practice might be as follows:

DISCOUNT RATE COMPONENT	RATE
Risk-free rate[2]	6.48
Equity risk premium[3]	8.00
Small company risk premium[4]	2.60
Specific company risk premium	4.00
Discount rate (rounded)	21.00

Capital Asset Pricing Model (CAPM)

CAPM is generally used for determining the appropriate discount rate for larger companies. Therefore, its usefulness in the appraisal of a physician's practice is limited, since most physician practices would not constitute a large company. However, there are a number of valuation practitioners who prefer CAPM to the build-up method. Before CAPM can be applied to a smaller closely held company, such as a medical practice, you must understand how it applies to larger companies. In theory, the use of CAPM eliminates the unsystematic risk through the use of the beta attributable to the subject company. The appropriate beta can be found from several sources. The most commonly used source is the *Cost of Capital Yearbook* (available with quarterly updates), published by Ibbotson Associates (www.ibbotson.com). The formula for applying CAPM to a larger company is as follows:

$$k_e = R_f + [\beta \times (R_m - R_f)]$$

where:

k_e	=	Expected rate of return
R_f	=	Risk-free rate
β	=	Systematic risk (beta)
$(R_m - R_f)$	=	Long-term average risk premium of the stock market as a whole minus the average risk-free rate (equity risk premium)

2 Barron's, December 13, 1999.

3 *Stocks, Bonds, Bills and Inflation 1999 Yearbook, Valuation Edition* (Chicago, IL: Ibbotson Associates, 1999).

4 See note 3.

However, for smaller closely held companies such as physician practices, the notion of the elimination of unsystematic risk can hardly be assumed. Most small business owners do not have the ability to invest funds in other vehicles to sufficiently diversify their portfolio, which includes the stock in their medical practice. Therefore, when applying CAPM to a smaller business, the formula needs to be modified to include a component for unsystematic risk. For smaller companies, the formula is as follows:

$$k_e = R_f + [\beta \times (R_m - R_f)] + SCP + SCA$$

where:

k_e	=	Expected rate of return
R_f	=	Risk-free rate
β	=	Systematic risk (beta)
$(R_m - R_f)$	=	Long-term average risk premium of the stock market as a whole minus the average risk-free rate (equity risk premium)
SCP	=	Small company premium
SCA	=	Specific company adjustment

An example of the application of CAPM might work as follows, assuming that our industry has a beta of 1.2:

DISCOUNT RATE COMPONENT	**RATE**
Risk-free rate[5]	6.48
Equity risk premium[6]	9.60
Small company risk premium[7]	2.60
Specific company risk premium	2.50
Discount rate (rounded)	21.00

In each valuation, it is helpful to take off your appraiser's hat and put on the hat of an investor. Ask yourself, "If I were investing in this medical practice, would a rate of return equal to my discount rate be appealing or seem reasonable?"

> *CAUTION:* Do not fall into a pattern of believing that certain types of businesses or medical practices should have a discount rate that is always approximately a certain amount. Every single valuation engagement is separate with each subject practice having its own special characteristics. There are circumstances in almost every medical practice appraisal that make the discount higher or lower than "the

[5] Barron's, December 13, 1999.

[6] *Stocks, Bonds, Bills and Inflation 1999 Yearbook, Valuation Edition* (Chicago, IL: Ibbotson Associates, 1999).

[7] See note 6.

norm" assuming that is there is an animal. To fall into a pattern of believing that the discount rate for every medical practice should fall within some narrow range is not only dangerous, it's not true.

Physician's Compensation

Another item to consider when you use the income approach to appraise a physician practice is the compensation. Compensation is the one area where the principle of "fair market value" conflicts somewhat with regulatory requirements. For most "fair market value" valuations, it is necessary for you to adjust the owner's or physician's compensation when normalizing the financial statements. By using sources such as the MGMA *Physician Compensation and Production Survey*, the compensation is adjusted to approximate benchmarks for practices with similar levels of revenue within the same medical specialty.

However, when performing a physician practice valuation that you know is subject to review by Medicare you must give special consideration to the level of physician's compensation. For example, if you determine that the normalized physician's compensation for an internal medicine practice should be $150,000, but the acquiring organization is going to pay the physician $200,000, the normalizing adjustment for compensation may need to be $200,000. Making such an adjustment may be considered contrary to the hypothetical willing buyer component normally contemplated in a "fair market value" appraisal. However, the acquiring entity that agrees to pay physician compensation of $200,000 and an enterprise value for his or her practice based on cash flows that uses $150,000 is overpaying for the value of the practice and may be subject to physician inurement issues. Inurement may exist because the acquiring organization has paid for an estimated $50,000 ($200,000 – $150,000) of annual cash flows that will not exist due to the increased compensation. Therefore, when performing a practice valuation for an acquiring non-profit entity, the appraiser must obtain an understanding of the contemplated compensation that will be offered to the physician. For appraisal engagements that do not relate to acquisitions or mergers by non-profit organizations, this issue may or may not apply to the valuation from a legal standpoint, but will still apply for common sense purposes.

The area of the physician compensation can provide you with opportunities for additional services to your client. The physician's compensation can often range between 40 percent and 60 percent of the net medical practice revenues (collections). Therefore, the development of a compensation package is not only critical as it relates to the resulting value of the practice in the report, but it also is important for making sure that the client does not use a method that is in violation of federal regulations.

Other chapters of this publication discuss the intricacies of physician's compensation, so we will not "beat a dead horse" at this juncture. However, the normalizing adjustment for the physician's compensation in the application of the DCF method is probably the most significant adjustment made to the practice's income statement. Therefore, it is critical that you make the proper adjustment. Remember, you can prepare a report for the best valuation ever performed, but if you make a mistake on the physician's compensation, the resulting value can be greatly over- or understated.

Market Comparison Approach

The market comparison approach uses various methods such as comparable sales method, the public companies method, and industry benchmarks or rules of thumb. These methods are used to determine the value of the entire business enterprise rather than only components thereof. Since medical practices do not normally have any comparable public companies, transactions of comparable nonpublic entities are normally analyzed.

Comparison to Publicly Traded Companies

Some appraisers prefer to utilize data from the publicly traded physician practice management companies (PPMCs). However, most PPMCs are not necessarily providers of healthcare services, but providers of management services. There are not many publicly traded companies available that only provide the physician practice type of healthcare services. As mentioned above, some of the PPMCs do provide the services, but most also include a large component for management services revenue. Access to the publicly traded companies' SEC filings may provide some detail of larger practices acquired by the PPMCs. The information included in the publicly traded companies acquisitions can be found, among other places, in the SEC's database—EDGAR. It can be accessed for free at www.sec.gov/edgarhp.htm.

Comparable Sales Method

The comparable sales method or market transaction method is similar to the method that most people are familiar with when it comes to real estate transactions. The market data method has its theoretical basis in the principle of substitution, which states that, "prudent individuals will not pay more for something than they would pay for an equally desirable substitute."[8] For this method you would search for actual transactions of similar medical practices. Once a population of transactions for similar companies has been identified, you attempt to identify relationships within the population that appear to influence or indicate value.

Sources of Transactions

Transactions for physician practices that are similar to the subject practice can be found from a number of sources. See Table 14-4 for some of those sources.

[8] Gary R. Trugman, *Understanding Business Valuation: A Practical Guide to Valuing Small to Medium-Sized Businesses, 2nd edition* (New York: American Institute of Certified Public Accountants, Inc., 2002), pp. 55-56.

TABLE 14-4 SOURCES OF TRANSACTIONS

The Goodwill Registry. Detailed in Table 14-2. *The Goodwill Registry* is the most comprehensive source available for physician practice transactions. A recent edition had over 3,500 transactions of physician and dental practice transactions.

The Institute of Business Appraisers, Inc. (IBA). The IBA's database is available to IBA members. Not all transactions denote the specialty of the practice sold. However, details regarding sales price, revenues, earnings, owner's compensation, location, and date of transaction are provided. Requested transactions are faxed or e-mailed in Excel format to the member. Although the database is only available to IBA members, access to the database is worth the membership price alone. Contact the IBA at P.O. Box 17410, Plantation, FL 33318, (954) 584-1144, www.instbusapp.org.

World M&A Network—Done Deals Database. At the time of this publication, Done Deals had over 5,800 transactions in their database. The last search of physician practice transactions provided 64 acquisitions of practices of varying specialties. Done Deals provides key ratios and financial data, sales price, terms of deal, and buyer and seller description. Subscription to the service on disk is updated quarterly. The online subscription is updated weekly. The database is available on disk or online at nvst.com/donedeals.

Pratt's Stats. As of August 2003, Pratt's Stats had approximately 5,100 transactions in its database. The number of transactions for physician practices totals approximately 58. Pratt's Stats provides eight different valuation multiples for each transaction, financial statements, terms of transaction, and additional important factors. Subscription to the service on disk is updated quarterly. The online service is updated monthly. It is available on disk and online at www.bvresources.com or (888) BUS-VALU.

BIZCOMPS. As of August 2003, BIZCOMPS had approximately 5,500 transactions in its database. BIZCOMPS is a fairly popular source of transactions for appraisers. However, it only had one transaction for physician practices. Information provided for transactions in the database includes sales price, gross revenues, seller's cash flow, and terms of transaction. BIZCOMPS is available on disk and online. The database is updated annually. Contact BIZCOMPS at P.O. Box 711777, San Diego, CA 92171, (858) 457-0366 or online at www.bizcomps.com.

Practice Tip: It may seem obvious, but you need to ensure that if you use transactions that included stock, the sale price should be converted to a cash sales price basis. In many cases, the sale price that includes the acquirer's stock may vary significantly due to the risk associated with the stock used as consideration. Additionally, restrictions on the sale of such stock by the recipient can affect the price "paid" for a medical practice.

Analysis of Selected Transactions. After you have selected the transactions of the comparable physician practices you can calculate various multiples. As with the income approach, the subject practice's revenues and expenses are normalized. Applicable multiples are then applied to the normalized revenues, cash flows, and earnings. In using the databases mentioned above, or any others, you must be careful to determine whether you are using public company or private company data. In most medical practice acquisitions, the acquired practice is a private company. The databases referred to above generally report a value for 100 percent of the company. Therefore, if the comparable transaction used is a public company, it provides a value that is a minority, marketable value. If the comparable transaction is for the acquisition of a private company, it provides a value that is a control, nonmarketable value. This is important when determining whether any premiums or discounts for control or minority interest and marketability apply to the resulting value.

Consideration of the Three Approaches

In the previous sections we have discussed the various situations in which each of the three approaches (cost, income, and market) might apply to the valuation of a medical practice. In performing such an engagement, it is necessary for the appraiser to at least consider the use of all three approaches. Additionally, the appraisal report should state that all three approaches were considered. It is perfectly acceptable for one or even two of the approaches to be considered not relevant or not applicable. But the reasons should be given in the report as to why certain approaches were not deemed appropriate.

After all approaches to value have been considered, you must use your professional judgment to determine an estimate of value. Appraisers differ on whether weighting of the methods should be considered or whether specific estimates from one of the methods utilized should be chosen. The appropriate value conclusion may be (1) exactly the amount of one of the valuation approaches, (2) an overall conclusion based on the range of values obtained from the various approaches, or (3) a weighted average of the various approaches used.

In many cases, the last two conclusions are actually the same. The actual mathematical weighting of values should be used only to inform your client of your own professional judgment as to the importance of each approach used in the valuation. If you are using explicit weights, you should acknowledge in the written report that there are no empirical bases by which to assign weights to various methods and that the purpose of the quantitative weighting is only to aid the client in understanding your thought process.[9] The weighting only serves to quantify the appraiser's confidence in the various conclusions of value reached during the engagement. Even when using a mathematical weighting of valuation methods, it is imperative for you to discuss, in narrative form, the reasons for relying on one method over another. For valuations not including going concern value (goodwill), only the asset approach is necessary. For valuations that do include going concern value, all three approaches may be necessary. However selected, the estimate used should be the one that, in your professional judgment, is the best indication of fair market value as defined in Revenue Ruling 59-60.

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[9] Shannon P. Pratt, Robert F. Reilly, and Robert P. Schweihs, *Valuing Small Businesses and Professional Practices, Third Edition* (Burr Ridge, Ill.: McGraw Hill, 1998), p. 484.

Estimates of value for medical practices are under careful scrutiny from federal regulators. It would appear that transactions can take place at fair market values, but not in excess. Transactions above fair market value run the risk of fines or sanctions from the Internal Revenue Service or the Office of Inspector General (OIG), for violations of the Internal Revenue Code or Stark legislation. Appraisals of medical practices should not be taken lightly.

SUMMARY

The research, collection of relevant data, and analysis of such data are the backbone of the valuation engagement. Without them, the appraiser has nothing on which to base his or her assumptions or professional judgment. There are many situations during a valuation engagement in which the appraiser must make decisions based on his or her professional judgment. The data gathered and analyzed is the foundation for those decision points. In the body of the written valuation report, the appraiser must substantiate and justify the reasoning behind such decisions or judgments. Having valid data that has been properly analyzed and correlated with the subject practice is the basis that gives an appraiser the confidence that his or her assumptions and opinions are correct and justifiable.

An appraiser can be "perfect" when it comes down to making the mathematical calculations involved in a valuation engagement. However, if he or she cannot adequately describe and substantiate his or her positions, the entire report can lose its credibility—even if the calculations are correct. Therefore, it can't be emphasized enough how important the data collection and analysis process is. It is the "backbone" that gives your report the ability to stand on its own.

Chapter 15

How to Conduct the Valuation Engagement

When it comes to conducting the valuation engagement, the steps are not too different from those in conducting the medical practice review. Yet while the steps listed below may seem redundant with those covered earlier, in Section 2, this chapter includes tips and guidelines for applying them to a valuation engagement.

STEPS FOR A COMPLETE, THOROUGH VALUATION ENGAGEMENT

Defining the Engagement

If you do not have an exact understanding of the client's expectations and the reasons for the valuation, the remainder of the steps beyond this one can be rendered worthless. Foremost in this process is the reason for the valuation. You can assist the client with determining the standard of value to be measured if he or she has a thorough understanding of the reason for the engagement. Is the engagement for an acquisition, development of a buy-sell agreement, a divorce, or some other purpose? This part of the process is also used for determining what part of the practice will be appraised. For example, will the valuation be for 100 percent of the assets or the stock? Will it be for a portion of the practice that is less than 100 percent (possibly a minority interest)? Who will be the end user of the valuation report?

All of this information goes into the engagement letter. Although engagement letters are not required by the various standard-setting organizations, they are critical to defining the objectives of the engagement and minimizing potential misunderstandings that can lead to legal problems.

The appraiser and the client (or in some cases the client's attorney) should execute an engagement letter that includes certain items defining the engagement.

1. *Identification of the property to be valued.* Will intangible assets be included? Is the subject of the appraisal the practice assets or the corporation's stock? Is real estate owned by the practice or the physicians to be included in the engagement?
2. *Effective valuation date.* Depending on the reason for the engagement, it is usually best to let the client's legal counsel determine the date of the valuation.
3. *Relevant ownership characteristics.* This section can dovetail with the section on the identification of the subject property.
4. *Definition (standard) of value.* Is the standard of value "fair market value" or some other standard? In many instances, the client requesting the valuation will not know what standard of value they want. It is important to listen and clearly understand the objectives of the appraisal to adequately assist the client with determining the proper standard of value to use. This will be an opportunity to educate the client on the outcome of the engagement.

5. *Access to information sources and any known limiting conditions.* Define the information necessary to perform a complete valuation of the practice. If access to certain documents is limited during the engagement, this can become an important section of the letter.
6. *Scope of written and/or oral report.* This part of the letter is merely to define the expected outcome (not in terms of final value) of the report and to assist the appraiser in adequately meeting the expectations of the client.
7. *Intended use or uses of the appraisal.* As the appraiser, knowing the intended use of the appraisal is crucial to meeting the client's expectations. Additionally, you will want to limit the use of the report to the intentions stated to you by the client so that you do not unknowingly accept additional liability. For example, if you are requested to perform a valuation for acquisition purposes that never come to fruition, you don't want the client also using the report for obtaining credit without your knowledge or approval.
8. *Contractual relationship with the client.* How much will the engagement cost? If this is a new client, how much of a retainer will be required before undertaking the engagement? (Retainers are standard operating procedure for most professional appraisers. Don't be afraid to ask for it.) When are payments expected?
9. *Any special instructions from the client or attorney.* Close with any standard language deemed necessary by the firm or other areas deemed necessary by any of the parties involved in the engagement (appraiser, client, or attorney).

See Tool 15-A, "Sample Valuation Engagement Letter."

Tool 15-A: Sample Valuation Engagement Letter *(Toolkit CD-ROM)*

Requesting Documents

Now that you know what is being appraised, you have agreed to do it, and the client has agreed to pay for it, the data gathering begins. The first part of this portion of the appraisal is to send the client or client representative a questionnaire or checklist of items that are needed to perform the engagement. (See Tool 14-1 on the *Toolkit CD-ROM* for a sample practice valuation questionnaire and document request list.)

Most professionals who perform valuations have a standard checklist that is sent to the client to begin the data gathering process. However, keep in mind that each business or physician's practice is different and the various items needed will differ from one engagement to the next. As mentioned in the preceding paragraph, knowing the reasons for the valuation will dictate which items to include in the document request list. Standardized questionnaires are nice to have, but no one document should ever be assumed to be all-inclusive.

Visiting the Site

The same time that you send the questionnaire and checklist to the client, you should schedule a site visit to retrieve the requested information. This helps the client commit to a due date for gathering the information and keeps the engagement on pace towards the necessary completion date. Take this moment to verify directions to the client's office and determine who are the practice representatives to be interviewed.

In a physician practice setting, it is generally helpful to interview the physician(s), the office manager, and the bookkeeper. As with the medical practice review, the most important aspect of the site visit is to listen to the client's representatives during the interview process. Almost without exception, the interviews and a quick scan of the data provided by the client will generate the need for additional items or data to adequately perform the engagement. However, unlike a medical practice review, your site visit will also include an inventory of the furniture and equipment used in the practice. It may be important to make note of vendors and model numbers on some equipment in the event that further research is needed regarding the value of significant pieces of equipment.

If performing the site visit will involve some travel, you can also use this time to contact the local chamber of commerce office and obtain some demographic data on the area. At the end of the site visit, make sure the client has a clear understanding of the additional information you need to complete the appraisal (in other words, leave the client a list).

Gathering and Analyzing the Data

Now that you have gathered all the data you can retrieve from the client, it is necessary to perform the next step of the data gathering process. To progress to the next step, you must gather all the industry and economic information necessary to perform an adequate analysis of the practice. Some of those sources have been discussed in prior chapters of this guide. Other additional sources are listed in Chapter 14, Table 14-3, "Sources of Economic Data for Valuation of a Physician Practice."

This portion of the engagement is used to prepare exhibits, schedules, and graphs that will be used in the report to support the analysis and the conclusions regarding the value estimates included in the report.

The next step of the process is to perform an analysis of the data gathered to date.

> **Practice Tip:** At this point in the process, it may be helpful to begin writing the portion of the report up to the value estimates. Writing the portions of the report that include the history of the practice, the economic analysis, and the financial data analysis can assist the appraiser with forming opinions or conclusions about the practice that will have an impact on the calculations performed under the various approaches.

This step might include analyzing historical financial trends of the practice, comparisons to industry data, and other practice data such as payer mix, accounts receivable aging, fee schedules, production reports, and participation with managed care contracts. A complete

understanding of the practice and industry is necessary to making some of the subjective professional judgment decisions that will occur later in the process. After performing the financial and data analysis, you need to be able to answer the following questions.

- What is the financial outlook for the practice (reimbursement, number of providers, leveraging)?
- What are the strengths and weaknesses of the practice compared to its peers?
- What are management's plans for the future (capital or personnel expenditures and availability of capital)?
- Who are the competitors?
- What other alliances are being formed locally?
- Is the provider market overserved or underserved?
- Is the practice more or less profitable than others in its peer group?
- Are there areas of financial data that are outliers when compared to the practice's peer group?
- Are any of the physician's personal expenses "buried" in the financial statements?

Other unforeseen questions or facts will invariably arise during the data gathering process. Any or all of these questions or factors may steer your thought process in a particular direction. The key to performing an effective analysis of the practice data is to listen and ask pertinent questions during the data gathering portion of the engagement.

Preparation of Value Estimates

At this point in the engagement, you are ready to value the practice. In Chapter 14 we discussed the three different approaches to value—cost, income, and market. We also gave guidelines on determining which of those approaches should be used to value the practice. At this point in the engagement, it is also prudent for you to perform a "sanity check" for the value estimates you calculate. Another term used for this process is the "smell test." This may be done by using a "justification of purchase test" or by comparing the value to the value conclusions reached in other similar engagements. The justification of purchase test assumes a reasonable portion of the purchase price is paid "up front" and the balance is financed at a reasonable rate of interest over a reasonable rate of time. The resulting repayment schedule can be an excellent indicator as to whether the value estimate is within a reasonable range. Finally, ask yourself, "Knowing the risk associated with the investment, would I pay this amount for the return generated by this practice?"

Writing and Reviewing the Report

At this point in the valuation engagement, you are ready to write the report. When writing the valuation report, you must understand which appraisal standards apply to the current engagement. Depending on the organizations in which you hold membership, different sets of standards may apply. However, many of the standards have similar requirements. Some of the different sets of standards that apply to business valuations include:

- Uniform Standards of Professional Appraisal Practice (USPAP)
- AICPA Management Consulting Services (MCS) Statement on Consulting Services
- Institute of Business Appraisers (IBA) Standards
- American Society of Appraisers (ASA) Standards

Application of these standards may be determined by association membership. For example, a CPA appraiser credentialed through the IBA would be required to comply with their standards in addition to the AICPA standards. The Uniform Standards of Professional Appraisal Practice generally apply to all appraisers. A description of the various standards listed above is included in Table 15-1.

TABLE 15-1 VALUATION STANDARDS THAT MAY APPLY TO THE APPRAISAL OF A PHYSICIAN PRACTICE

Uniform Standards of Professional Appraisal Practice (USPAP). USPAP is probably the one set of standards that valuation professionals are most familiar with. USPAP is published by The Appraisal Foundation. They not only apply to business appraisers, but also to appraisals of things such as real property and personal property. It is highly recommended that all valuation professionals possess a copy of USPAP. Standards 9 and 10 of USPAP are the sections that apply to business valuation. However, various parts of the other sections also apply to business valuations. The main issue in regards to whether to apply USPAP to a valuation engagement is whether the transaction in question is a "federally related transaction." FIRREA legislation dictates that USPAP must be followed for all such transactions. The language "federally related transaction" is somewhat vague. However, in the context of a physician practice valuation, if the engagement is for acquisition by a non-profit entity that will be subject to IRS or Office of Inspector General (OIG) scrutiny, USPAP may apply. Additionally, USPAP may apply to valuations performed for estate tax purposes. When in doubt as to whether USPAP applies, follow the standards to make sure that your report is not dismissed from court proceedings at a later date.

AICPA MCS Statement on Consulting Services Standards. The AICPA's Management Consulting Services Division has issued standards that cover consulting services in general—including valuation services. The standards reference Rule 201 of the AICPA Code of Professional Conduct, which includes areas such as competence, due professional care, planning and supervision, and obtaining sufficient relevant data. The standards are designed to cover the range of consulting services provided by its members.

IBA Business Appraisal Standards. All members of the Institute of Business Appraisers, Inc. are required to follow the standards. The IBA's standards are possibly the most comprehensive of all the business standards. They cover six standards: (1) professional conduct, (2) oral appraisal reports, (3) expert testimony, (4) letter form written appraisal reports, (5) formal written appraisal reports, and (6) preliminary reports. The IBA's standards probably offer more direct guidance than any of the other standards.

(continued)

TABLE 15-1 VALUATION STANDARDS THAT MAY APPLY TO THE APPRAISAL OF A PHYSICIAN PRACTICE *(continued)*

ASA Business Valuation Standards. All members of the American Society of Appraisers are required to follow the ASA's standards. The ASA standards are also very comprehensive and lend direct guidance to appraisers regarding a number of matters. They cover seven general areas: (1) general requirements, (2) financial statement adjustments, (3) asset-based approaches to valuation, (4) income approaches to valuation, (5) market approaches to valuation, (6) reaching a conclusion, and (7) written valuation reports.

In the context of the appraisal of a physician's practice, following any or all of the above listed standards cannot hurt the valuation professional. Depending on memberships to the various organizations, some standards may or may not apply. However, all are generally applicable to most valuation engagements and can often provide specific guidance regarding certain issues.

NOTE: The AICPA Consulting Services Executive Committee is issuing for public comment the first in a new series of valuation standards, proposed Statement on Standards for Valuation Services No. 1, early in 2004. CPAs performing valuation services should be alert to the issuance of the final standard. To view the exposure draft, go to www.aicpa.org.

There are a number of excellent sources available with sample reports for various types of valuation engagements.

> *CAUTION:* The use of boilerplate language with certain parts of valuation engagements is inevitable. However, you must keep in mind that each engagement is different. Reliance on boilerplate language for every report will cause trouble. The most important part of a valuation engagement is the expression of the appraiser's thoughts, opinions, and analyses and how they contribute to the final outcome of the engagement. In many parts of a valuation report, boilerplate language can stifle the professional's ability to properly explain and support his or her opinion.

Tool 15-B, "Sample Valuation Report," includes a sample valuation report for the acquisition of a physician practice by a nonprofit hospital. The sample report is intended to illustrate appraisal practice and serve as a guide in the application of business appraisal methodology, report drafting, report organization and structure, and use of graphics and tables. This sample report is believed to depict good appraisal practice, but no warranty of this is made. Users are admonished to perform their own due diligence in determining that the appraisal methodology they employ is consistent with good appraisal practice.

Tool 15-B: Sample Valuation Report ***(Toolkit CD-ROM)***

Table 15-2 contains other sources for sample reports. Not all are for medical practices, but can be helpful regarding content nonetheless.

TABLE 15-2 OTHER SOURCES FOR SAMPLE VALUATION REPORTS

Valuing Small Businesses and Professional Practices (third edition, 1998) by Shannon P. Pratt, Robert F. Reilly, and Robert P. Schweihs. This book includes a sample report for a pediatric medical practice. The book also includes a case study and solution that is in a basic report format for a distributing company that can also lend guidance to a general report format.

Business Appraisal Reports Library by the Institute of Business Appraisers, Inc. (www.go-iba.org). The IBA has a library of reports that can be ordered on CD-ROM or book form by members and non-members. Eight sample reports include one report for a medical practice—divorce engagement. Other reports, although not physician practice related, that can be useful include a restaurant (divorce), manufacturer (gift tax), family limited partnership (gift tax), manufacturer (estate settlement), oppressed shareholder action (dissenting stockholder suit), contractor (actual sale), and a high tech company (ESOP related). The CD-ROM also includes the IBA Data Analyzer, a Glossary of Business Appraisal Terms, the IBA Standards, tutorials, and selected Web site links.

Understanding Business Valuation—A Practical Guide to Valuing Small to Medium-Sized Businesses (2nd edition, 2002) by Gary R. Trugman. This book does not include an example of a physician practice valuation, but does include both formal and informal sample reports, which can be helpful in an appraisal engagement.

Basic Business Appraisal by Raymond C. Miles. This book includes both an informal letter report and a formal written report. Neither examples are medical practices. However, excellent guidance can be extrapolated from the samples on the types of information, format, discussion, analysis, and conclusions that should be included in a "typical valuation report."

Financial Valuation: Applications and Models by James R. Hitchner. This book includes a sample report for a manufacturing company. Even though the example is not a medical practice, the format and substance of the sample report is quite useful. This book includes a chapter on valuation issues in professional practices.

After you write the report you need to review it, and there are two parts to the review stage. First, make certain that the facts and assumptions flow together from section to section. For example, make sure that positions taken during the value estimate portion of the report do not conflict with the financial analysis performed earlier in the report. Also use this time to run the "spell check" function for the application used to write the report.

Next, have another person review the report. It is great if you have another professional with valuation experience to review the report for technical correctness. However, even the appraiser without that luxury should have a second person read the report. Another professional who has no valuation experience should be able to understand the flow of the report and the conclusions reached, and make certain that the spelling and grammar are correct. In many cases the end user does not have any valuation experience either. However, he or she needs to be able to understand how the appraiser reached the conclusions regarding the estimates of value and why. Tool 15-C, "Valuation Checklist and Processing Form," and Tool 15-D, "Valuation Engagement Work Program Checklist," can be used to help manage and facilitate the valuation process.

Tool 15-C: Valuation Checklist and Processing Form *(Toolkit CD-ROM)*
Tool 15-D: Valuation Engagement Work Program Checklist *(Toolkit CD-ROM)*

Delivering the Report

Although it is not always possible, delivery of the valuation report should be done through a face-to-face meeting with the end users. It is helpful for the appraiser to walk the client through the report and the process in general. The meeting facilitates a better understanding not only of the results of the report, but also of the amount of work involved in producing the report.

Further Sources of Information

Table 15-3 provides useful sources you can turn to for help.

TABLE 15-3 FURTHER SOURCES FOR VALUATING MEDICAL PRACTICES

American Medical Association. *Physician Marketplace Statistics.* Chicago, IL, annual.

American Medical Association. *Physician Characteristics and Distribution in the U.S.* Chicago, IL, annual.

Fishman, Jay E., Shannon P. Pratt, J. Clifford Griffith, and D. Keith Wilson. *Guide to Business Valuations, Ninth Edition.* Fort Worth, TX: Practitioners Publishing Company, 1999.

Health Care Group, The. *Goodwill Registry.* Plymouth Meeting, PA, annual.

Ibbotson Associates. *Stocks, Bonds, Bills and Inflation Yearbook, Valuation Edition.* Chicago, IL, annual.

Institute of Business Appraisers, Inc., The. *Business Appraisal Reports Library.* Plantation, FL.

TABLE 15-3 FURTHER SOURCES FOR VALUATING MEDICAL PRACTICES *(continued)*

Medical Group Management Association. *Cost Survey*. Englewood, CO, annual.

Medical Group Management Association. *Physician Compensation and Production Survey*. Englewood, CO, annual.

Miles, Raymond C. *Basic Business Appraisal*. Boynton Beach, FL: Southeast Business Investment Corp., 1984.

Pratt, Shannon P., Robert F. Reilly, and Robert P. Schweihs. *Valuing Small Businesses and Professional Practices, Third Edition*. New York, NY: McGraw-Hill, 1998.

Rosenthal, R. Christopher, "Helping Your Primary Care Physician Clients Value and Sell Their Practice: A Case Study." November 17, 1996, Presentation at the 1996 AICPA National Business Valuation Conference.

Trugman, Gary R. *Understanding Business Valuation, A Practical Guide to Valuing Small to Medium-Sized Businesses, Second Edition*. New York, NY: American Institute of Certified Public Accountants, Inc., 2002.

Wilhoite, Charles A. "Implications of Stark Legislation with Regard to the Valuation of Affected Health Care Entities," *Willamette Management Associates Insights: Special Health Care Issue*, 1995.

SUMMARY

Short of providing an oral report for your valuation (which is very seldom), the written valuation report is the one tangible, deliverable item provided by the appraiser during the engagement. It is critical that the valuation report convey the thought processes used during the engagement, the factors that influenced your judgment, and the reasons for your conclusions. As CPAs or analysts, we tend to focus on the mathematical gymnastics of the engagement—which are important—and not the narrative conveyance of the engagement process. We all have sample reports or templates that we utilize during the report writing process. However, those should be used more for making sure that all critical elements of a valuation report are included. Boilerplate language should be avoided whenever possible. You can be the best "spreadsheet guru" or "pencil pushing professional," but if you cannot effectively describe your reasoning for the decisions made during the engagement, the report can be rendered worthless. Remember, another valuation professional should be able to take your report and replicate it based on having the same information. He or she may not draw the same conclusions, but should be able to replicate your work. Valuation is both an art and a science.

Section 5

Limited Medical Practice Engagement Opportunities

Chapter 16

Medical Practice Mergers

Industry Snapshot: *When the healthcare environment was slowly changing in the pre-health maintenance organization (HMO) landscape, physician practices had little incentive to change, and varied little from year to year. The HMO model may have revolutionized healthcare on the patients' end, but the consolidation of plan benefits and reimbursements also brought increased financial pressures and controls down to the physician level. The growth in HMOs and other insurance cost savings plans, coupled with a changing regulatory and legislative environment and increased competition for reimbursement dollars, lead the healthcare industry to become a fierce battleground for Wall Street styled mergers and acquisitions on both the for-profit and nonprofit levels. A wave of mergers and acquisitions swept through the industry, affecting both small and large practitioners, healthcare and hospital systems, and patients' choices. Although the level of mergers has lessened from the peak levels reached in 1997—when healthcare mergers exceeded that of regular business mergers—the healthcare environment remains one of fast-paced change. Facing the flux of regulatory changes, provider plan changes, liability issues, technology advances, and other financial and management pressures requires quick response and expertise.*

* * * *

In response to the challenges facing the healthcare industry, medical practices continue to choose to combine and merge, for reasons of consolidation, practice growth, and financial improvement, among others. Medical practice mergers are complex and challenging arrangements in which the CPA consultant's considerable expertise can be a welcome addition to the sometimes painful process.

TYPES OF MEDICAL PRACTICE MERGERS

Mergers of medical practices include:

1. *Solo physicians merging with other solo physicians.* Solo physician mergers typically occur in an attempt to achieve economies of scale in terms of practice expense and call coverage from a clinical perspective. Economies of scale can be achieved in the reduction of administrative staff (one receptionist, one office manager, and so on) and administrative space (reception area, business office) with a single location.
2. *Solo physicians merging with group practices.* Solo physicians may be motivated to merge with group practices by the desire to sign on to a more sophisticated management system and the perception of a reduction in management time. Many times a fear of competition (especially in the case of specialty practices) may encourage a solo physician to merge.
3. *Group practices merging with group practices.* Multi-specialty practice mergers were popular in the mid-90s by specialists desiring to align with primary care "gate keepers" in order to retain referral sources. Typically, economies of scale are not achieved in group mergers because the groups are not as likely to give up their existing locations and staff. Group mergers may provide some degree of clout in negotiating with managed care payers and may allow the practice to benefit from shared technology.

THE CPA CONSULTANT'S ROLE IN MERGING MEDICAL PRACTICES

The CPA consultant can assist the merging practices in identifying and quantifying their merger goals. A successful merger results when premerger goals are achieved. The first step in achieving goals is to identify them. Merging practices must be encouraged to communicate their objectives openly and honestly. Many mergers fall apart due to lack of open communication during the premerger period.

Assessing the Physician's Expectations

As an independent intermediary, the CPA consultant can assist the physicians in quantifying their objectives openly and honestly through the use of a premerger survey. Each physician should be asked to complete the survey and return it to the CPA who will compile and analyze the results. From the surveys, the CPA can assist the practices in developing group goals and objectives.

Sample questions include:

- What is the compelling factor for merging?
- What are your greatest concerns regarding the merger and its outcome?
- What are your recommendations for governance of the combined group?
- What major issues should be addressed during the premerger discussions?
- What short-term and long-term benefits due you see in the merged group?

Due Diligence

The CPA consultant can play an important part in the due diligence phase, obtaining, reviewing, and analyzing data. Information you should request and review as part of due diligence premerger includes:

- *Financial statements and tax returns for the past three years and year-to-date financial statements for the current year*. This information is used to review trends in the practice and in the preparation of financial models for the combined group. The tax returns should be reviewed in order to identify potential tax issues (Chapter 17, "Tax Aspects of Practice Mergers").
- *Physician compensation for the prior year and year-to-date, including compensation formula calculations and employment agreements*. The CPA consultant should review the existing agreements and formulas for similarities and differences. An understanding of the existing compensation plans will be essential in the development of a combined plan (see the Case Study in Chapter 12). Additionally, the formulas should be reviewed in light of compliance with Stark regulations (Chapter 12).
- *Charges, collections, and adjustments (by physician) for the past three years and year-to-date*. A review of charges and collections will assist in the identification of potential billing issues and will also assist in the development of financial models.
- *Aged accounts receivable*. This data is used to estimate contributions to the new entity for cash flow purposes and as part of the valuation of the contribution.

- *Aged accounts payables.* Since most practices prepare financial statements on the cash or tax basis, payables may not be reflected on the balance sheet. This information is important not only for valuation purposes, but also to gauge the financial health of the practices. For example, large or delinquent balances may be an indication of underlying financial problems. If the physicians have been receiving compensation from the practice instead of paying bills, this information needs to be considered in the development of a combined compensation plan.
- *Practice fee schedule.* The CPA consultant can play a significant role in the merger process in the analysis of existing fee schedules. Since anti-trust provisions regarding price fixing prohibit the groups from sharing fee information premerger, the CPA can serve as an independent intermediary to receive and analyze the existing fee schedules and provide recommendations for the postmerger combined fee schedule.
- *List of managed care contracts.* The list of contracts should be compared to insure cross-credentialing of providers in managed care plans for each group.
- *Inventory of fixed assets.* Detailed, updated depreciation schedules should be obtained along with a listing of any assets that will not be transferred to the entity postmerger.
- *Copies of all notes payable.* This information is important for both valuation and cash flow planning purposes.
- *Employee census.* A listing of all employees in the practice along with job title and compensation should be reviewed as part of the organizational planning for the combined practice.
- *Employee benefit plans.* Copies of all benefit plans (insured plans, qualified retirement plans, cafeteria plans) should be obtained for review and analysis in order to provide the best practice alternative for the combined entity.
- *Employee policy manual.* A review of policies regarding holidays, sick time, vacation, and so on should occur, comparing and contrasting the policies of the existing practices, to develop the best alternative for the combined practice.

Analysis and Facilitation

After quantifying expectations and obtaining due diligence information, the CPA consultant can provide a facilitation role in the merger process through the analysis and assistance in the development of critical factors in the combined group.

Financial Modeling

Preparing a financial model of the combined group is important to assist the physicians in visualizing the economic implications of the merger. The financial model provides a financial preview of what the combined group might look like.

Prior year data provides the basis for the model. The prior year data is then adjusted for:

- Trending increases or decreases, such as adjusting for the effect on income and expenses of the addition or retirement of a physician
- Economies of scale (such as combining locations and staffing economies)

- Effect of a combined or revised fee schedule
- Effect of the combined physician compensation plan—financial modeling allows the CPA to review the effect of different compensation scenarios

Compensation

Designing a workable compensation plan for a merged group is one of the key factors to the success of the group. In most cases, the practices will each have their own unique way of dividing the revenue "pie." And, in the case of solo physicians, they must learn to simply share the pie.

The CPA consultant should review the compensation plans of the combining practices. Similarities and differences in the combining plans should be compared and contrasted. The consultant should review the existing plans for Stark I and Stark II compliance. Any Stark violations must be corrected in the merged compensation plan.

If the existing plans divide income in a similar manner and are in compliance with the Stark regulations, establishing the merged plan should simply entail committing the plan to a written document. If the plans are dissimilar, a model should be developed and applied to financial projections for the combined group. It is important that everyone in the group understands the financial implications of the decisions they make concerning the postmerger division of compensation.

Practice Valuation

Incorporated medical practices may merge as a tax-free reorganization. As such, assets are combined at book value, which, in the case of a cash basis corporation, does not include a value for accounts receivable. Additionally, practices that have utilized accelerated depreciation methods may have relatively new assets with no book value. The CPA consultant should provide the merging practices with a comparison of all assets (including net accounts receivables) and liabilities. The merging practices must decide how to account for any differences in value.

EXAMPLE

Practice A and Practice B (both professional corporations) are combining in a tax-free (statutory) merger. Each practice will own 50 percent of the new entity in exchange for their assets in their existing entity ("A" reorganization under Internal Revenue Code Section 368(a)(1)(A)).

The entities will combine assets and liabilities at "book value" and, postmerger, each entity will own 50 percent of the combined assets.

As part of the premerger analysis, there is a comparison of the assets (the practices have no liabilities and all payables, including accrued vacation pay, will be cleared premerger). Accounts receivable are valued net of contractual adjustments and estimated bad debts, and equipment and furniture is valued at its fair market value in use. The analysis yields the following:

Fair market value	Practice A	Practice B
Cash	$ 10,000	$ 15,000
Accounts receivable (net)	500,000	450,000
Furniture and equipment	75,000	50,000
Total assets	$585,000	$515,000

Each entity will own 50 percent of the combined assets; however, there is a differential of $70,000 in the fair market value of the premerger assets. The differential might be addressed as follows:

- *Cash.* As much as possible, cash accounts should be cleared premerger (used to pay practice expenses or bonused to physicians).
- *Accounts receivable.* The differential in accounts receivable ($50,000) could be provided for as part of a deferred compensation arrangement (paid out at termination of employment) or as part of the compensation agreement to be bonused to the physicians over some period of time (perhaps two years).
- *Furniture and equipment.* The differential in furniture and equipment ($25,000) should be provided for in the deferred compensation agreement.
- *Utilization of assets.* If the practices combine locations, all the assets of the combining entities may not be required in the merged group. The practices must decide which assets will go and which will stay and how to account for both.
- *Staffing.* If economies of scale are to be achieved, the practices may be faced with the tough decision of which employees to retain in the new entity.
- *Location.* Typically, when a solo physician combines with a group, the solo physician will relocate to the group location. The decision of location is complicated when group practices combine. In some cases, each group may own its building and may not be willing or able to sell.
- *Management and governance.* Decisions regarding practice management are critical. In too many instances, the practice defers appointing a practice manager or administrator. The establishment of "co-managers" is not a workable solution. The combining practices must make the tough decision at the outset as to who will manage. Management teams may be created from existing practice management individuals; however, the combined practice may designate only one practice manager or administrator.

CULTURAL ISSUES IN MERGED PRACTICES

In addition to management concerns, practices must also consider cultural issues in combining practices. A basic clash occurs between the physicians' need to be organized and their resistance to being organized. Physicians of all specialties have resisted being organized into bureaucratic structures. In the pre-managed care days, there was no perceived need on the part of most physicians to organize and manage efficiently.

Physicians are trained to think and practice autonomously which may lead to divergent thinking and behavior in a group practice setting. In order to facilitate a successful combination, physicians must adapt to a group mentality.

Combining different specialties as in the case of multi-specialty groups may lead to clashes in terms of practice style and culture. For instance, combining a surgery practice that shares income based on production with a pediatric practice that shares income equally will certainly lead to intense discussions over compensation. Likewise, pediatricians tend to approach decision making through discussion and consensus, whereas surgeons are accustomed to making quick decisions based on available facts.

In single-specialty mergers, age differentials can lead to divergent values and goals. Additionally, the practice may have to deal with differences in work intensity either based on style of practice or, perhaps, related to age or lifestyle issues.

In order to effectuate a practice merger, both conflict and change must be managed. In the resolution of conflict, communication is essential for the creation of trust. Communication must include the solicitation of opinions in addition to the distribution of information. Merger meetings must be scheduled and participative. Consultants may be involved to reduce organizational strain and facilitate consensus.

SUMMARY

The merger of physician practices can provide the combining entities opportunities for long-term continuity and financial rewards. However, proper planning, consensus building, and follow-through are essential. Poorly conceived and implemented mergers are destined for failure. The CPA consultant provides an essential role in assisting the combining practices in the development of expectations and as an independent facilitator to enable the practices to make the critical merger decisions.

Chapter 17

Tax Aspects of Practice Mergers

Industry Snapshot: *The number of physicians in group practices is an increasing trend. Group practices evolve either through a solo physician employing physicians or through a combination of existing physician practices (mergers). The CPA consultant can assist physicians in practice combinations by providing tax guidance in the most efficient method of organization. In this chapter, we will explore the various tax entities in which medical practices may operate and ways to bring the various entities together in the most efficient tax structure.*

* * * *

TYPES OF MEDICAL PRACTICE ENTITIES

Medical practices may organize for tax purposes under a variety of options—proprietorships, partnerships, professional limited liability companies (PLLCs), S corporations, and C corporations.

Proprietorship

Solo physicians may practice as a sole proprietor for tax purposes. Obviously, this structure is not available to practices with more than one physician owner.

Partnership

General partnerships provide an option for entity structure for practices consisting of two or more physicians. A flow-through entity, the partnership structure provides flexibility in distributions and a structure that facilitates the accumulation of capital without the double taxation incurred in C corporations. In general partnerships, however, all partners share jointly and severally in all liabilities (including malpractice), creating a risky structure for medical practices.

Professional Limited Liability Company

A state registered PLLC can be taxed as a partnership for federal income tax purposes, but its members (owners) are not personally liable for the entity's debts or liabilities. Unlike limited partners, PLLC members may participate in management without risking personal liability. No limitations are placed on the number of owners (unlike S corporations). Another advantage over S corporations is the ability to make disproportionate allocations and distributions and to distribute appreciated property to members without the recognition of gain. Members may also exchange appreciated property for membership interests without recognition of gain.

The conversion of a general partnership to a PLLC that is taxed as a partnership for federal income tax purposes is treated as a nontaxable partnership-to-partnership conversion. Practices that are organized as C corporations, however, will incur tax consequences on

conversion since the transfer to a PLLC will in effect constitute a liquidation of the C corporation. The PLLC will benefit in a step-up in basis in assets transferred at fair market value from the C corporation. The tax consequences of corporate liquidation should be compared to the tax benefits of the step-up in basis in making a decision to convert.

Limited liability combined with the flexibility of a partnership structure makes the PLLC an attractive entity alternative.

S Corporation

An S Corporation is a corporate entity whose shareholders (no more than 75) have elected to be treated as a pass-through corporation (corporate income passed through its shareholders). The election may be made when the corporation is organized (by the 15th day of the third month) or may be made in any subsequent year by the 15th day of the third month in order to be effective beginning with the year made.

The election by a C corporation is not in and of itself a taxable event, making it an alternative for C corporations in search of a pass-through entity structure without the tax implications of converting to a PLLC. The S corporation, however, may be subject to a built-in gains tax (corporate level tax on S corporations that dispose of assets that appreciated in value during years when the corporation was a C corporation).

The S corporation provides a pass-through alternative to practices already organized as a C corporation; however, the built-in gains implications must be considered. Likewise, if the practice exceeds 75 owners, the election will be terminated.

C Corporation

Before PLLC status was available (first state to adopt an LLC statute was Wyoming in 1977; the IRS revenue ruling allowing LLCs to be taxed as a partnership occurred in 1988), physician practices desiring limited liability were organized as C corporations or S corporations. Practices organized as C corporations have experienced a reduction in tax attributes over the years as unincorporated entities and S corporations gained parity with C corporations in respect to qualified retirement plan contributions and other benefits (such as health insurance). Additionally, the flat rate federal tax (35 percent) imposed by Internal Revenue Code Section 269A on personal service corporations (a corporation that furnishes personal services performed by employee-owners) combined with the potential for double taxation has put medical practices organized as C corporations at risk for unreasonable compensation adjustments as reflected in the tax case below.

Court Case: Pediatric Surgical Associates, P.C. v. Commissioner

In a recent Tax Court Memorandum decision, *Pediatric Surgical Associates, P.C. v. Commissioner*, the IRS was victorious in its argument that the physician-owners of a professional corporation (P.C.) received unreasonable compensation and therefore, the deduction for a portion of their compensation was denied to the P.C. This resulted in additional tax (35 percent flat rate federal tax on the amount of the denied compensation), interest, and even penalties for the corporation.

Prior to this case, compensation was considered deductible for a corporation if it met the tests of being (1) ordinary and necessary, (2) paid or incurred during the year, (3) for personal services rendered, and (4) reasonable. Traditionally, it has been thought that

compensation paid to physicians practicing in the form of P.C.s would be deductible compensation since it was a result of the physicians' personal services rendered. Additionally, it was considered reasonable if it was comparable when measured against medical industry standard averages.

However, in *Pediatric Surgical Associates, P.C. v. Commissioner*, the Tax Court did not determine reasonable compensation based on comparable industry averages, but accepted the IRS argument that net profits generated by non-owner physicians and paid to physician-owners should be considered unreasonable compensation.

The P.C.'s compensation system treated owner and non-owner physicians differently. The four owners were paid a fixed monthly salary plus monthly bonuses based upon available cash. The two non-owners were paid only a fixed monthly salary with no bonuses. The P.C. deducted the full amounts paid to the owners as compensation. The IRS disallowed a deduction for a portion of those payments arguing that those payments were not derived purely from the services of the owners.

The Tax Court looked at net collections for the non-owner physicians less their allocated expenses for both direct costs and shared overhead (allocated expenses were determined by the Tax Court) and recharacterized the difference as profits to the P.C. and that portion of the owners' compensation was treated as a nondeductible dividend. The final determination by the Tax Court drastically reduced the disallowed deduction amounts to $61,234 and $9,037 for 1994 and 1995. While it was a significant decrease from the initial adjustments, the additional tax and penalties due for the corporation were approximately $30,000.

TAX IMPLICATIONS FOR ALL MEDICAL GROUPS

The methodology used in *Pediatric Surgical Associates, P.C. v. Commissioner* will allow the IRS to find dividends in virtually every regular C corporation P.C. that derives profits from any sources other than the physician owners. The IRS could treat as dividends net profits derived from non-owner physicians, paraprofessionals such as physician assistants and nurse practitioners, and from ancillary services such as X-rays, lab tests, physical therapy departments, pharmacies, and so on.

Some argue that *Pediatric Surgical* is based upon faulty logic, not consistent with existing case law, lacking in precedential weight, and may even be unreasonable. However, the case is now a part of the law and is available in the arsenal of the IRS to attack compensation deductions of P.C.s.

Because of the magnitude of potential tax costs, P.C.s that are operating as regular C corporations must consider taking steps to mitigate the problems created by this Tax Court decision. There are two basic ways for a P.C. to protect itself, but there are many factors to weigh with each method.

The P.C. could go through a dissolution process and reorganize as a new pass-through entity such as a professional limited liability company (PLLC). This does create a taxable event, and requires careful planning to minimize the tax consequences. Since assets are valued at fair market value upon liquidation, the practice must consider the valuation of practice goodwill and its potential impact on the liquidation value. Additionally, the medical practice will be required to obtain new billing/provider numbers.

To eliminate the risk of an unreasonable compensation determination, P.C.s may want to consider a conversion to S corporation status. An S corporation is a pass-through entity, which means it does not generally pay federal taxes since the net profits flow to the individual owners. This eliminates the double taxation that may be caused by unreasonable compensation.

Practice Tip: Conversion of an existing C corporation to an S corporation may trigger "built in gains" tax on the distribution of appreciated assets. For cash basis corporations, the most significant appreciated assets may be accounts receivable. Additionally, consideration must be given to the recognition of goodwill, if applicable. The tax is computed by applying the highest corporate income tax rate to the S corporation's net recognized built-in taxable gain income. However, any net operating loss carryforward arising in a tax year in which the corporation was a C corporation is allowed as a deduction against the net recognized built-in gain of the S corporation. Capital loss carryforwards may also be used to offset recognized built-in gains tax. Additionally, business tax credit carryovers of an S corporation arising in a tax year in which the corporation was a C corporation can offset the built-in gains tax of the S corporation.

The net recognized built-in gain is computed based on the lesser of the amount that would be the taxable income of the S corporation if only recognized built-in gains and recognized built-in losses were taken into account or the corporation's taxable income. Obviously, if the net income of the S corporation is distributed in the form of compensation (versus dividend distributions), the net recognized built in gain would be eliminated.

When practices combine through mergers, the organizational structure of the merging practices and the manner in which they combine can ultimately influence the tax consequences.

CAUTION: In this chapter, we address several scenarios of possible combinations and the tax consequences incurred. Keep in mind that the scenarios listed below are not all-inclusive and factors not addressed in the examples below or changes in circumstances may change the outcome of the merger for tax purposes. Independent tax research based on the facts and circumstances of the merger is recommended before advice is given.

COMBINATIONS OF ENTITIES AND THEIR TAX CONSEQUENCES

The tax consequences of practice mergers are primarily dependent on the types of entities that are combining. The following sections illustrate various scenarios of possible combinations and the related tax treatment.

Combination of Proprietorships

Assume Dr. Smith and Dr. Jones, who operate separate medical practices as sole proprietorships, decide to combine their offices and consolidate their practices into one entity. This type of combination can best be achieved through the formation of a professional limited liability company (PLLC). Dr. Jones and Dr. Smith contribute the assets and liabilities (book value) from their individual practices to the PLLC. The book value of the respective practices creates the initial capital contribution into the PLLC. Barring any complicating circumstances (such as immediate sale after combination), the practices may combine without incurring any tax consequences.

Combination of Proprietorships and PLLCs

A proprietorship may combine with a PLLC under the same methodology as above. Assume Dr. Smith decides to combine his practice with Family Practice, PLLC. Dr. Smith may contribute the book value of his practice assets and liabilities to the PLLC in exchange for a partnership interest. The book value of Dr. Smith's practice constitutes his capital contribution into the PLLC and no taxes should be incurred on the exchange.

Combination of a Proprietorship or PLLC With a Corporation

A proprietorship or PLLC may not exchange its assets and liabilities for stock in a corporation in a tax-free exchange. Consideration should be given to a sale of assets (equipment, furniture, supplies) to the corporation and a subsequent purchase of stock by the proprietor or partners in the PLLC. Although taxes will be incurred on the sale of assets, the amount paid to the corporation for stock will provide basis in the event of a sale of the stock back to the corporation upon termination or retirement. Accounts receivable may be included in the sale or may be retained and collected by the proprietor or the PLLC.

Combination of Corporations

The tax law provides for the tax-free combination of corporations under a variety of Internal Revenue Code (IRC) sections based on the facts and circumstances of the combination. The following judicial doctrines, however, apply in all corporate tax-free reorganizations:

- *Business purpose.* The combination of the practices must have a legitimate business purpose and cannot be for the evasion or avoidance of income taxes.
- *Continuity of business enterprise.* A significant portion of the combining practice's business assets must be transferred. Unlike a sale of practice assets, if the merging practice does not transfer its accounts receivable, the continuity of business enterprise criteria may not be met.
- *Continuity of shareholder interest.* Another important judicial doctrine is that the merging entity's shareholder(s) need to maintain some continuing interest in the new entity. The merging shareholders may create a problem if they receive stock in the merged entity and then dispose of the stock after a relatively short period of time. The specific facts and circumstances will determine if the tax-free exchange will be jeopardized.

IRC Section 368 defines seven types of reorganizations that will yield tax-free status to all parties assuming no boot is involved in the transaction and that the principal amount of securities received and tendered are the same (even though the fair market value may be different). The seven types of reorganizations offer alternative means of accomplishing the same result and often look very similar.

EXAMPLE

IRC Section 368(2)(1)(A) defines one type of tax-free reorganization. The "A" reorganization is very flexible in its terms and provides for the exchange of stock in the surviving entity for the assets and liabilities of the combining entity. Assets and liabilities are transferred at carryover basis (book value) and carryover holding period. This type of combination is known as a statutory merger, meaning the transaction is governed by state law.

A legal consideration in combining corporations relates to the carryforward of liabilities. The form of the transaction can have significant effects on the degree to which the successor corporation incurs economic exposure for the combining corporations' past actions or inactions. If the acquiring corporation acquires the stock of the combining corporation, the outstanding legal issues of the combining corporation will follow the corporation into the merged entity. If the combining corporation is audited (tax or reimbursement), the new entity will be responsible for any amounts due, even if the audit relates to periods prior to the merger.

There are ways, however, that the successor corporation may protect itself against such economic consequences, even if it acquires stock, but these methods are not foolproof. To the extent the amount of the liability is known with some certainty before the terms of the transaction are fixed, the successor can protect itself by requiring the liabilities to be reserved for or otherwise taken into account in computing the consideration to be paid to the acquired corporation, if the stock is purchased. Another alternative to limit exposure would be to have the acquiring corporation structure the transaction as a tax-free asset acquisition. In certain acquisitions, the parties may specify by contract which corporate liabilities will be assumed by the acquiring corporation. In all cases, due diligence is recommended prior to any corporate combination.

SUMMARY

The CPA consultant can provide professional assistance to the physician practice in deciding upon the best entity structure based on the facts and circumstances. The entity structure of the combining entities in a merger must be considered to advise the practices on the most advantageous merger strategy from a tax standpoint.

Chapter 18
Professional Divorces

The inherent risk in any practice merger is the possibility that the merger will fail and the physicians will go their separate ways. Not unlike a premarital agreement, a well thought out buy-sell agreement will aid in a structured separation. The best time to plan for a separation is predivorce when cool heads prevail. The buy-sell agreement should detail the financial ramifications of a separation and how assets will be divided. In this chapter, we will discuss additional items that should be considered when a physician(s) decides to separate from a group.

Working Capital

In most buy-sell agreements, the methodology for the buyback of assets (equipment and furniture) is detailed. In most instances, patient receivables are retained by the group. The lack of receivables to generate cash flow can create a working capital shortfall for the departing physician. A projection of future working capital cash requirements will be a necessity. Working capital requirements will need to be determined based on a thorough review of financial data. This should be analyzed on a monthly basis for a minimum of two years. Arrangements should be made with a financial institution to access capital shortfalls on an as-needed basis.

Impact on Patient Base

Leaving the current group typically means losing the leverage afforded larger physician organizations, and possibly losing the covered lives associated with that organization's managed care contracts. Existing contracts should be analyzed to determine which ones can and should be renegotiated and brought over to the new practice. Covenants not to compete may affect the ability of the departing physician to retain existing patients. The covenant prevents the physician from leaving the practice and taking all of his or her patients. In some cases there is a patient buy-out option, but in most cases the physician cannot take any patients and sometimes may not even practice in the same area. If a covenant is in place, the physician may have to rely on marketing for new patients and referrals to create a new patient base. To maintain bargaining power and patient base, strategic alignment with an independent practice association (IPA), physician hospital organization (PHO), or other physician network must also be considered.

Financial Projections

In order to prepare financial projections for the new practice, income and expenses must be carefully estimated. Absent a noncompete, the departing physician might project income to be comparable with past results. If patient receivables remain with the group, a delay in collections (60 to 90 days) should be factored into the cash flow projections. If the

group has a noncompete and the physician is relocating, specialty medians such as those published by the Medical Group Management Association (MGMA) may serve as a starting point for estimating revenue.

Expenses should be carefully planned. The more critical expenses include nonphysician salaries and benefits, medical supplies, and occupancy costs. It is also a good idea to compare expenses with various specialty norms using the MGMA *Cost Survey.*

Nonphysician staffing requirements for the new practice and availability of staff must be determined. Contractual arrangements with the group may preclude or penalize departing physicians from employing existing group practice employees. A physician should first look at what support is needed rather than hiring the number of staff he or she was accustomed to with the group. Whereas two people might have been needed at the group practice for separate jobs, such as scheduling and chart management, one person might be able to handle both jobs. Until the practice is up and running, the support staff should be minimal. Specialty norms for salaries and benefits should be determined. Median staffing guidelines can also provide guidance when determining the number of staff required to run the practice efficiently.

Practice location is a primary consideration not only for estimating occupancy costs but also for practice visibility and patient retention. If the physician is not bound by a restrictive covenant, an office location that is convenient to the existing patient base and hospital would be advantageous. Location is important, but the physician cannot allow the lease payment to take up all the expenses just for a prime location. Guidelines for square footage and cost (by specialty) are also available through MGMA publications. Careful review of lease obligations is advised.

PRACTICE MANAGEMENT SYSTEM

Often the largest decision concerning future expenses is the transaction involving the practice management system. The practice management system is used to process claims by submitting charges to the payer, posting payments to patient accounts, and keeping up with accounts receivable. Most of these systems include a program for scheduling patients and some include electronic medical record storage. The choices available are lease, purchase, or outsource. Leasing the software might be an option as these software packages can run from $5,000 to $40,000 for physician practices. Outsourcing the work through a clearinghouse can be beneficial because the staff and software expense are eliminated in exchange for the clearinghouse fee. The practice management system will have a material effect on the future success of the new practice and will be elaborated more in Chapter 19, “Corporate Compliance Plans.”

SUMMARY

Dissolving any relationship is a serious matter that deserves adequate time and attention. In some cases, the physician will be starting from square one once again, depending on how much is received from the buy-sell agreement, which is why the physician and the consultant must understand the terms of the buy-sell agreement. An overview of the costs and processes needed for the separation and start-up must be reviewed before the physician decides to leave. Once the separation is complete, careful planning and the right information are necessary for the ongoing success of the new practice.

Chapter 19

Corporate Compliance Plans

Industry Snapshot: *On September 25, 2000, the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) released its final version of "Compliance Program Guidance for Individual and Small Group Physician Practices." (For the full text go to http://oig.hhs.gov/authorities/docs/physician.pdf.) The Guidance is intended to assist individual and small group physician practices in developing and implementing internal controls and procedures that promote adherence to statutes and regulations applicable to the federal healthcare programs. According to the OIG, the document is responsive to "physicians who have expressed an interest in protecting their practices from the potential for fraudulent or erroneous conduct."*

* * * *

In its simplest terms, a compliance plan is a comprehensive strategy to ensure an organization consistently complies with the applicable laws relating to its business activities. A compliance program, however, is much more than a policy communicating the organization's desire to comply with the applicable laws. In order to be effective, the plan must address the organization's activities and related risks. Education, audit, and enforcement are critical components of an effective plan.

A compliance plan consists of both a structural component and a substantive component. The structural component encompasses the framework and essential elements of the plan. It is the process and mechanism by which organizations approach the task of compliance. The substantive component is the body of law (in this case, fraud and abuse) with which an entity is seeking to comply. In order to be effective, the entity must have substantive knowledge about the applicable laws and regulations. (Information on Local Medical Review Policies [LMRPs] of the Centers for Medicare & Medicaid Services [CMS] is posted at http://cms.hhs.gov/providers/mr/lmrp.asp.)

The model compliance plan for physician practices provides an excellent foundation on which organizations can build their own compliance programs. The model provides the tools to construct and operate a compliance program. See Tool 19-A, "Model Compliance Plan for Physician Practices."

Tool 19-A: Model Compliance Plan for Physician Practices *(Toolkit CD-ROM)*

WHY ADOPT A COMPLIANCE PLAN?

The OIG is not mandating that all physician practices have a corporate compliance plan in place. Nevertheless, while some providers may view the introduction of compliance activities as another administrative expense and burden, the reality is that a well designed and implemented program can provide positive benefits for the practice.

Implementing a plan can assist a practice in preventing misconduct, and help detect and contain misconduct that does occur before it grows into a greater problem (that is, an OIG investigation). Former Inspector General June Gibbs Brown compared voluntary compliance programs to "practicing preventive medicine; it helps identify and treat small problems before they become big problems."

Implementing a compliance plan is a positive factor in the event of a government investigation. Documenting your efforts to comply with applicable laws may assist in avoiding criminal prosecution and possible exclusion from federal healthcare programs. Likewise, a compliance plan may reduce potential penalties by up to 95 percent.

Additional benefits of a compliance plan include:

- Improved communication within the practice
- Improved operational quality and efficiency
- Improved ability to identify compliance-related risks and concerns
- Enhanced reimbursement through focusing of staff on data quality in coding and billing and documentation
- Competitive advantage with patients, employees, and third-party payers through greater credibility and assurance
- Decreased potential for retrospective overpayment audits through enhanced documentation, coding data quality, and focused billing reviews that minimize claim adjudication problems before claim submission

SEVEN COMPONENTS OF A MODEL COMPLIANCE PLAN

The seven key elements of the model compliance plan for physician practices are comparable to the previously issued key elements for other healthcare entities (such as hospitals and laboratories). However, unlike prior plans, the OIG has conceded that small practices do not have to implement all seven components. The agency instead takes a step-by-step approach and prioritizes the compliance elements in the order that they should be implemented. The key elements for physician compliance plans in order of priority are as follows:

1. *Audit and monitor*. The OIG wants practices to conduct a baseline audit three months after implementing a training program and then on an annual basis. Practices are advised, at a minimum, to audit 5 to 10 medical records per doctor and 5 or more per federal payer.
2. *Develop standards and procedures*. Physicians are advised to identify specific risk areas and develop standards and procedures accordingly to minimize risk. The following should be included in the standards and procedures: record retention policy, clinical protocols, and the pathways and treatment guidelines followed by the practice.
3. *Designate a compliance officer*. It is acceptable to designate more than one person in charge of compliance. Although the OIG states that one individual could serve as the compliance officer for more than one practice, the agency prefers that practices not outsource the compliance officer function. This recommendation is so that the

compliance officer is always available and has a better understanding of what compliance risks exist in the office, since he or she is there on a daily basis.

4. *Train and educate.* Training should occur initially and then on a recurrent basis, at least annually. Education programs should include the operation of the compliance program, consequences for violating the standards and procedures, and conduct, coding and billing requirements, and applicable statutes. It is acceptable to utilize outside training sources.
5. *Respond to detected violations.* The OIG wants each practice to develop its own set of monitors and warning indicators. The practice should develop steps for prompt referral or disclosure, full internal assessment of detected violations, and provisions to ensure that a violation is not compounded once discovered.
6. *Develop open lines of communication.* An open door policy is sufficient. The policy should include the requirement that staff report problems, and that failing to report problems is a violation of the compliance program. Additionally, the plan should include a means of communicating with a billing company, if applicable.
7. *Enforce disciplinary standards.* A disciplinary policy should be flexible to account for mitigating circumstances but include oral warnings, written reprimands, probation, demotion, temporary suspension, termination, restitution, and referral for criminal prosecution.

CAUTION: The four major risk areas for the physician in the final model plan are:

1. Coding and billing
2. Reasonable and necessary services
3. Documentation and improper inducements
4. Kickbacks and self-referrals

COMPLIANCE PLAN DESIGN STEPS

Designing a compliance plan is not a simple task. There are several steps which a practice must take in order to ensure that the compliance plan is both consistent with the OIG Compliance Program Guidance and otherwise meets the practice's goals and strategies in relation to compliance activities. The model compliance plan provides general guidelines that should be tailored to meet the specific needs of the individual practice.

The key steps to plan design and implementation include:

- *Identifying the risks.* The practice will need to review its organizational structure, existing policies and procedures, and the regulations that apply. Baseline audits of claims should be conducted to identify areas of billing and coding risk.
- *Obtaining management buy-in.* Management should demonstrate a high level of commitment to compliance activities. The compliance plan must have management support and an organizational climate that holds persons at all levels in the practice accountable for their role in compliance activities.

- *Protecting the practice.* The development and implementation of a corporate compliance plan is not without risk. Baseline audits conducted to identify areas of risk may likewise identify areas of noncompliant behavior. If the audit activities are covered under attorney-client privilege, the practice may be in a better position to disclose and defend noncompliant activities.
- *Creation of the plan.* Key elements of creating a compliance program include defining the goals of the plan, identifying the necessary participants in plan development and administration, and dedicating the resources necessary for the practice to accomplish the plan. The practice should determine what it expects from the end product. The end product should include those components necessary to ensure that the compliance plan meets the minimum requirements included in the OIG Compliance Program Guidance and otherwise achieves the organization's goals.

COMPLIANCE PLAN AUDIT PROCESS

In conducting audits, reviewers are asked to identify both substantive problems (such as inadequate documentation or upcoding) and technical problems (such as failure to obtain beneficiary signatures). Audits will enable the practice to appropriately target and measure the effectiveness of its educational efforts, to ensure that appropriate corrective actions are taken, and to quickly identify problems in the claim development and submission process that may give rise to civil or criminal exposure.

The audit process typically includes the following steps:

- Select the audit sample. A sample selection should be done in a manner that ensures the integrity of the samples selected. This means that the practice should audit a variety of claims, and the claims audited should be selected on a random basis. However, it is not necessary to utilize valid sampling methodologies for compliance audits. Typically, if there is a problem it will be prevalent throughout most of the data set. Therefore a simple, random audit will be adequate in most cases.
- Gather all necessary documentation relating to each claim, including registration information, physician orders, the complete patient's medical record, and itemized claim detail (HCFA 1500).
- Review the documentation and note errors or discrepancies between the documentation and the itemized claim detail. Compare actual charges and note discrepancies such as charges billed but not documented and charges documented but not billed. Also note CPT and ICD-9-CM coding[1] discrepancies between the documentation and items billed.
- Summarize the errors and discrepancies to arrive at an error rate by provider and site of service, if applicable. Summarize the errors in a report and make appropriate recommendations for actions necessary to reduce the error risk.

[1] CPT = current protocol terminology. ICD-9-CM = International Classification of Diseases, Ninth Revision, Clinical Modification. See Chapter 4 for more information on coding.

There are four basic types of audit activities that may be used in developing a monitoring system for an effective compliance plan.

1. *Baseline audit.* In order for a practice to develop an effective compliance plan, it must first identify its areas of functional weakness and risk. The baseline audit is designed to identify both substantive and technical deficiencies in the billing process in order for the practice to develop strategies and education programs which will eliminate these deficiencies. The specific objectives of the audit include:
   —Documenting and analyzing the phases of the claim development and submission process from patient registration through payer invoicing (billing)
   —Preparing a data base from which to conduct audits
   —Identifying significant process weaknesses or areas where employees have been inadequately trained or equipped
   —Translating the information into a priority list which will insure that principle areas of exposure or noncompliance are addressed first
   —Designing programs to educate employees in compliant procedures

   The findings and reports generated through the baseline audit enable the practice to identify areas of noncompliance and to develop specific education programs, policies, and procedures.

   The most common risk areas identified in baseline audits are (a) the need for providers to fully document the services provided, (b) the need to ensure that patient charges are recorded appropriately, (c) the need for training in the area of CPT and ICD-9-CM coding, and (d) the need to communicate and reinforce requirements for supervision of physician extenders.
2. *Periodic audits.* A second component of an effective audit program is a periodic claim audit process. The periodic audit should be designed to uncover both intentional and inadvertent failures to comply with the applicable Medicare and Medicaid program requirements. These audits should be conducted frequently to ensure that the practice can detect patterns of improper billing before they become significant. These are typically done on a quarterly or semi-annual basis. The costs of these can be an agreed-upon flat rate as the steps will be the same, for the most part, on each review. (See Tool 19-B for four examples of periodic audits.)

Tool 19-B: Sample Periodic Audits *(Toolkit CD-ROM)*

3. *New employee audits.* The new employee audit is designed to audit the work of employees who are new to the practice or job function and whose work requires a thorough understanding of detailed laws and regulations. New employee audits should be designed to ensure that employees fully understand the requirements of their job before being given full responsibility in the claim submission or development process. For example, the practice may want to randomly audit the work of new employees for a 30-day period after hire and training.
4. *Complaint audits.* Complaint audits are typically conducted in response to employee or patient complaints. These types of audits may involve a review of claims, interviews of participants in the claim development and submission process, and a review of applicable laws and regulations.

IMPORTANCE OF ONGOING TRAINING AND EDUCATION IN COMPLIANCE

In many practices, the most significant risk results from lack of training and education on the part of employees and providers. Education, training, and providing employees with appropriate resources may result in decreasing risk and errors in most practices. A compliance program will never be effective if the employees do not understand the substantive rules applicable to their jobs. Employees must receive training in the specific Medicare and Medicaid rules that relate to their job function.

Training can occur in a variety of ways from live presentations to videos. Communication of compliance requirements can occur in special meetings or educational programs designed for that purpose. Staff or departmental meetings can incorporate compliance education topics. In all cases, the training content, along with attendance, should be adequately documented.

In addition to ongoing training, employees and providers must be provided with adequate resources. Up-to-date coding and diagnosis reference guides are the minimum. The practice should maintain and distribute applicable Medicare Local Medical Review Policies (LMRPs) as they pertain to the practice (see http://cms.hhs.gov/providers/mr/lmrp.asp). Coding and billing newsletters also may provide helpful billing information.

SUMMARY

With the audits and training in place, a practice should be able to have a very efficient compliance program. The practice will benefit from this by less risk of a Medicare audit and, hopefully, increased collections.

Chapter 20
Fee Schedule Analysis

In medical practices, current protocol terminology (CPT) codes provide the units used for billing services provided. For example, if a patient receives a chest X-ray, CPT code 71020 is assigned to describe that service. (CPT coding is discussed in detail in Chapter 4.) The CPT code describes the service and a "price" or fee is assigned to each CPT code. In the example of a chest X-ray, the fee attached to the CPT code 71020 may be $90 (global fee). For each CPT code, the practice assigns a fee; the listing of all fees assigned constitutes the fee schedule for the practice.

Prior to managed care, medical practices typically reviewed fee schedules on a routine basis. With most commercial payers, reimbursement was based on the "usual, reasonable, and customary" fees charged by similar specialty physicians in a geographic location. Therefore, it was important for medical practices to increase their fees so that they could increase the usual, reasonable, and customary rates and maintain reasonable reimbursement.

With the advent of managed care and the Medicare fee schedule (based on relative value units [RVUs] versus fees charged), medical practices have tended to neglect the regular review of their fee schedules. "Why increase fees? The insurance companies are going to pay a fixed amount regardless of what the fee is—if I increase my fees, I only increase my write-offs." This is the typical response from many medical practices when the subject of fee schedule analysis comes up.

As a consultant, you should perform a fee schedule analysis to enable the physician office to increase revenue and bring collection percentages to national averages. In this chapter we will address the importance of a regular fee schedule analysis and how an effective analysis is performed.

Three Steps to Performing the Fee Schedule Analysis

Step 1: Explanation of Benefits

A good place to start would be a review of explanations of benefits from commercial carriers. The review should compare the fee charged by the practice for the top 20 procedures to the insurance company allowable fee. If fees are reimbursed at 100 percent of the fee charged, this is a good indication that the practice fee is below the amount the carrier determines to be reasonable and customary. In other words, this is an opportunity to increase fees and increase reimbursement.

Step 2: Geographic Fee Comparisons

A comparison of the top 20 procedures can also be made with published ranges. A good source is the *Physicians' Fee and Coding Guide* published annually by MAG Mutual

Healthcare Solutions, Inc. In the *Guide*, a range of fees (low and high) is provided for each CPT code. Additionally, the *Guide* provides geographic adjustment factors so that fees can be adjusted based on the location of the medical practice.

EXAMPLE

The fee range for a 99213 (level III established office visit) is $61 (low) to $77 (high).[1] If the practice were located in Bismarck, North Dakota, the fee would be adjusted by a geographic factor of .96. Consequently, the fee range in Bismarck would be $59 to $74. If the practice were located in Washington, D.C., the geographic adjustment factor would be 1.24. Doing the math, the fee range in D.C. for the same CPT code would be $76 to $95.

The goal of the comparison should be to establish fees for the practice that are not below the mid-range. In the above example, a practice in D.C. would want to establish a fee for CPT code 99213 somewhere in the $85 range. A fee that is set too low may result in decreased reimbursement from commercial (non-managed care) payers. This is because a payer might be reimbursing a 99213 at $90, but if a practice is charging $75, it will only receive $75. While this does enable the practice to have a 100 percent collection percentage, it prevents it from collecting that extra $15 per instance. Under this methodology, raising the fee range can improve collections without negatively affecting the collection percentage. If the fees are below the range of fees for the locale, the practice should anticipate a higher-than-average collection percentage, as discussed above. Conversely, however, if the fees are above the fee range, the practice may experience a below-average collection percentage.

These types of statistics are important for the consultant to know when providing benchmarks and setting expectations for collections. It would be inappropriate for the consultant to recommend the median collection percentage as a goal for a practice when its fee schedule is below average. Published medians (such as in the Medical Group Management Association *Cost Survey*) assume that the practice maintains an average fee schedule. Therefore, if a consultant compares the collection percentage for a practice that maintains its fee schedule below or above the average to a published median, the comparison may not be appropriate.

Step 3: Physician Productivity

Physician production is a major component of most compensation formulas. If the formula uses gross charges as a means to define production, it is imperative that the fee schedule used to establish those gross charges be appropriate. A fee schedule that is based on RVUs should provide a fair estimate of work performed.

Basing the fee schedule on RVUs consists of establishing RVUs as the building block for setting fees. The RVU for each procedure (CPT code) is multiplied by the practice established conversion factor to set the fee. The conversion factor is typically tied to the Medicare conversion factor as a multiple (150 percent to 200 percent) and may vary based on specialty. For example, a family practice physician may establish a fee schedule based on 150 percent of Medicare and an orthopedic surgeon may use 200 percent.

[1] Source: *2002 Physicians' Fee and Coding Guide*, published by MAG Mutual Healthcare Solutions, Inc.

EXAMPLE

The RVU for CPT code 99213 is 1.37. If the practice establishes a conversion factor at 175 percent of the Medicare conversion rate ($36.1992) the fee would be computed as follows:

RVU 1.37 × (36.1992 × 175%) = $87

Using the RVU methodology to establish fees also allows the practice to update all fees by revising the conversion factor or the multiple. Since many managed care organizations compute their reimbursement as a percentage of Medicare, using RVUs and a multiple of the Medicare conversion rate as the basis to set fees should align the fee schedule with anticipated reimbursement. Obviously, efficient utilization of this methodology for setting fees is contingent upon the system being able to perform the conversion of CPT codes to RVUs.

SUMMARY

Using the information in this chapter, a consultant can help a practice not only raise revenue, but fall in line with average collection percentages. The following steps should be used as a basis:

1. Review explanations of benefits to pinpoint low fees for immediate revision.
2. Compare the top 20 fees to established averages to determine appropriateness.
3. Consider linking the fee schedule to RVUs to provide for consistent pricing.
4. Review the fee schedule routinely (annually) based on the criteria above.

Chapter 21

Managed Care Contract Review

Industry Snapshot: *Managed care organizations contract with physician providers in an attempt to manage and control the cost and use of healthcare services. The contracts provide for a discounted fee or a capitated payment and restrict the ability of patients to "self refer." Additionally, the network or panel of physicians may be controlled through the credentialing process.*

By maintaining control of the network of providers, managed care organizations have been able to encourage physicians to sign contractual agreements without proper analysis of the provisions of the contract and the financial impact on the practice. In competitive markets, the potential lack of access to patients through network exclusion has given managed care organizations a competitive advantage in negotiating.

* * * *

Analysis of managed care contracts and effective negotiating of the contract provisions is essential to the financial well-being of the practice. Without proper analysis, the practice may commit to an arrangement that will both compromise the delivery of care through referral and coverage provisions and the financial stability of the practice through sub-optimal reimbursement. The CPA consultant can provide invaluable assistance to the medical practice client in identifying and quantifying potential hazards in the managed care contract.

A contract with a managed care organization will have a profound effect on every aspect of the physician practice:

1. *Finance.* The managed care contract should clearly provide the methodology for reimbursement. If the contract provides for reimbursement under a capitation arrangement, will there be a "carve out" for certain services? If the reimbursement is fee for service, is the fee schedule or the methodology for determining fees provided? Unfortunately, many managed care contracts do not provide a schedule of fees that will be paid for services provided by the physician. Physician practices that sign these contracts put their practices at financial risk since the managed care company has the ability to decrease fees as needed to control costs.
2. *Quality of care.* The contract may restrict and control coverage of care through precertification requirements before care is provided (that is, for surgical procedures, hospitalization, and certain diagnostic testing) and approved referrals for care by a specialist. If the physician fails to follow the requirements set forth in the agreement for approval of care, the managed care payer, at its discretion, may deny reimbursement for the services provided.
3. *Patient satisfaction.* The control of coverage exercised by the managed care payer may be perceived by the patient as imposed by the physician. The physician can be viewed as a "gatekeeper" by patients if their role is to control access to more care. Medical practices must exercise care in complying with contract provisions to insure that the patient is not needlessly inconvenienced.

Whether the impact is positive or negative depends to a great extent upon understanding and considering in advance the operational demands the contract places upon the practice.

Operational dynamics differ from practice to practice. While a managed care contract might contribute to the success of one practice, the same contract might work poorly for another. It is crucial for every medical practice to analyze carefully each managed care contract before it is executed, looking not only at its financial aspects but also examining other factors that are an integral part of overall operations. If you overlook the operational impact, a contract can actually be detrimental to the practice instead of bringing anticipated benefits.

The following steps in this chapter will help guide the CPA consultant to better review and help negotiate the contract. It is a very time-consuming, intensive task to review, analyze, and negotiate changes to existing contracts or new contractual arrangements with managed care organizations. However, it is time and effort well spent, as the practice will benefit with a reimbursement contract that is more on target with its practice needs. If the practice negotiates a contract in haste, it may be forced to live with many years of regret due to that action.

OPERATIONAL ANALYSIS

A good place to begin the analysis of the managed care contract is to identify who and what within the practice will be affected by this agreement. All coverage and payment aspects should be reviewed and addressed in detail. The CPA consultant can be a valuable resource to the practice in providing this analysis, as he or she can help the practice see the effects of the current contract and what differences the new contract will bring. Remember that the terms of the contract must be integrated into every aspect of practice operations.

EXAMPLE

The contract may provide that surgical procedures be precertified before they are performed. If approval is not obtained from the managed care payer, payment for the procedure may well be denied. This contractual provision will have an impact on the system for scheduling surgical procedures within the medical practice. In addition to confirming the availability of hospital facilities and anesthesia providers, the practice must also obtain managed care approval as part of the scheduling process.

If the practice anticipates a competitive advantage from the managed care contract, consideration should be given to the availability of physician and staff coverage to handle any projected increases in patient visits. Other volume considerations include:

- Will the practice have the personnel and information system in place to handle the increased volume in billings, paperwork, and records?
- Will it be necessary to rearrange or modify the office space configuration to operate efficiently?
- Will additional telephone lines, new filing systems, and revised collection procedures be required?

The practice must determine if current procedures and job descriptions provide a system that complies with contract requirements for authorizations and referrals. Additionally, does the plan provide patients with insurance cards that identify services that are covered? Are lab and pharmacy services covered separately? How are contracts added or subtracted under the contract? The answers to these questions can dramatically affect the operations of a practice.

The practice, with the assistance of CPA and legal counsel, should consider every aspect of the contract to determine the impact on operations. Practice goals should be revisited to determine whether the contract will contribute to their attainment.

The practice must honestly evaluate all of its operational resources to determine if it has the capability of providing quality patient care, maximizing reimbursement, and meeting physician and staff expectations under the terms of the managed care contract. A good operation can be transformed into an inefficient, money-losing practice under the operational strain of a managed care contract. Operational weaknesses can be transformed into debilitating problems.

STAFFING ISSUES

Another element crucial to the operational success of the contract is properly trained staff. Availability of personnel who are prepared to comply with contract requirements is essential to patient satisfaction, revenue increase, and overall effectiveness.

A staff prepared to operate under the terms of the managed care contract will be more efficient. Patient questions can be answered promptly and accurately, reducing the need for costly follow-up. Errors will be avoided, minimizing the need to revise or re-file paperwork. Time for ongoing training and information resource development must be considered in the operational analysis of the contract.

In many practices the office personnel use an insurance directory for guidance in processing patients according to contractual obligations. The directory provides the major contractual provisions of the managed care payers. Assembling this directory can be an operational challenge, depending on the number of managed care payers, but it is imperative as personnel must be kept informed of contractual obligations before service is provided to patients.

The insurance information directory must clearly provide accurate, current information on the plans in which the group participates, the identity of providers participating in each plan, requirements for referrals or authorizations under each plan, any carve-outs or noncovered services, conditions for waivers of liability, requirements for copayments, and restrictions on lab services.

CONTRACT PAYMENT PROVISIONS

In the case of capitated contracts, covered services must be clearly defined and any carve-outs carefully reviewed. For example, in a pediatric practice, it would not be financially wise to include reimbursement for immunizations in the cap payment because of the great volume of immunizations newborns and children require.

Does the contract specify a fee schedule for payment? Surprisingly, many do not. The plan should provide a payment amount for each CPT code. The "promised" fee schedule should be in writing. Additionally, the practice should be alert to clauses written in the contract that allow unilateral adjustment of rates or automatically limit stated rates. Many contracts allow the insurers or managed care organizations (MCOs) to offer unilateral amendments that are deemed accepted if not rejected in writing within a short window of time.

Establishing reimbursement rates prior to signing the contract may assist in reducing after-the-fact negotiations that are typically unsuccessful. The CPA consultant should help set these rates by reviewing the practice's fee schedule and current managed care payment ranges as published in annual books such as the *Physicians' Fee and Coding Guide*, by MAG Mutual Healthcare Solutions, Inc. Without a firm agreement concerning fees, the only remedies available if fees are subsequently altered are to:

- Propose a new contract rate by CPT code
- Terminate the contract

The contract may specify the remedies available to the provider in the event of dispute. Many provide for arbitration that requires the provider to set forth their complaint in a letter 30 days before requesting arbitration. The provider must then agree to a binding hearing. In most cases of arbitration, the provider waives their right to a subsequent court hearing. Additionally, the arbitration decision may include a nondisclosure requirement. The nondisclosure requirement prevents other providers from identifying similar problems. Although arbitration may be a good alternative in some cases, the contract should offer arbitration if both sides agree, but not require arbitration.

Ready to Execute the Contract?

The following list of questions can help serve as a benchmark to determine if your medical practice is prepared for the operational impact of adding or maintaining managed care contracts.

- Will the current physician and staffing levels be able to provide adequate coverage for the additional members? Becoming a network physician may increase the patient volume of the practice. The physician and medical office staff must be able to accommodate the increase.
- Do you know what is included in the definition of "covered services" and "medical necessity"? Are the providers comfortable with the standards of the managed care organization? The managed care payer should provide guidance or agree to comply with Medicare published policies on medical necessity and coverage.
- Does the managed care payer comply with generally accepted bundling policies? Bundling occurs when the physician bills more than one service and the managed care payer "bundles" the services billed and only pays for one service. The Centers for Medicare & Medicaid Services (CMS) (formerly the Health Care Financing Administration [HCFA]) publishes the *National Correct Coding Initiative*, which provides a comprehensive list of services that are not reimbursable (services will be bundled) if provided to a patient on the same day. The managed care payer should

agree to abide by these published guidelines. Otherwise, the managed care payer may arbitrarily and inappropriately combine services for reimbursement.

- Does the practice management system have the capabilities and setup to monitor the contract adequately? Are edits in place to determine if the managed care payer is reimbursing at a lesser rate than the fee provided in the contract or if services billed by the medical practice are arbitrarily being denied for medical necessity or bundling?
- Are the physicians and nurses knowledgeable about the drug formularies?
- Will registration be able to identify the members in the network? Are the patients issued coverage cards?
- Will the cashiers have the information necessary to collect the appropriate co-payments or deductibles required by the contract?
- Does the plan provide fee schedules and reimbursement requirements?
- Is the filing and appeals process reasonable?
- Has the practice included the financial impact of the contract in the practice budget? The CPA consultant could help set up a pro forma to demonstrate the effect of the contract over the term of the contract. If renegotiating a contract, the consultant could input the proposed contract fees into the previous years' charges to get an idea of the increase in payment when compared against current collection numbers.

EVALUATING EXISTING CONTRACTS

The CPA consultant should obviously encourage medical practice clients to review all managed care contracts before signing and should likewise encourage practices to periodically review contracts that are in place. The consultant may assist the practice in a random review of reimbursement from managed care payers to insure that the payers are complying with reimbursement and coverage provisions. A sample of explanations of benefits (EOBs) supplied by the managed care payer when reimbursement is made should be compared to the fee schedule to determine if reimbursement is appropriate. Additionally, a sample of payment denials should be analyzed to determine if the payer is inappropriately denying coverage.

If a contract in place is vague and the practice is experiencing consistent problems with denials (for medical necessity or by bundling) or if reimbursement does not appear to be consistent or is declining, the CPA consultant should encourage the medical practice to contact the payer to renegotiate the contract. If the payer is reluctant to renegotiate a contract with clear coverage and reimbursement provisions, the medical practice must evaluate the ramifications of terminating the contract. If the managed care payer is reimbursing at a level below the cost of providing care, the practice will benefit financially from termination. Additionally, the threat of termination may provide the practice with a negotiating advantage if the practice provides services to a large percentage of the plan members and there is no available alternative.

SUMMARY

The managed care contract is something that should be taken seriously by physician practices. If effectively negotiated, it can lead to a better contract and better revenue. Once a contract has been negotiated and is in place, the CPA consultant can help the practice by performing an EOB analysis after a year to make sure the payer is paying in terms of the contract. If all looks well, the EOB analysis would only be needed again upon indicators triggering suspicion, such as decrease in reimbursement or higher adjustments.

Chapter 22

The Strategic Planning Engagement

Small Town Family Practice has always been a thriving, growing entity. Centrally located between several small towns, the practice acquired patients from a 30-mile radius. Recently, a multi-specialty group has opened a practice in an adjoining town and Small Town Family Practice is experiencing a decline in patient visits. Should they consider opening another office to compete with the multi-specialty group? What happens if physicians open practices in the other adjacent towns?

As you can see from this example, medical practices must decide how they intend to position themselves in the future in order to maintain their net income, grow their practice, transition the owner(s), and compete with others for patients and managed care contracts. In other words, if they are to grow and prosper, medical practices need to formulate a strategic plan.

The field of strategic planning for business is derived from strategic planning for winning a battle or war. This is an accurate analogy because the ultimate goal is to develop strategies for positioning the practice for success in the future. As in wartime, the strategies developed in the planning process must be flexible and easily adjustable as circumstances and opportunities change. This chapter illustrates how to guide your medical practice clients through the strategic planning process.

Strategic planning engagements involve showing and assisting the practice through the following critical steps:

- Evaluating the current status of the practice
- Setting goals for future performance within the practice
- Creating tactics for reaching practice goals
- Assigning responsibility to various members of the practice for achieving goals
- Monitoring the practice's progress in applying its strategic action plan

THE STRATEGIC PLAN VERSUS THE ANNUAL BUSINESS PLAN

Like all businesses, medical practices should develop an annual business plan.

Along with goals for growth, such as the addition of a new treatment modality, the annual plan typically includes a financial projection or budget with targeted goals for revenues and expenses. Typically, the annual plan is focused on reviewing the current year and projecting operations into the next period. Its intent is to make sure what is happening today is being addressed and taken care of.

Strategic planning includes the basic components of the annual plan but expands the plan to include goals that go well beyond the next fiscal period. Strategic planning goals are "futuristic." They are used to project where the practice plans to be with growth. Whereas the annual plan focuses on improving or maintaining income or expenses from the

previous year, the strategic plan projects how the company plans to market for new patients, increase staff, implement new technology, or train employees for new processes and rules. The strategic plan looks at the whole picture to show what the practice needs to do to adjust to new modalities and breakthroughs in technology to meet the needs of the practice's current and future patients and enable growth.

THREE STAGES OF THE STRATEGIC PLANNING ENGAGEMENT

There are basically three stages of the successful strategic planning engagement:

1. Advance preparation
2. Input and interaction
3. Action and monitoring

How to Help the Medical Practice Client Prepare for a Strategic Planning Session

Because planning sessions work best if held away from the daily stresses of the office, you will want to begin by planning a retreat. You should establish the date far enough in advance to allow for physician schedules to be free. For most practices, a Saturday date is most efficient to insure participation without interruption. The location should be off-site in a facility that will provide for uninterrupted interaction by the stakeholders. To ensure participation, it may be best to meet in a local hotel or retreat facility, rather than an out-of-town location.

The CPA consultant or an independent facilitator should be selected by the practice to guide the process. The CPA consultant can certainly fill this role, or be an active participant in the planning session by compiling extensive notes and working in tandem with the facilitator, interjecting to keep the session on track. Practices that use a physician member or practice administrator to facilitate the meeting start with two disadvantages. First, the process will lack the impartiality and inclusiveness of an outside facilitator. Second, if a key person is conducting the session, he or she is apt to be excluded from the process or to exert too much influence over it.

Prior to the planning retreat, you should accumulate practice data. Here is a list of the financial and practice management data you will need to request and assemble:

- Comparative financial statements (compared to prior year, budget, and median for the specialty)
- Comparative analysis of charges (by location, provider, and current procedural terminology [CPT] code), payments, contractual adjustments, and bad debt write-offs (compared to prior year, budget, and median for the specialty)
- Accounts receivable aging (compared to the prior year and median for the specialty)
- Computation and comparison of the gross collection percentage, net collection percentage, and accounts receivable ratio (compared to the prior year, budget, and median for the specialty)

- Practice payer mix (compared to prior year and median for the specialty)
- Practice fee schedule
- Comparative analysis of charges by referral source (compared with the prior year)

Next you should gather input from the physicians in the practice to identify issues that they want brought up and discussed. See Tool 22-A, "Sample Strategic Planning Physician Questionnaire." Before the retreat, you will need to analyze the data and summarize results by compiling the answers to the survey and highlighting areas of concern, such as equipment needs or low morale.

Tool 22-A: Sample Strategic Planning Physician Questionnaire ***(Toolkit CD-ROM)***

How to Facilitate the Strategic Planning Session

An interactive planning session provides the time and structure for listening to, discussing, and understanding each person's views and perspective. Through open discussion, you can reach consensus and a commitment to the desired outcome. Sometimes this can be done through exercises such as role-playing, or a moderator may start and summarize discussion to draw conclusions for the practice.

At the beginning of the meeting the physicians should obtain consensus on commonly held values. For example, a practice whose providers value time with their families may set a different course than a practice that seeks revenue at any cost.

The next step is to identify where the practice is today. The practice must understand and agree on the current status of the practice before considering strategies for future direction. In this phase the financial data gathered prior to the planning retreat is introduced. The practice can use this data to identify strengths and weaknesses and to identify areas that require immediate attention for improvement. For example, assume declining reimbursement is a major issue for the practice. The next step would be to address how the practice might attack and even reverse the trend. Examples might be given as to how this problem could be fixed. The survey might give some insight as to why the collections are down, such as the need for an extra staff member, or problems scheduling patients.

Once the current situation is summarized, the practice can begin to develop its vision for the future. The practice begins to address the question, "Where do we want to be in the future?"

The last phase of the planning retreat is the development of goals, objectives, strategies, and action plans. At this point, the practice has identified its current situation, developed its future vision, and is ready to answer the question, "How do we get there?" It's important to do more than simply outline long-term strategic goals. You will need to develop specific and measurable tactics to achieve those goals. The strategic plan will lay out these goals with reasonable guidelines and assign them to the staff with the resources and knowledge to complete them.

Tactics are the actions designed to assist the practice in meeting its strategic goals. It is advisable to develop several tactics to achieve a particular goal so that if one fails, several

others will be in place. The action plan will include specific tactics for accomplishing each strategy, the names of the individuals responsible for its accomplishment, and an achievable deadline. By assigning responsibility you will allow the practice to maintain accountability and monitor progress.

Implementation and Monitoring

Monitored follow-up of the implementation plans will ensure that the practice moves forward towards its goals. By putting the strategic plan in writing, you give the practice a blueprint for implementation and monitoring. The planning session should be documented in writing. The strategic planning document may be as short as 10 pages or as long as 100, depending on the size and complexity of the practice and the amount of available data. Whatever the plan's length, it is important to include each of these elements:

- Introduction—mission statement
- Practice summary—current situation analysis
- Vision for the practice and practice goals
- Strategies and objectives
- Assignment of responsibility, and monitoring and evaluation techniques

Once the plan document is completed, it must be clearly communicated to all the stakeholders. Everyone must understand their role in accomplishing the strategic plan.

Follow-up is critical to ensure the effective implementation of the strategic plan. The practice should review (at least quarterly) the progress toward accomplishing the action plan. Additionally, a progress report should be provided at all physician meetings. Usually, the consultant or moderator will ask each member who plays a part in the strategic plan to give a summary of what tasks they have completed and what steps they have taken toward unfinished assignments. All of the team members' responses will be compiled and summarized to be presented during the meeting to demonstrate where the practice is with the plan and where they need to be.

SUMMARY

Strategic planning is a process that will assist the practice in identifying the forces that drive change, analyzing the effect of those changes, and developing action plans that will adapt the practice to navigate the changes while achieving its goals. Strategic planning will assist the practice in maintaining its competitive advantage in the rapidly changing healthcare environment. Just as physicians embrace the new medicines, technology, and procedures that come along to help treat patients, they need to be ready to embrace these new tools to benefit their practice.

Chapter 23

Selecting Practice Management Software

Medical practice management software is a critical component for efficient practice management. Unfortunately, many times the software is merely evaluated for its capabilities in maintaining charge and payment data and sending out insurance claims and patient statements. Over and above its billing functions, practice management software should provide assistance in collections management and managed care contract administration, and provide detailed management reports to assist in overall practice management. The system should enable the practice to streamline day-to-day activities while providing information that will help it operate efficiently and achieve its goals.

A medical practice might look to their CPA or healthcare consultant to help guide them in the decision making process. The practice might want to know what system the CPA recommends as best for financial reports for receivables and collections. While most of these systems produce these reports, some are more detailed than others, and a CPA might voice an opinion on which systems' reports are best to help monitor the practice's financial condition. As a healthcare consultant, the medical practice would want to know which system would benefit their office from an operational standpoint. Some systems track claims better; some offer better electronic medical records management; some are more user-friendly, geared more to the medical office staff. Financial and operational questions will play a role in the selection of a management system, and more than likely the practice will want to know the CPA's or consultant's opinion.

The options available for practice management software are numerous. Without including specific names of software options, practices should be encouraged to research the options. The evaluation, installation, and implementation of a practice management system can be very time-consuming. However, it is certainly time well spent. If not carefully planned, the process of introducing a new system can be operationally and financially devastating to a practice. Medical practice software must meet the specific needs of the practice (that is, the specific needs of the specialty). Additionally, the practice must plan operationally for the conversion of data to a new system.

MEDICAL PRACTICE SOFTWARE ASSESSMENT

A good place to begin the software selection process is to define the system needs and expectations of the practice. Query each department of the practice as to the capabilities of the current system. The departments should provide information regarding the qualities of the current system that they would like to see included in the new system as well as capabilities not provided with the current system that would be desired in the new system. The compilation of the departmental needs assessment will provide the basis for the request for proposal (RFP). See Tool 23-A, "Sample Request for Proposal."

Tool 23-A: Sample Request for Proposal ***(Toolkit CD-ROM)***

Operationally, the software should be evaluated based on five basic functions:

1. Appointment scheduling and registration
2. Billing
3. Collections
4. Managed care
5. Reporting capabilities

Appointment Scheduling and Registration Requirements

In addition to basic appointment scheduling, practice management systems can perform a range of helpful functions. For example, in specialty practices, the system may provide a list of patients who require primary care referrals prior to their appointment. The system can also provide reminder notices for appointments and may allow for many of the registration functions to be completed prior to the patient visit. Information regarding co-pays and deductibles may also be included in the registration module, which allows for collection of co-pays at registration and allows the scheduler to inform the patient about their financial responsibility for payment of deductibles prior to the visit.

Billing Requirements

Efficiency and accuracy in the posting of patient charges is an essential component of any practice management system. The system should allow for efficient posting and should also have the capability to assist in assuring posting accuracy. For example, the system should have the capability to assign control numbers to charge tickets. At the end of the posting cycle, the system should provide a missing ticket report for any tickets issued but not posted, thus assisting the practice in insuring that all charges are captured. Additionally, coding edits may be included in the software, which assists the practice in reducing coding errors.

The software must provide electronic billing capabilities to third-party payers. Filing claims electronically expedites payments and reduces errors and practice expense. In addition, electronic payment posting of remittance advices from the payers increases accuracy in posting and reduces staff posting time significantly.

The software should provide an automated system for the filing of secondary claims. The system should automatically file the secondary claim when the primary insurance payment is posted. An automated system will insure that secondary filings are not missed.

Collection Requirements

Collection of past due accounts can voraciously consume valuable staff time and resources. Billing software can automate many functions to streamline collections. For both patient balances and insurance pending accounts, the software should allow staff to "work" the accounts online. The system should allow the collection staff to review and add notes,

demand statements or claims within the collection module, and future date the account for follow-up.

Management software systems can assist in the systematic collection of patient balances. The software should have the ability to:

- Set up payment plans and generate payment statements to the patients.
- Provide exception reports for patients who become behind on their payment schedule.
- Provide a series of collection letters that are sent automatically with each billing cycle or can be sent on demand.
- Sort accounts by patient name, provider, account balance, or age of account.

Collections for pending insurance claims can also be more effective when the practice management system has the ability to:

- Sort pending accounts by payer, provider, age, and account balance.
- Re-file a claim or one item on the claim form.
- Send letters to patients requesting information needed to process a claim.

Managed Care Requirements

Most practices operate under several managed care contracts. It is a huge task to keep staff informed of all the requirements of the different contracts. However, without this crucial information the practice cannot manage and monitor its contracts successfully or maximize reimbursement by complying with the contract terms. Practice management software systems can assist a medical practice in the management of contracts in several ways. The system can track eligibility, referrals, and co-payments. (Treating patients without verifying eligibility or referrals can be costly.) Another available option can track multiple fee schedules and provide notification during posting of payments if the payer did not pay the practice accurately.

Management Reporting Requirements

The reporting requirements for every practice are different. Reports from a practice management software system should aid in decision-making for all aspects of the practice including contract analysis, physician utilization, physician compensation payer review, and marketing. The ability to write ad hoc reports is a necessity. One particularly valuable report is the trend report by current procedural terminology (CPT), which can be used to identify problems with payers, outlier coding, payer mix, and so on. With the right reports, a practice can make better financial, clinical, and operational decisions.

SELECTING A VENDOR

Once the needs of the practice have been identified, a request for information from various vendors should be prepared. This request should include information about the practice, a request for background information about the vendor organization, estimated timeframe for installation and implementation, and a deadline for response. A point-by-point

questionnaire should be prepared for the vendor to complete and return. The questionnaire should list the practice needs with a place for the vendor to respond whether (1) those needs can be met with the standard module, (2) a separate module must be added, or (3) the software will not perform the tasks at all. After a limited group of qualified vendors has been chosen, the practice should schedule a presentation and site visit with each vendor, obtain information on current users, and verify references. An in-depth cost-benefit analysis should be prepared. As with any other major purchase, it is important to weigh the benefits against the associated costs. The practice must determine which software will work best for its particular needs. Most important, the practice must be certain that the managers and end-users are part of the decision process in order to have buy-in on the selection.

ELECTRONIC MEDICAL RECORDS

Electronic medical records, or EMR, has become a big selling factor with practice management software. EMR enables a physician practice to maintain all patient charts in the system. The EMR system works with the billing system to maintain a paperless office. Many new practices are using the EMR system to have better control of medical charts and to keep up with workflow. Most systems come with a tabular laptop or handheld personal data assistant (PDA) to enable the physician to take notes and fill out the encounter form directly into the system. It can also give the physician access to the schedule at all times, along with keeping up with which patients are in each room. While many of the more established practices are hesitant to go to EMR because of their large amount of existing charts, most medical practice software companies are targeting these offices as examples of offices needing the EMR function.

EMR can benefit the CPA because most, if not all, of the test data needed for an assessment, fee schedule analysis, or chart audit is available electronically. This can cut down on the time spent on a project and help pass on savings to the client. Also, EMR can help put up more internal controls on patient and financial data.

> *CAUTION:* In the event the computer server crashes, a practice risks losing all of its information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule addresses this issue by requiring medical practices to protect the patient information and have a disaster recovery plan in place. With a daily backup in place, the most a practice has to lose in the event of a system crash is one day's work.

SUMMARY

The selection of the right practice management software is just the first step in the ability of a practice to meet its objectives successfully. The software is just a tool. To be a useful tool, the staff must be able to operate the software system to its optimal capabilities. Continual training is essential.

The decision to purchase a practice management system is a serious one that affects all areas of the medical practice. The right practice management system will enable employees to work effectively, enhance relationships with patients and payers, increase efficiency, and improve bottom-line results.

Chapter 24

Accounting System Review

Appropriate accounting procedures and policies are important to the success of a medical practice. Much attention is given to the management of the billing function; however, lack of proper controls and inappropriate procedures in general accounting functions can be as damaging to a practice's financial well-being as inaccurate or untimely billing.

A comprehensive accounting review of a medical practice generally comprises these four reviews:

1. A review of internal controls over accounting functions
2. A review of the system of financial reporting
3. Cash management review
4. Review of overall procedures to assess efficiency

REVIEWING INTERNAL CONTROL TO ENSURE SEGREGATION OF DUTIES

Segregation of duties is the most important safeguard of internal control. Yet, in the smaller medical practice it is not unusual for the same employee to open the mail, prepare the deposit, take the deposit to the bank, and post the payment.

EXAMPLE

Dr. A is an internal medicine physician in Small Town, USA, and operates his office with one business employee and one clinical employee. The business employee assumes the duties of receptionist, data entry clerk, insurance clerk, and bookkeeper. The business employee has been employed by the practice for 15 years and is considered by Dr. A to be a very trustworthy and dedicated employee. Because of an auto accident, the business employee will be out of the practice for 60 days.

During her absence, Dr. A asks his CPA to provide temporary staff to assume some of the billing and bookkeeping duties. Statements are printed and mailed to patients with open balances. Immediately, Dr. A receives numerous phone calls from patients who claim they have paid their accounts, mostly in cash. Dr. A is devastated and realizes that his steps towards efficiency and cost saving in the office have left him venerable. He likewise begins to question why his CPA did not advise him of this weakness in cash control.

When such a lack of segregation of duties exists, proper procedures and periodic monitoring are essential. In situations such as the example above, the CPA should advise the physician of the weakness in controls and the possible ramifications. Likewise, the CPA should be proactive and recommend independent review and monitoring.

For example, at a minimum the employee should be required to prepare and make the deposit daily. Additionally, the total payments posted for the day must be reconciled to the amount deposited either by the physician in a small office or by the CPA. The CPA should assist in monitoring these procedures by comparing the amount deposited to the payments posted for the month when preparing the financial statements.

Even in larger practices, proper internal controls may not exist. For example, the practice may not use a purchase order system for ordering supplies. The purchase order system allows the practice manager to approve purchases prior to ordering. Without a system to authorize orders, the practice may over-order, thus, accelerating cost.

Additionally, many larger practices do not maintain an inventory of supplies. Without an inventory, practices may order inappropriately or inventory may be misused or misappropriated. Perishable supplies (medications) must be monitored for expiration dates and possible misuse.

Internal controls over cash disbursements are essential. Practices should discourage the use of a petty cash fund to routinely purchase supplies or, worse yet, to cash employee checks. Procedures such as the use of purchase orders should be in place to control ordering and the practice manager or physician should approve all invoices prior to payment. Check signing authority should only be assigned to a physician or physician and administrator (with certain dollar limitations). A "stamp" should never be used for signing checks.

When working with a relatively small practice where segregation is not a cost-effective option, several reconciling options should be put in place to increase internal control. The practice's CPA can play a key role in this process as well as the office managers. A spreadsheet with the daily cash/check/remit deposit should be maintained by month. This sheet can then be compared to the daily posting of these items to the system. Daily posting is essential. This provides a balance between the system and daily deposit ticket. In addition, the bank statements should be mailed directly to the physician and opened only by the physician. The physician should take a few moments to briefly review the statement for irregularities that may appear. The bank reconciliation should be reviewed, by an individual independent of the accounting function, on a monthly basis. See Tool 24-A, "Sample Internal Control Questionnaire." This questionnaire can serve as a checklist during the review process.

Tool 24-A: Sample Internal Control Questionnaire ***(Toolkit CD-ROM)***

FINANCIAL REPORTING REVIEW: DETERMINING WHETHER TO USE CASH BASIS OR ACCRUAL

Financial reports should comply with sound accounting principles set forth by the Financial Accounting Standards Board (FASB) and other authoritative bodies. The term "generally accepted" means either that an authoritative accounting standard-setting body has established a principle of reporting in a given area or that over time a given practice has been accepted as appropriate because of its universal application. Given the changing accounting environment, it is important that individuals with responsibility for financial

reporting stay abreast of current technical standards and regulatory requirements to ensure compliance. This information is widely available through annual seminars, conferences, and self-study courses. Having knowledge of new standards or modifications to current standards that have effective dates in the future allows medical practice personnel to assess the impact in advance and plan an implementation strategy.

Financial reports should provide the practice with the information needed to make informed management decisions. Financial reports should be timely, reliable, and in a format that the users of the information understand.

The majority of medical practices prepare financial statements on the cash basis, which corresponds to the basis of tax reporting. The cash basis statements, however, may not accurately reflect the results of operations. For example, a clever office manager may delay paying bills in order to create a cash profit. When overstated profits become the basis of physician bonus computations, the practice takes on financial risk. Additionally, a practice with falling production may be able to sustain collections for a period of time, thus appearing to be healthy while the practice volume is actually declining.

Accrual based financial statements require that the practice accumulate information regarding both receivables and payables. The practice must establish an accounts receivable allowance to account for contractual write-offs and uncollectible accounts. The establishment of this allowance is a good management exercise in that it encourages the practice to establish collection goals. Likewise, it is important for the practice to review accounts payable so that management is aware of the commitment on cash when making financial decisions.

The practice may present financial reports in a comparative format, with current reports compared to prior periods. Although this allows the practice to compare where they were with where they are financially, changes in circumstances (new offices, new providers, and new modalities) may not make the figures really "comparable." A better indicator of practice performance may be to compare the actual results with budget amounts. This enables the practice to review practice operations in light of anticipated results. Additionally, the practice should compare actual ratios (that is, collections as a percent of charges and expenses as a percentage of collections) to financial benchmarks for the specialty (such as Medical Group Management Association's [MGMA's] *Cost and Production Survey*).

You can also departmentalize statements into results by office location or specialty. This may assist the practice in establishing responsibility for operational results.

CASH MANAGEMENT REVIEW

Because of the nature of the business, sound cash controls for the medical practice are essential. Collections must be deposited daily, intact. Depending on the size of the practice, a lockbox account or a sweep account may allow for increased control and improved utilization of cash. The lockbox provides for the immediate deposit of cash by an employee of the physician's bank. The bank likewise copies all remittances and provides them to the practice to post payments. Obviously, there is a charge for the lockbox service that should be compared to the cost savings in the practice resulting from the removal of the deposit and photocopying duties along with the benefits of increased control.

A cash report should be prepared weekly indicating the cash balance and requirements for the upcoming week. The cash report will assist management in making informed decisions regarding the use of funds. A daily report should be prepared to indicate daily collections in light of cash needs for the week.

Accounts payable should not be paid more than weekly. Paying bills daily is inefficient and results in poor cash management. Yet, accounts should always be paid timely to take advantage of potential discounts and to avoid costly late fees.

OPERATIONS REVIEW

Efficiency in overall operations is key to establishing appropriate controls and minimizing overhead burden. Inefficient chaotic offices create an unpleasant work environment, which leads to turnover, errors, and higher overall cost.

Office procedures should be streamlined and automated. With the availability of low cost accounting programs (such as Peachtree and QuickBooks), even the smallest practice should be able to automate the accounts payable and bookkeeping functions. Payroll services (such as Paychex and ADP) provide a low-cost alternative for payroll processing and recordkeeping. Automated timekeeping systems (such as Cronos) provide accuracy in cost allocation and streamline the computation of salary calculations.

By having an automated bookkeeping system, the practice will be able to better evaluate its efficiency in meeting budgets and goals. This will also assist in benchmarking the practice with other practices in the area. Most automated systems will give you a wide variety of different reports and provide you with much more accurate information. The system will also cut down on the time it takes to review books being kept by hand. This will dramatically decrease the cost of the accounting service and allow the practice to provide the accountant with an electronic version of the accounting information. In addition, it provides a backup, whereas paper systems are just that, and when something is destroyed, most of the time there is no safe duplication.

Salary overtime can be a costly result of an inefficient office. Employees may work longer hours than necessary to complete tasks. Practices that consistently encounter overtime should review procedures for efficiency and necessity. If overtime continues, perhaps a part-time or additional full-time employee should be added. It is less expensive to add an employee than to pay time-and-one-half for overtime.

A thorough review by the CPA consultant of the practice's accounting processes and procedures will assist the practice in making decisions regarding the operational changes needed in order to achieve desired efficiencies and to establish necessary accounting controls. Tool 24-B, "Sample Accounting Review Report," assists in the decision making process.

Tool 24-B: Sample Accounting Review Report *(Toolkit CD-ROM)*

SUMMARY

Medical practices frequently are weak in the area of internal control. Physicians are not trained to be financial managers and they rely on their CPAs to both educate them and assist them in the financial management of their practices. The bottom line is that efficient medical offices are more profitable. The CPA can provide a vital service by helping the practice recognize weaknesses and correct operational deficiencies.

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The CPA's Guide to

MEDICAL, DENTAL, AND OTHER HEALTHCARE PRACTICES

TOOLKIT

Lucy R. Carter, CPA
Sara S. Lankford, CPA

The CPA's Guide to Medical, Dental, and Other Healthcare Practices
Toolkit CD-ROM

Introduction

The *Toolkit CD-ROM* provided with *The CPA's Guide to Medical, Dental, and Other Healthcare Practices* provides forms, checklists, and other practical aids. Subject to the conditions in the License Agreement, which may be viewed on the READ-ME file on the CD-ROM, you may duplicate and modify the tools, and create your own customized forms.

The tools are accessible under the "List of Tools" tab found on the opening screen of the *Toolkit*. The tools are numbered by their respective chapter (for example, "Tool 1-A, Specialty Categories" is found in chapter 1), and cross-referenced in the "List of Tables, Exhibits, and Tools" following the book's Table of Contents. **The tools appear only on the Toolkit CD-ROM.**

With two exceptions, the forms and checklists on the *Toolkit CD-ROM* are produced in Microsoft Word 2000 or Excel for Windows 2000. (Note: "Tool 6-A, Advance Beneficiary Notice (ABN)" and "Tool 10-A, Sample Graph for Presentation" are provided in portable document format or PDF. Adobe Acrobat Reader 5.0 is provided for viewing purposes. These tools may be viewed and printed, but cannot be altered on screen.)

[Note: Provided you have the appropriate software, you may open, copy, and save the files to your local drive. If you wish to convert a file to another software program, please consult the appropriate software manual to ascertain whether or not that a conversion is possible.]

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The CPA's Guide to Medical, Dental, and Other Healthcare Practices
Toolkit CD-ROM

Installation Instructions

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To Install and Use the Toolkit CD-ROM

1. The *Toolkit-CD ROM* is self loading. Insert the *Toolkit CD-ROM* (label side up) into your computer's CD-ROM drive and wait for CD-ROM to load. If the CD-ROM should fail to load, you can load it from the "Run" menu accessible from the Start Tab on your screen.
2. The *Toolkit CD-ROM* will open to a title page screen containing 4 tabs: INSTRUCTIONS, INTRODUCTION, READ-ME, and LIST OF TOOLS.
3. To access the Tools, double click on the LIST OF TOOLS tab.
4. A linked table of contents for the tools contained on the CD-ROM will open. There are thirty tools on the CD-ROM (20 Word, 8 Excel, and 2 PDF, see the INTRODUCTION Tab for a breakdown.)
5. Click on the tool you wish to open. The tool file will open on screen in Word, Excel, or Adobe Acrobat. For example, "Tool 1-A, Specialty Categories" will open as a Word document. [Note: "Tool 6-A, Advance Beneficiary Notice (ABN)" is a portable document format (PDF) file that can be printed out and filled-in by hand. It will open in Adobe Acrobat for viewing and printing purposes but it cannot be altered on screen. Note also that "Tool 10-A, Sample Graph for Presentation" (PDF) is for illustrative purposes only.]
6. Use the "Save As" method to save the file to your hard drive and rename as appropriate for your uses.

Important. In order to reuse the original exhibits on your hard drive without modifications, you must save your work using the *Save As* command and give your work a different name. This will allow you to always have the unaltered files available on your hard drive and to continue to customize new documents as needed. Otherwise, you will need to pick up files from the CD-ROM each time you wish to make new documents.

Note to Users: As a general rule, remember to save your data frequently.

Tool 1-A: Specialty Categories*

Primary Reported Specialties per U.S. Physician Database

Allergy & Immunology
Anesthesiology
Cardiology
Dermatology
Emergency Medicine
Endocrinology, Diabetes, & Metabolism
Family Practice
Gastroenterology
General Practice
Geriatrics
Infectious Disease
Internal Medicine
Medical Genetics
Nephrology
Neurological Surgery
Neurology
Obstetrics & Gynecology
Oncology (Cancer)
Ophthalmology
Orthopedics
Otolaryngology
Pathology
Pediatrics
Physical Medicine & Rehabilitation
Plastic Surgery
Preventive Medicine
Psychiatry
Radiology
Surgery
Urology

*Source: U.S. Physician Database. See http://www.dr-411.com/

Self-Reported Primary and Secondary Specialties per U.S. Physician Database

Abdominal Radiology
Abdominal Surgery Addiction Medicine
Addiction Psychiatry
Administrative Medicine
Adolescent Medicine-Internal Medicine
Adolescent Medicine-Pediatrics
Adult Reconstructive Orthopedics
Aerospace Medicine
Allergy & Immunology/Clinical & Lab Immunology
Allergy And Immunology
Allergy
Anatomic And Clinical Pathology
Anatomic Pathology
Anesthesiology
Blood Banking/Transfusion Medicine
Burns (Ccm)
Cancer (On)
Cardiac Electrophysiology
Cardiology (Cd)
Cardiothoracic Surgery
Cardiovascular Diseases
Chemical Pathology
Child & Adolescent Psychiatry
Child Neurology
Clinical & Lab Dermatological Immunology
Clinical & Lab Immunology-Internal Medicine
Clinical & Lab Immunology-Pediatrics
Clinical Biochemical Genetics
Clinical Cytogenetics
Clinical Genetics
Clinical Molecular Genetics
Clinical Neurophysiology
Clinical Pathology
Clinical Pharmacology
Colon And Rectal Surgery
Cosmetic Surgery
Craniofacial Surgery
Critical Care Medicine-Anesthesiology
Critical Care Medicine-Internal Medicine
Critical Care Medicine-Neurological Surgery
Critical Care Medicine-Obstetrics & Gynecology
Cutanous Micrographic Surgery
Cytopathology

Dermatologic Surgery
Dermatology
Dermatopathology
Developmental-Behavioral Pediatrics
Diabetes
Diagnostic Radiology
Emergency Medical Service
Emergency Medicine
Emergency Room (Em)
Endocrinology, Diabetes & Metabolism
Epidemiology (Ph)
Epidemiology
Facial Plastic Surgery
Family Practice (Fp)
Family Practice
Forensic Pathology
Forensic Psychiatry
Gastroenterology
General Practice
General Preventive Medicine
General Surgery
Genito-Urinary Surgery (U)
Geriatric Medicine-Family Practice
Geriatric Medicine-Internal Medicine
Geriatric Psychiatry
Geriatrics (Fpg)
Gynecological Oncology
Gynecology
Hand Surgery
Head And Neck Surgery (Hns)
Head And Neck Surgery
Hematology (Hem)
Hematology-Internal Medicine
Hematology-Pathology
Hematology/Oncology
Hepatology (Hep)
Hepatology
Hospitalist
Immunology
Immunopathology
Infectious Diseases (Id)
Infectious Diseases
Internal Medicine/Pediatrics
Internal Medicine/Physician Medicine & Rehabilitation
Internal Medicine
Interventional Cardiology

Laryngology
Legal Medicine
Maternal & Fetal Medicine
Maxillofacial Surgery
Medical Genetics
Medical Management
Medical Microbiology
Medical Oncology
Medical Toxicology-Emergency Medicine
Medical Toxicology-Pediatrics
Medical Toxicology-Preventive Medicine
Musculoskeletal Oncology
Musculoskeletal Radiology
Neonatal-Perinatal Medicine
Nephrology
Neurodevelopmental Disabilities (Pediatrics)
Neurodevelopmental Disabilities (Psychiatry)
Neurological Surgery
Neurology/Diagnostic Radiology/Neuroradiology
Neurology
Neuropathology
Neuroradiology
Neurotology
None Specified
Nuclear Cardiology
Nuclear Medicine (Nm)
Nuclear Medicine
Nuclear Radiology
Nutrition (Ntr)
Nutrition
Obesity (End)
Obstetrics And Gynecology
Obstetrics
Occupational Medicine
Ophthalmology
Oral And Maxillofacial Surgery
Orthopedic Surgery Of The Spine
Orthopedic Surgery
Orthopedic Trauma
Orthopedics-Foot And Ankle
Osteopathic Manipulative Medicine
Other Specialty
Otolaryngology
Otology
Pain Management
Pain Medicine

Palliative Medicine
Pediatric Allergy
Pediatric Anesthesiology
Pediatric Cardiology
Pediatric Cardiothoracic Surgery
Pediatric Critical Care Medicine
Pediatric Emergency Medicine-Emergency Medicine
Pediatric Emergency Medicine-Pediatrics
Pediatric Endocrinology
Pediatric Gastroenterology
Pediatric Hematology-Oncology
Pediatric Infectious Diseases
Pediatric Nephrology
Pediatric Ophthalmology
Pediatric Otolaryngology
Pediatric Pathology
Pediatric Pulmonology
Pediatric Radiology
Pediatric Rehabilitation Medicine
Pediatric Rheumatology
Pediatric Surgery-Neurology
Pediatric Surgery-Surgery
Pediatric Urology
Pediatrics Orthopedics
Pediatrics
Pharmaceutical Medicine
Pharmacology (Pa)
Physical Medicine And Rehabilitation
Plastic Surgery Within The Head And Neck
Plastic Surgery
Preventive Medicine-Clinical Medicine
Preventive Medicine-Public Health & Gen Prev Med
Proctology
Psychiatry/Neurology
Psychiatry
Psychoanalysis (Pya)
Psychoanalysis
Public Health And General Preventive Medicine
Pulmonary Critical Care Medicine
Pulmonary Diseases
Radiation Oncology
Radiological Physics
Radiology
Reproductive Endocrinology
Rheumatology (Rhu)
Rheumatology

Selective Pathology
Sleep Medicine
Spinal Cord Injury
Sports Medicine (Fsm)
Sports Medicine (Physical Medicine & Rehabilitation)
Sports Medicine-Emergency Medicine
Sports Medicine-Family Practice
Sports Medicine-Internal Medicine
Sports Medicine-Orthopedic Surgery
Sports Medicine-Pediatrics
Sterility And Fertility (Os)
Student Health (Fp)
Surgery Critical Care-Surgery
Surgery Of The Hand-Plastic Surgery
Surgery/Plastic Surgery
Surgical Oncology
Thoracic Surgery
Transplantation Surgery
Trauma (Trs)
Trauma Surgery
Undersea Medicine & Hyperbaric Medicine
Urology
Vascular & Interventional Radiology
Vascular Medicine
Vascular Surgery (Vs)
Vascular Surgery

Tool 1-B: Sample Job Descriptions – One- to Two-Physician Group Practice

Employee Handbook: Drs. A and B, PC

Job Title: Front Desk – Check In/Registration (Medical Receptionist)

Supervisor: Dr. A

GENERAL SUMMARY OF DUTIES:

The front desk duties include answering the phone, scheduling appointments, greeting the patients, obtaining registration forms, and pulling charts for the day's visits. This position is shared with the front desk check out staff as the two positions work together to expedite the flow of patients and their paperwork in an efficient manner.

SPECIFIC TASKS:

1. Telephone
   - First in rotation
   - Contact answering service for on/off service
2. Appointments
   - Schedule all patient office appointments for both physicians
   - Cancel and reschedule per physician instructions
   - Prepare recall cards
3. Registration forms
   - Medical history forms – completed by patient
   - Registration forms – completed by patient
   - Verify insurance
   - Copy insurance card and driver license for chart
   - Verify and obtain referral/authorization from attending physician
4. Charts
   - Pull all charts in pm for next day's visit – attach encounter slips
   - Set up new patient charts
5. Greet patients
   - Smile
6. Prepare sign in sheet for daily visits
7. Periodically straighten waiting room magazines
8. Back up check out window

Education requirement: High school diploma
Experience requirement: Two years medical receptionist experience
Continuing education: 16 hours annually in Medicare/Medicaid reimbursement and compliance.

Employee Handbook: Drs. A and B, PC

Job Title: Front Desk – Check Out/Cashier (Medical Receptionist)

Supervisor: Dr. A

GENERAL SUMMARY OF DUTIES:

The front desk duties include answering the telephone, scheduling appointments and other tests as ordered by physicians, placing fees on encounter slips, collecting co-pays, deductibles and co-insurance, batching encounter slips, and filing charts. This position is shared with the front desk check in staff as the two positions work together to expedite the flow of patients and their paperwork in an efficient manner.

SPECIFIC TASKS:

1. Telephone
   - Second in rotation
2. Appointments
   - Schedule all return visits as ordered by physician
   - Schedule all lab and diagnostic tests as ordered by physician
3. Encounter Slips
   - Apply fees to services checked on encounter form, total
   - Request payments from patients
   - Batch encounter slips for posting
   - Post all encounter slips
4. Charts
   - File charts daily
   - File all lab and other reports in charts
5. Periodically straighten waiting room magazines
6. Back up check in window

Education requirement: High school diploma
Experience requirement: Two years medical receptionist experience
Continuing education: 16 hours annually in Medicare/Medicaid reimbursement and compliance.

Employee Handbook: Drs. A and B, PC

Job Title: Billing and Insurance

Supervisor: Dr. A

GENERAL SUMMARY OF DUTIES:

Billing and Insurance includes posting of payments, denials, and correspondence; processing insurance and statements according to procedures and issuing collection letters; assisting patients with billing questions. This position is responsible for the billing and collection of all patient accounts, and follow-up of insurance claims. The position provides reporting to the physicians on a weekly and monthly basis as described in the procedures manual.

SPECIFIC TASKS:

1. Payments
   - Post all payments and adjustments from copies of checks and original explanation of benefits (eob) to patient accounts.
2. Denials and correspondence
   - Post all zero payments for denials from eobs and correspondence.
   - Research denial actions and resubmit as necessary.
3. Insurance and Statements
   - Print paper claims daily and mail.
   - Process electronic insurance twice weekly.
   - Process and mail patient statements weekly.
   - Review claims pending reports weekly, contact insurance companies, resolve issues with payment.
   - Review collection accounts monthly, issue collection letters monthly, advise physician on accounts for collections.
4. Assist Patients
   - Answer all patient phone calls regarding accounts.
   - Assist patients in the office with insurance and billing questions.
5. Insurance Contracts
   - Maintain contracts files with managed care.
6. Process end of day reporting.
7. Process month reporting and balancing.

Education requirement: High school diploma
Experience requirement: Two years medical office billing experience.
Continuing education: 16 hours annually in Medicare/Medicaid reimbursement and compliance.

Employee Handbook: Drs. A and B, PC

Job Title: Clinical Assistants – Registered Nurse

Supervisor: Dr. A and B

GENERAL SUMMARY OF DUTIES:

Provides professional nursing care for patients following established standards and practices. Prepares equipment and assists physicians during examinations and treatments. Administers prescribed medications, changes dressings, cleans wounds, and monitors patient's vital signs. Observes and maintains records on patient's condition, reaction, and progress.

SPECIFIC TASKS:

1. Patient Visit
   - Prepare equipment and assist physician during examination.
   - Administer prescribed medications, change dressings.
   - Collect specimens for analysis (i.e., venipuncture).
   - Perform in-office laboratory tests ordered by physician.
   - Schedule hospital admissions and tests.
   - Escort patient to check out.
2. Equipment
   - Responsible for maintenance of equipment.
   - Order and control medical supplies.
3. Patient Records
   - Review medical record to assure all documentation is captured and encounter slip is appropriately checked for that day's service.
4. Telephone
   - Screen patient phone calls.
   - Call in prescriptions per physician orders.
5. CLIA and OSHA manuals
   - Maintain
6. Assist physician and patient as required.

Education requirements: Graduation from an accredited program of nursing.
Experience: None
Certification/License: Valid state license.

Employee Handbook: Drs. A and B, PC

Job Title: Clinical Assistants – Medical Assistant

Supervisor: Dr. A and Dr. B

GENERAL SUMMARY OF DUTIES:

Performs a variety of patient care activities to assist physicians, physician assistant, and nurses. Prepare treatment rooms and equipment as directed.

SPECIFIC TASKS:

1. Escort patients to rooms.
2. Take vital signs.
3. Prepare exam rooms and instruments for examinations and testing. Sterilize instruments. Stock supplies.
4. Deliver tests and obtain results.
5. Assist physicians and nurse as needed.

Education: Graduation from high school.
Experience: One year of clinic work experience.
Certificate/Licensure: Medical Assistant Certificate.

Tool 1-C: Sample Job Description – Three- to Five-Physician Group Practice

Employee Handbook: Drs. A, B and Associates, PC

Job Title: Office Manager

Supervisor: Physicians

GENERAL SUMMARY OF DUTIES:

Supervises administrative and clinical assistant staff. Oversees the daily operation of business office, handling patient dissatisfactions and complaints, and coordinates day-to-day operations.

SPECIFIC TASKS:

1. Directs and implements procedures relative to billing and collection of patient accounts receivable. Establishes priorities and assigns work, including projects and non-routine tasks.
2. Maintains third party payer contract files and educates staff on rules and regulations of each contract.
3. Supervises and trains administrative personnel. Evaluates performance and recommends merit increases, promotions, discipline actions.
4. Monitors monthly insurance reimbursements and appeals denials and underpayments. Works with physicians to resolve medical necessity denials.
5. Prepares end-of-day, end–of-month, and end-of-year reports.
6. Runs monthly refund report, researches and resolves credit balances.
7. Runs practice activity reports for physicians monthly.
8. Coordinates annual compliance audits with outside consultants.

Education requirement: High school diploma
Experience requirement: Three years experience in physician clinic with at least one year supervisory responsibilities over three to five employees.
Continuing education: 24 hours annual courses in Medicare/Medicaid regulations, Compliance, and/or Management Training.

Tool 1-D: Sample Job Description – Administrator 26+ Physician Group Practice

Appendix to Employment Agreement – Administrator

Basic function
The Administrator is responsible to the Board of Directors for the planning, direction, coordinating, and controlling of the operation and activities of the group, except those directly involving professional medical judgment.

General areas of responsibility
1. Operation of the financial aspects of the group, i.e., billing and collection for medical services, and payment of accounts receivable.

2. Management of the non-medical aspects of the delivery of healthcare, including renovating, equipping, and staffing ambulatory office space.

3. Management of salary and fringe benefit plans for the physicians.

4. General liaison with the hospital in those matters of mutual interest, including laboratory administration, space allocation, personnel management, etc.

Specific duties and functions
1. To develop and maintain an effective organizational structure designed to facilitate achievement of the objective.

2. To delegate to members of his/her staff appropriate portions of his responsibility with corresponding authority for the fulfillment with the understanding that he may not abdicate his overall responsibility for results of any portion of his accountability.

3. To supervise and direct all immediate subordinates in their performance of assigned responsibilities, and in the manner in which their individual objectives are being pursued, to render advice, assistance, and guidance as necessary.

4. To determine, promulgate, and enforce general operating and administrative procedures required to implement basic policy established by the Board of Directors. To assume responsibility for the conduct, operations, and results of the non-physician staff and to ensure that they operate with the support of the medical staff in providing the highest quality of patient care at the most reasonable cost.

5. To establish and implement such systems of reporting as are necessary to maintain a continuing analysis of results and developments, including regular financial and performance reports to the Board of Directors and the President (e.g., weekly cash reports, monthly income and expense statements and balance sheets, and annual financial reports).

6. To satisfy all federal and state regulations relating to the corporation and in the delivery of healthcare.

7. To search constantly for improvement in methods, more efficient equipment, and better utilization of manpower.

8. To represent the medical group with other medical groups, hospitals, civic government and general business groups, and medical agencies.

9. To serve as liaison between the Group and hospital administration.

10. To acquire sufficient knowledge of pension, life insurance, disability, and other fringe benefit services so as to be able to make recommendations to the Board of Directors in this area.

11. To review all third-party payer contracts and make recommendations to the Board for participation or termination of those contracts.

12. To participate on the compliance committee, and implement internal monitoring and auditing for compliance purposes.

Basic knowledge

1. An advanced degree in Business Administration, Hospital Administration, or equivalent background.

2. Administration experience, preferably in the field of healthcare.

3. Ability to communicate well in speaking and writing.

4. Basic understanding of general accounting and general business law.

Independent action

With expansion of General Policy guidelines from the President and the Board of Directors, totally independent action.

Supervisory responsibilities

Directly supervise all non-physician supervisors and administrative personnel. Indirectly responsible for all non-physician employees.

Physician:	EVALUATION & MANAGEMENT					ADDITIONAL CPT CODES
	OBSERVATION CARE DISCHARGE					
		99217	OBSERVATION CARE DISCHARGE			
Patient Name:	INTIAL CARE					
	OBSERVATION			HOSPITAL		
		99218		99221		
Patient MRN:		99219		99222		
		99220		99223		
	SUBSEQUENT			OBSERVATION / INPATIENT		
Site of Service:	HOSPITAL CARE			HOSPITAL CARE		
		99231		99234		
		99232		99235		
Date of Service:		99233		99236		
	HOSPITAL DISCHARGE SERVICES					
		99238		99239		
Notes:	INPATIENT CONSULTATIONS					
	INITIAL			FOLLOW-UP		
		99251		99261		DIAGNOSIS
		99252		99262		
		99253		99263	1)	
		99254		ER DEPT SERVICES		
		99255		99281	2)	
	CRITICAL CARE			99282		
		99291 (FIRST 30-74 MIN)		99283	3)	
		+99292 (EACH ADD 30 MIN)		99284		
				99285	4)	

Tool 2-A.1: Sample Encounter Form

FAMILY MEDICINE

PROVIDER:
PATIENT NAME:
PATIENT MRN:
INSURANCE:
DATE OF SERVICE:
CURRENT ACCOUNT BALANCE:

PRACTICE NAME AND/OR LOGO

STREET ADDRESS
CITY, STATE ZIP CODE
TEL:
TAX ID:

EVALUATION & MANAGEMENT			
NEW PATIENT		**ESTABLISHED PATIENT**	
99201		99211	
99202		99212	
99203		99213	
99204		99214	
99205		99215	
PREVENTIVE MEDICINE			
99381 (< 1 YR)		99391 (< 1 YR)	
99382 (1-4 YR)		99392 (1-4 YR)	
99383 (5-11 YR)		99393 (5-11 YR)	
99384 (12-17 YR)		99394 (12-17 YR)	
99385 (18-39 YR)		99395 (18-39 YR)	
99386 (40-64 YR)		99396 (40-64 YR)	
99387 (> 64 YR)		99397 (> 64 YR)	

WOMEN'S HEALTH		
Q0091W	COLLECTION OF PAP	
G0101W	CERVICAL / VAGINAL SCREENING	
57454*	COLPOSCOPY WITH BIOPSY AND/OR ECC	
PULMONARY		
94060	BRONCHOSPASM EVALUATION	
94664	INHALER INSTRUCTION	
94760	NONINVASIVE EAR PULSE OXIMETRY; SINGLE	
94761	NONINVASIVE EAR PULSE OXIMETRY; MULTIPLE	
94640	NEBULIZER TREATMENT	
94010	SPIROMETRY	
INCISION AND DRAINAGE*		
10060	INCISION & DRAINAGE OF ABSCESS; SINGLE; SIMPLE	
100--	INCISION & DRAINAGE	
EXCISION LESIONS		
11200	SKIN TAG REMOVAL; UP TO 15 LESIONS	
114--	EXC., BENIGN LESION _____	
DESTRUCTION, BENIGN LESIONS (ACTINIC KERATOSES)		
17000*	DEST BENIGN LESION, ANY LOCATION, FIRST LESION	
17003+ /EACH	DEST BENIGN LESION 2-14 ANY LOCATION (USE WITH 17000)	
17340*	CRYOTHERAPY (CO2, LIQUID NS) FOR ACNE	
OSTEOPAHIC MANIPULATIVE TMT		
98925	OMT 1-2 BODY REGIONS INVOLVED	
98926	OMT 3-4 BODY REGIONS INVOLVED	
98927	OMT 5-6 BODY REGIONS INVOLVED	
97010	HOT PACKS	
97140	MYOFASCIAL RELEASE, 15 MIN. EACH	
SUPPLIES / SPLINTS (DME)		
A6430	ELASTIC COMP BANDAGE; LIGHT; WIDTH 3<>5 IN.	
A6432	ELASTIC COMP BANDAGE; LIGHT; WIDTH >=5 IN.	
A4570	ALL SPLINTS, ARM, FINGER, WRIST, LEG	
L3800	THUMB SPLINT, WRIST/HAND/FINGER	
REPORTS		
99080	MEDICAL REPORT FOR INSURANCE PURPOSES	
	PER 30 MINUTE UNIT	
3333	MEDICAL RECORDS COPIES	
EXAMS - NO CHARGE		
3336	OFFICE VISIT N.C. HOS ADMIT OR ER REF	
99024	POST OP FUP (INCLUDED IN GLOBAL SERVICE)	

CHILD IMMUNIZATIONS		
90658	INFLUENZA VACCINE, SPLIT 3 YRS & GTR.	
90700	DTaP	
90703	TETANUS TOXOID	V03.7
90709	RUBELLA - MUMPS	V06.8
90713	POLIO-INACTIVATED (IPV)	V04.0
90744	HEPB PED/ADOL	
90748	HEPB/HIB/RECOMB	V05.3
ADULT IMMUNIZATIONS		
90471	ADMIN OF INJ - SINGLE	
90472+ / EA	ADMIN 2 OR MORE SINGLE OR COMBO VACCINE TOXOIDS X _____	
G0008	ADMIN FLU-MEDICARE	
G0009	ADMIN PNEUMOVAX - MEDICARE	
90713	POLIO-INACTIVATED (IPV)	V04.0
90718	TD	
90658	INFLUENZA VACCINE, SPLIT	
90732	PNEUMO VAX	V03.82
TRIGGER POINT / INJECTIONS		
20550*	TRIGGER INJ, IF MULTI x _____	
20610*	ASPIRATION OF JOINT - LARGE	
THERAPEUTIC OR DIAGNOSTIC INJECTIONS SUBCUTANEOUS, INTRAMUSCULAR OR IV		
90782	_____ ADMINISTRATION OF INJECTION	
J0696	_____ ROCEPHEN PER 250mg	
J1000	_____ DEPO ESTRADIOL UP TO 5 mg	
J1055W	_____ DEPO-PROVERA 150mg	
J1070	_____ TESTOSTERONE CYP UP TO 100mg	
J1885	_____ TORADOL PER 15mg	
J2000	_____ LIDOCAINE HCI, 50cc	
J2550	_____ PHENERGAN UP TO 50mg	
J3301	_____ KENALOG PER 10mg	
J3410	_____ VISTARIL	
J3420W	_____ B-12 INJ UP TO 1000 meg CYANOCOBALAMIN	
LAB		
81000	URINALYSIS W/MICROSCOPY	
81002	URINALYSIS W/O MICROSCOPY DIPSTICK	
81025	URINE PG TEST BY VISUAL COLOR	
36415/ G0001	VENIPUNCTURE BLOOD DRAW	
82948	FINGER STICK GLUCOSE	
87220	KOH PREP (TISSUE EXAM BY KOH SLIDE)	
82270/ G0107	HEMOCCULT TEST	
87210	WET MOUNT W/INTERP. FOR INFEC, AGENTS	
87880	STREPTOCOCCUS, GRP A (RAPID STREP)	
AUDIOLOGIC TESTING		
92567	TYMPANOMETRY	
92568	ACOUSTIC REFLEX TESTING	
MISCELLANEOUS		
51701	CATHERIZATION	
69210	IRRIG EAR, CERUMEN REMOVAL	
93000	EKG W/ INTERPRETATION	
99173	SCREENING TEST VISUAL ACUITY	

ADDITIONAL CPT CODES

DIAGNOSIS

1.	
2.	
3.	
4.	

FEE FOR SERVICE

$ CASH

$ DEBIT CARD

$ VISA

$ MC

$ CHECK #

$ TRAV CK

$ OTHER

$ PAID ON ACCT

$ TODAY'S COPAY

$ AMOUNT PAID

RETURN VISIT:

* PROCEDURES:
USE WITH MODIFIER -25 + E&M CODE
CHARGE FOR SUPPLIES
+ ADD ON PROCEDURES
W - MEDICARE WAIVER REQUIRED

FORM 001 04/03

Tool 2-A.2: Sample Encounter Form

Tool 2-B: Sign In Sheet

OFFICE NAME

PLEASE SIGN IN:_____ TODAY'S DATE:_____

Patient Name	Appt. Time	Physician	Parent/Account Name

Tool 2-C: Patient Registration Form

Name: First Middle Last Nickname

Birthday Social Security #

Address: Street City State Zip Code

Employer: Name Address Phone #

Occupation: _____ Referred by:_____

Daytime phone #_____ Home phone #_____

In the event of an emergency contact:

Name: Address: Telephone:

May Doctors name be left on voice mail or answering machines:

Insurance information: (provide all insurance cards for us to copy)

Primary insurance company:_____ Group #_____

Name of insured: Relationship to patient:

Insured's birthday: Soc Sec #

Employer: Date employed:

Occupation: Employer telephone #:

Deductible:_____ Co-Pay:_____

Authorization or referral needed:_____

Secondary insurance company:_____Group #_____

Name of insured: Relationship to patient:

Insured's birthday: Soc Sec #

Employer: Date employed:

Occupation: Employer telephone #:

Deductible:_____ Co-Pay:_____

Authorization or referral needed:_____

OTHER insurance company:_____Group #_____

Name of insured: Relationship to patient:

Insured's birthday: Soc Sec #

Employer: Date employed:

Occupation: Employer telephone #:

Deductible:_____ Co-Pay:_____

Authorization or referral needed:_____

AUTHORIZATION AND RELEASE OF INFORMATION

I hereby authorize you to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay insurance benefits otherwise payable to me directly to the physician or physician group. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent (if minor):_____

Date:_____

Tool 2-D: Batch Ticket

Date of Service:_____ Date of Deposit:_____

Date Prep:_____ Prep by:_____

Date Entered:_____ Entered by:_____

Type of entry (circle one): Charges Payments Adjustments

Batch Totals:

CPT codes _____

Charges _____

Payments _____

Adjustments _____

Dr # _____

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

Tool 7-A: Data Information Request and Survey

In preparation for the upcoming assessment of your clinic we request that you provide copies of the following information. If the item requested is unavailable, please indicate next to the corresponding number. We have also attached a list of pertinent questions about your clinic that will enable us to maximize our on-site assessment.

1. A list of each employee, position, date of hire, years of healthcare experience, current salary and any bonus received in the past year.

2. An organizational chart.

3. A copy of all job descriptions.

4. A copy of the personnel policy manual that is given to each employee.

5. A copy of all policies and procedures for the clinic.

6. For the current and last fiscal year, a copy of year-to-date and the previous year-end charges, payments, and adjustments by physician, and total for the clinic. A report by payer and a detailed list of all adjustments such as Medicare, Medicaid, managed care, bad debt, etc. should be provided.

7. Procedure productivity report by CPT code and frequency for each provider for the current year-to-date and the last fiscal year totals.

8. Fee schedules for the clinic or each doctor. For example, furnish the clinic fee schedule with any others that you have in your practice management system such as your standard fee, Medicare, Medicaid, Blue Cross Blue Shield, or Workers Compensation.

9. Copy of all Superbill/Encounter forms used by the clinic.

10. Copy of the Patient Registration form.

11. Copy of the Patient Sign-In Sheet used at check-in.

12. Sample copy of a Patient Statement.

13. Clinic Practice Brochure.

14. Copy of the Medicare Waiver of Liability or Medicare Advance Beneficiary Notice used in the clinic.

15. Copy of Patient Promissory Note.

16. Statement of income and expenses for last month with year-to-date information.

17. Statement of income and expenses for the last fiscal year end.

18. A copy of the aged accounts receivable totals for the most recent month end and the previous year end that reports aged categories.

19. A year-to-date accounts receivable summary that indicates patient name, account number, dates of service, and corresponding CPT codes.

20. Copy of each physician's curriculum vitae, date they joined the clinic, specialty, and clinic board position or committee they sit on.

21. Names of any physicians who have left or retired from the clinic and dates of termination.

22. List of all managed care plans the clinic participates with.

23. Copy of clinic marketing materials such as patient survey, yellow pages, direct mail, etc.

General Operational Questions

1. Year the practice was established_____

2. Name of establishing physician(s)_____

3. Type of corporate entity:
   - ❑ Sole Proprietor Date of formation _____
   - ❑ Partnership Date of formation _____
   - ❑ C Corporation Date of incorporation _____
   - ❑ S Corporation Date of incorporation _____

4. Does the clinic have ownership in any other entity such as Ambulatory Surgicenter, Laboratory, MRI, etc.?
   - ❑ Yes, Name of entity_____
   - ❑ No

5. Does the clinic have more than one location?
   - ❑ Yes, list locations_____
   - ❑ No

Schedule

1. Hours of operation:

Monday	_____ o'clock to _____ o'clock
Tuesday	_____ o'clock to _____ o'clock
Wednesday	_____ o'clock to _____ o'clock
Thursday	_____ o'clock to _____ o'clock
Friday	_____ o'clock to _____ o'clock
Saturday	_____ o'clock to _____ o'clock
Sunday	_____ o'clock to _____ o'clock

2. Physician Call Schedule:

   Who prepares the physician call schedule?_____

   How often do physician rotate on call? _____

   What constitutes weekend call? ___Friday, Saturday, Sunday (or) ____ Saturday, Sunday

3. Does the clinic have a mid-level provider who rotates on call?
   - ❑ Yes, how often do they rotate on call_____
   - ❑ No

4. In which hospitals do the physicians have privileges?

   _____

   _____

Personnel Assessment

1. How often are employee performance evaluations performed?
   - ❑ Annually
   - ❑ As merited
   - ❑ Other _____
   - ❑ Please indicate who performs the evaluation_____

2. Does the clinic have employment agreements with any employees?
   - ❑ Yes
   - ❑ No

   (Enclose copy of employment agreements)

3. Employee wage increases are based on:
   - ❑ Performance
   - ❑ Cost of living
   - ❑ Tenure

4. Does the clinic pay bonuses? If Yes, please explain._____
   - ❑ Yes
   - ❑ No

5. Does the clinic pay for continuing education?
   - ❑ Yes
   - ❑ No

   If Yes, please explain_____

   _____

6. Does the practice perform reference checks prior to hiring employee?
   - ❑ Yes
   - ❑ No

   If yes, please indicate the type of reference check.
   - ❑ Former employer
   - ❑ Criminal background
   - ❑ Federal compliance

7. Does the clinic have a Practice Administrator?
   - ❑ Yes, Name_____ Date employed by the clinic_____
   - ❑ No

8. Are employees compensated for overtime?
   - ❑ Yes, time and one half paid.
   - ❑ No, reward with comp time.

9. Most of the clinic employees are compensated:
   - ❑ Hourly
   - ❑ Salary

Billing and Collections

1. Who makes up the business office, and what are their primary responsibilities?

NAME	RESPONSIBILITY

2. Are various fee schedules available in the system?
   - ❑ Yes
   - ❑ No

3. How often are claims transmitted/sent hardcopy to the insurance copy?
   - ❑ Daily
   - ❑ Biweekly
   - ❑ Weekly
   - ❑ Bimonthly
   - ❑ Monthly
   - ❑ Other_____

4. Does the practice file secondary insurance for the patient?
   - ❑ Yes
   - ❑ No

5. Does the practice offer "courtesy adjustments," "insurance only," or "accept assignment" accounts for physicians, providers, or patients?
   - ❑ Yes
   - ❑ No

   If Yes, does the office staff collect applicable contractual co-payment amounts at the time of service from these accounts?
   - ❑ Yes
   - ❑ No

6. When are new patients advised of fees?
   - ❑ When the appointment is scheduled
   - ❑ With a new patient booklet
   - ❑ When the patient reports for his or her appointment

7. How often are patient statements sent out?
   - ❑ Daily
   - ❑ Weekly
   - ❑ Monthly
   - ❑ Other_____

8. How are patient statements sent out?
   - ❑ Electronically through a vendor. Name of vendor_____
   - ❑ Hardcopy statements generated in the office.

9. Are phone calls used to collect past due patient accounts?
   - ❑ Yes
   - ❑ No

10. Are accounts that are referred to the collection agency adjusted off from the accounts receivable as bad debt?
    - ❑ Yes
    - ❑ No

11. How do you charge Medicare, Medicaid, and managed care carriers?
    - ❑ Your standard fee
    - ❑ Plan allowable

12. Who assigns the CPT and ICD-9 codes on the encounter form for services provided in the clinic?
    - ❑ Physician or mid-level provider
    - ❑ Nurse or clinical support staff
    - ❑ Front desk staff
    - ❑ Billing staff

13. Does the check-out staff:
    - ❑ Collect co-payment amounts from the patients.
    - ❑ Post charges in the practice management system at the time of patient check out.

14. The clinic fee schedule was last updated:
    - ❑ This year
    - ❑ Last year
    - ❑ Over two years ago
    - ❑ Never

15. When was the last review of the encounter form done?
    - ❑ This year
    - ❑ Last year
    - ❑ Over two years ago
    - ❑ Never

16. At registration, does the clinic:
    - ❑ Make a copy of the patient's insurance card(s)
    - ❑ Make a copy of the patient's driver license
    - ❑ Verify patient information with the patient

Computer System

1. Do you have a computer system for billing and collections?
    - ❑ Yes
    - ❑ No

    If Yes, Name of the software_____
    Date implemented software in clinic_____
    Software support vendor_____

2. The computer software includes the following modules:
   - ❑ Appointment scheduling
   - ❑ Electronic medical records
   - ❑ Collection
   - ❑ Prescription writing
   - ❑ Coding reference
   - ❑ Other_____

3. Number of terminals in the clinic_____

4. Is there a maintenance agreement on the hardware?
   - ❑ Yes, Name of vendor_____
   - ❑ No

5. Does the clinic process accounts payable in-house?
   - ❑ Yes, Name of software_____
   - ❑ No, Name of vendor_____

6. Does the clinic process payroll in-house?
   - ❑ Yes. Name of software_____
   - ❑ No. Name of vendor_____

Physical Plant and Ancillary Services

1. Total square footage of clinic_____

2. Number of exam rooms_____

3. The clinic has the following ancillary services:
   - ❑ Laboratory, CLIA Number_____
   - ❑ Pharmacy
   - ❑ Radiology
   - ❑ Ambulatory Surgery Center
   - ❑ Allergy
   - ❑ Sigmoidoscopy
   - ❑ Physical Therapy
   - ❑ Ultrasound
   - ❑ Doppler
   - ❑ EKG
   - ❑ Audiology
   - ❑ Other_____

4. Transcription services are performed:
   - ❑ In the clinic
   - ❑ Offsite by a vendor

(CLIENT)

BUSINESS ASSOCIATE AGREEMENT

This **BUSINESS ASSOCIATE AGREEMENT** (the "Agreement") is entered into on (Current Date), between (Firm)("Business Associate") and (Client) ("Covered Entity"). The parties are entering into this Agreement in order to comply with the national standards for the privacy of individually identifiable protected health information ("PHI") of the Covered Entity's patients adopted by the Department of Health and Human Services ("DHHS") as required by the Health Insurance Portability and Accountability Act of 1996, as published in a final rule dated December 28, 2000 (the "HIPAA Privacy Standards").

The parties agree as follows:

1. Definition of Protected Health Information, Use, and Disclosure.

The following definitions apply to this Agreement:

a. Protected Health Information means any individually identifiable health information in any form.

b. Use means, with respect to protected health information, the sharing, employment, application, utilization, examination, or analysis of such information within the entity that maintains the information.

c. Disclosure means, with respect to protected health information, the release, transfer, provision of access to, or divulging in any other manner such information outside the entity that maintains the information.

2. Underlying Business Relationship. Business Associate and Covered Entity have an existing business relationship, pursuant to which the Business Associate performs and will perform the services or functions listed below for the Covered Entity:

a. Business Associate will provide audit, accounting, and consulting services for the Covered Entity.

To enable Business Associate to perform its duties, the Covered Entity will give Business Associate directly or will allow Business Associate access to individually identifiable

protected health information. Business Associate must use this protected health information solely to perform its duties under this Agreement and only as allowed by this Agreement's terms. Additionally, Business Associate may use and disclose protected health information in managing and administering its business activities.

3. Duties of Business Associate. Business Associate shall comply in all material respects with the HIPAA Privacy Standards when using or disclosing protected health information that it receives from Covered Entity or from another person or entity on behalf of the Covered Entity. Specifically, Business Associate agrees to the following:

a. Business Associate will use and disclose protected health information received from or on behalf of Covered Entity only to perform functions and services listed in Section 2 above. But, if a law requires use or disclosure that is not listed in Section 2 above, Business Associate may engage in that use or disclosure.

b. Business Associate must have in place all precautions or safeguards necessary to prevent protected health information from being used or disclosed except as necessary to perform the functions and services listed in Section 2 above.

c. Business Associate shall report to Covered Entity when Business Associate uses or discloses protected health information except as provided for by this agreement or except as otherwise permitted or required by law. Business Associate must report any such uses or disclosures to (Name of Responsible Party), (Title of Responsible Party), or to another contact that Covered Entity identifies in a written notice to Business Associate.

d. If Business Associate discloses protected health information to subcontractors or agents, Business Associate must require that those subcontractors or agents comply with the restrictions, conditions, and duties that apply to Business Associate in this Agreement.

e. Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill Covered Entity's obligations to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to HIPAA Privacy Standards.

f. Business Associate will make available its internal practices, books, and records relating to its uses and disclosures of Covered Entity's protected health information to the Secretary of DHHS so that the Secretary may determine whether Covered Entity has complied with the HIPAA Privacy Standards.

g. When notified by Covered Entity, Business Associate must make amendments or corrections to any of Covered Entity's protected health information which Business Associate maintains.

4. Business Associate's Responsibility for Actions. Business Associate shall be responsible for the actions of its employees and shareholders in connection with its representation of Covered Entity including, without limitation, the services listed in Section 2 of this Agreement. Business Associate has and will maintain adequate insurance which provides liability coverage for Business Associate's, its employees' and its shareholders' failure to maintain confidentiality of PHI provided to Business Associate by Covered Entity in accordance with Business Associate's ethical obligations. Business Associate will provide Covered Entity evidence of such coverage upon request.

5. Term and Termination.

a. The Term of this Agreement regarding Protected Health Information shall remain in effect for the entire length of the underlying business relationship described in Section 2 above and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or received by Business Associate on behalf of Covered Entity, is destroyed. If it is infeasible to destroy Protected Health Information, protections of this contract are extended to such information, in accordance with the termination provisions of this Section.

b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation. If Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

2. Immediately terminate this Agreement, if Business Associate has breached a material term of this Agreement and cure is not possible; or

3. If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary of the Department of Health and Human Services.

c. Effect of Termination.

1. Except as provided in paragraph b of this section, upon termination of this Agreement, for any reason, Business Associate shall destroy all Protected Health Information received from Covered Entity, or received by Business Associate on behalf of Covered Entity, in accordance with its record retention policy. This provision shall apply to Protected Health Information that is in the possession of

subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information beyond its normal retention period as required for its compliance with applicable professional standards.

2. In the event that Business Associate determines that destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon any notice that destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

6. Change of Law; Applicable Law. If any state or federal laws or regulations, now existing or enacted or promulgated after the effective date of this Agreement, are interpreted by judicial decision, a regulatory agency, or legal counsel to a party to indicate that any provision of this Agreement may be in violation of such laws or regulations, the parties may amend this Agreement as necessary. The parties will act in good faith in attempting to preserve the underlying rights, duties and obligations established in this Agreement. This Agreement and its validity, construction, and performance shall be governed in all respects by the laws of the State of (State) and by the HIPAA Privacy Standards.

7. General Provisions.

a. Notices. Any notices or other communications required or permitted by this Agreement shall be in writing and shall be considered delivered when given in the following manner to the following addresses or telefax numbers:

(1) If to Covered Entity:

(Street Address)
(City, State, Zip)
Attn: (Name of Responsible Party)
(Title of Responsible Party)
Fax: (Fax Number)

(2) If to Business Associate:

(Firm)
(Street Address)
(City, State, Zip)
Attn: (Name of Appropriate Official)
(Title of Appropriate Official)
Fax: (Fax Number)

Notice may be given on behalf of a party by its counsel. Such communications shall be deemed to have been given (a) three days after mailing, when mailed by registered or certified postage-paid mail, (b) on the next business day, when delivered by a same-day or overnight national courier service or the U.S. Post Office Express Mail, or (c) upon the date of receipt by the addressees when delivered personally or by telecopier. Any notice of change of address shall be effective only upon receipt of such notice.

b. Entire Agreement; Amendment. This writing constitutes the entire and only agreement of the parties with respect to the HIPAA Privacy Standards and supersedes and cancels any and all prior negotiations, understandings, and agreements concerning such HIPAA Privacy Standards. This Agreement may be amended, modified, superseded, canceled, renewed, or extended only by a written document signed by the parties.

c. Waiver. If any party fails to require performance or compliance of the duties and obligations of this Agreement, this failure shall not affect the party's right to require such performance or compliance at any time in the future. The waiver by any party of a breach of any provision of this Agreement is not a waiver of any earlier or future breach of such provision or as a waiver of the provision itself. No waiver of any kind shall be effective or binding unless it is in writing and is signed by the party against which such waiver will be enforced.

d. Binding Nature; Assignment. This Agreement shall be binding upon and inure to the benefit of each party, its successors, and permitted assigns. Neither party may assign or otherwise transfer its rights or obligations under this Agreement, by operation of law or otherwise, without the prior written consent of the other party to this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the day and year first above written.

(FIRM)

By:_____
(Name of Appropriate Official)
(Title of Appropriate Official)

(CLIENT)

By:_____
(Name of Responsible Party)
(Title of Responsible Party)

Tool 7-C:
Engagement Letter—Comprehensive Review

"Date"

"Name"
"Address"

This letter is to confirm the services outlined in our proposal of "date" for a systems review of "Name." This review will complement the financial audit in that its scope will include a comprehensive review of operational procedures.

Procedure and Services

1. We will review the report issued by "Name," "Date" in light of recommendations and current operations.

2. We will provide a complete review of office procedures, specifically but not exclusively, as they relate to the function of patient billing, patient charge capture, third-party reimbursement, and collection procedures.

3. We will review procedures for internal control to ensure that records are maintained properly.

4. We will review the duties and job descriptions of the office staff and make appropriate recommendations designed to improve efficiency and maximum utilization of staff.

5. We will assist your accounting staff in the design of management reports which will provide you with the data needed to make informed decisions about your practice. Consideration will be given to the development of departmentalized financial reporting so that the efficiency of each operational area can be assessed.

6. We will review your procedures regarding the management of accounts receivables. We will perform tests to ascertain the adequacy of controls and will perform random confirmations of current balances (with physician approval) to establish a basis for accuracy of account balances. A review of adjustments and the control procedures for adjusting accounts will be performed. We will analyze the errors and corrections summary and accounts that do not balance. Procedures for processing patient refunds will also be reviewed.

7. We will review your system for accounts payable as it relates to control and proper utilization of cash. We will conduct a general review of overhead to provide recommendations in areas where cost containment should be considered.

8. We will review your contractual agreements with third-party payers to ascertain that proper procedures are followed and reimbursement is maximized.

9. We will assist in the completion of your procedure and policy manuals to facilitate the implementation of recommendations.

10. We will review your cash flow matrix for the stockholders' death and disability fringe benefits for accuracy. We will also review the matrix for agreement with corporate documents, such as insurance policies, pension plans, and ownership buy-sell agreements.

Expected Benefits

A project of this type can be expected to yield the following:

Recommendations for improvements

1. Modify the existing procedures to improve patient accounting and response. For the short term, we would expect to close major communication gaps and eliminate major redundancies.

2. Reduce paperwork volume through consolidation of forms, minor form modifications, and elimination of unnecessary paperwork.

3. Improve operation efficiency through limited adjustments of work loads and work assignments.

Implementation Projects

Until the detailed review is complete, we are not prepared to identify the prospective benefits of major recommendations, although our experience is that substantial additional improvement will result.

In presenting each major recommendation, we will clearly identify the specific benefits, the expected cost to implement, and the proposed plan. Thus, "Name" will be able to judge the value and priority of each project before proceeding with it.

Project Organization

The project will be under the overall supervision of myself, working closely with "Name." The staff will consist of "Name," "Name," and "Name."

We also ask that the clinic assign part-time liaison representatives from the clinical and business office staffs to provide technical support in those areas.

Fee Estimate and Timetable

We estimate our fee for this project will be "$." We will bill you for the entire amount when you receive our report.

We will keep you informed of our progress during the engagement. If we encounter extraordinary problems that could increase the quoted fee, we will inform you immediately.

We are pleased to have you as a client and hope this will begin a long and pleasant association.

If the above agrees with your understanding of the terms of our engagement, please sign the copy of this letter in the space provided and return it to us. .

Sincerely,

"Signed" Response: This letter correctly sets forth the understanding of "Name."

Signature

Secretary

Tool 7-D: Engagement Letter—Limited Review

<date>

<Name>
<Business Name>
<Address>

Re: Operational Assessment, Baseline Audit

Dear <Name>:

Thank you for considering <Group>, a division of <Group>, as a compliance and efficiency partner with <client>. We appreciate the opportunity to provide you with information regarding the services we can offer to <client>. As we understand the situation, <client> is interested in an assessment of its business office operations as well as billing and medical record compliance (baseline audit).

<Group>, established in 19XX, is the sixth largest CPA firm in the Southeast and among the top 100 in the nation. A growth-oriented firm, <Group> has over 250 professionals to provide the highest quality services to our clients in this changing environment of healthcare and finance.

<Group> consists of 50 professionals who have developed a systematic program from design to implementation that will exceed federal regulatory requirements and foster a culture of compliance within your organization. The <office> of <Group> will provide all staffing needs for this engagement. This team consists of consultants with 25 years experience in providing services to physician organizations. Included on the team are CPA consultants as well as CPCs (Certified Procedural Coders). Information on each team member is included with this proposal. Also included are several articles written by our professionals that pertain to the services you are requesting.

Heading up the team will be <project leaders and titles>. Other team members will be <team members and titles>. Experience of this group includes providing operational assessments, compliance audits, and plan implementation as well as representation in Medicare audits to the <specialty> practices with both hospital and private office practices.

Operational Assessment

<Group> proposes to provide an Operational Assessment, which will address the following operational procedures:

Provide a review of practice policies and procedures as they relate to the following billing and collections functions:

- Patient charge capture
- Timeliness of claims filing
- Accuracy of claims filing
- Assessment of denials
- Claims follow-up
- Payer contract maintenance
- Patient billing
- Collections and write off processes
- Practice benchmarks
- Refunds
- Effectiveness of procedures

This assessment will include interviews with personnel (to be identified prior to the site visit), and review and testing of documentation utilized in the billing processes. Based on your phone conversation, we will perform tests specific to the charge capture of services performed. These procedures would include interviews with the Department Manager at each facility. We would also propose to test a sample of services by tracing the hospital logs to charges captured.

Other areas to be reviewed include:

- Staffing levels,
- Job descriptions,
- Organizational structure,
- Procedures for internal controls to ensure records are maintained properly, and
- Accounting records.

The results of this assessment will be presented in a written report which will include recommendations aimed at resolving any weaknesses discovered in the operational processes of <client>.

Baseline Audit

The baseline audit will include two components:

(1) Chart audit, and
(2) Compliance assessment.

Chart Audit:

We will review a sample of 10 medical records per physician to determine the accuracy of CPT and ICD 9 coding. Our review will include verifying that the services billed are appropriately coded according to the medical record. Experienced Certified Procedural Coders will perform this review on-site. Our advice and recommendations are based solely on the "Guidelines" established by the American Medical Association (AMA) and the 200X CPT, Local Medical Review Policies (LMRP), and other published regulatory guidance available at the time of review.

While we may assist the practice in areas such as coding and complying with the myriad of government rules and regulations, the ultimate responsibility for compliance lies with the practice. Our engagement cannot be relied upon to detect and disclose errors, irregularities, or illegal acts, including but not limited to fraud, embezzlement, or defalcations. Therefore, we cannot be held liable for any direct, indirect, or consequential damages, losses, or penalties arising from the discovery or lack of discovery of any errors, irregularities, or illegal acts.

A written report will be prepared to summarize each provider's chart documentation and the practice.

Compliance Assessment:

We will review the current plan and determine the level of understanding of staff of the plan. Testing will be conducted to determine compliance with the plan. Our review of charts and interviews will provide the basis for this assessment. Our assessment will address compliance in the areas of coding, billing, and claims processing. State law requirements for patient care and privacy standards, Federal anti-trust laws applicable to physician organizations, OSHA standards, Department of Labor standards, tax compliance relating to qualified retirement plans and COBRA, etc. would not be addressed.

The objectives of the baseline audit are to determine that the practice submits claims only for those services provided that are documented in the medical record, that the billings are appropriately coded, and that the practice complies with all published regulations regarding billing for Radiology services.

A written report documenting our observations and recommendations will be prepared. The results of the audit should be used to correct any existing problems and design the ongoing monitoring/auditing system to detect and correct future problem areas.

Timing and Fees

Our fee for the services described above will be based on our standard hourly rates for the time required. Fees for this engagement are estimated as follows:

Operational Assessment	$
Baseline Audit	$

On-site field work for the operational assessment will take ____ business days for ____ staff and report writing and one presentation meeting an additional _____ business days. Baseline audit of 10 charts for __ providers (____ medical records) will require approximately ___ total hours or approximately __ weeks. Amount of on-site time to be determined.

If for some reason we are unable to complete our services in the estimated time frame stated above, we will inform you as soon as we become aware of the issues that affect our ability to perform this engagement as stated.

We propose to begin the assessment the week of <date> with reports issued by <date>.

Our invoices will be submitted semi-monthly as our work progresses and are payable upon presentation.

Summary

<Group> appreciates the opportunity to present this important proposal to <client>. This letter constitutes our understanding of the scope and estimated cost of this engagement. If you agree with these terms, please sign the enclosed copy of this letter, indicate the services requested and return it to us with your agreement. If you have any questions or need additional information, please do not hesitate to contact us.

Sincerely,

<signing shareholder>

Accepted as indicated:

_____
Confirmed by

_____
Date

Tool 9-A: Service Date to Date of Posting Form

Instructions For This Tool: Replace this sample with your own information and dates, and the formula will give you the "Days Lag"

XYZ Practice
Service Date to Date of Posting

Physician	#	Site	Patient Name	Date of Service	Date of Posting	Batch #	Type of Service	Days Lag
Physician 1	111	1	Patient 1	06/25/03	06/30/03	25	L-spine	5
		1	Patient 2	06/25/03	06/30/03	25	CXR	5
		1	Patient 3	06/25/03	06/30/03	9	CXR	5
		1	Patient 4	06/25/03	06/30/03	9	Xray	5
		1	Patient 5	06/25/03	06/30/03	9	CXR	5
Physician 2	112	2	Patient 1	06/27/03	07/03/03	29	Ultra	6
		2	Patient 2	06/27/03	07/03/03	29	Mammo	6
		2	Patient 3	06/27/03	07/03/03	29	Ultra	6
		2	Patient 4	06/27/03	07/03/03	29	Xray	6
		2	Patient 5	06/25/03	06/30/03	9	Mammo	5
Physician 3	113	3	Patient 1	06/11/03	06/25/03	5	T-spine	14
		3	Patient 2	06/11/03	06/25/03	5	CXR	14
		3	Patient 3	06/26/03	06/30/03	34	CXR	4
		3	Patient 4	06/14/03	07/02/03	37	CT	18
		3	Patient 5	06/15/03	06/28/03	2	US	13
Physician 4	114	4	Patient 1	06/27/03	07/03/03	30	Mammo	6
		4	Patient 2	06/25/03	06/30/03	25	MRI	5
		4	Patient 3	06/25/03	06/30/03	25	Xray	5
		4	Patient 4	06/25/03	06/30/03	25	CXR	5
		4	Patient 5	06/20/03	06/29/03	5	Myelogram	9
Physician 5	115	5	Patient 1	06/11/03	06/25/03	5	Mammo	14
		5	Patient 2	06/25/03	06/30/03	9	Mammo	5
		5	Patient 3	06/25/03	06/30/03	9	Mammo	5
		5	Patient 4	06/26/03	06/30/03	63	Ultra	4
		5	Patient 5	06/26/03	06/30/03	63	Pyelo	4

Tool 9-B: Sample Chart Audit Worksheet

XYZ Practice
Chart Audit
July, 2003

	Per Charge Ticket	Per Medical Record	Per HCFA 1500	Per Auditor	Error Code
Patient Name	Patient 1	Patient 1	Patient 1	Patient 1	
Date Of Service	4/12/2003	4/15/2003	4/12/2003	4/12/2003	2
Place Of Service	Clinic	Clinic	Clinic	Clinic	
Referring Physician					
Performing Physician	Dr. Physician	Dr. Physician	Dr. Physician	Dr. Physician	
CPT Codes					
1	99214	99214	99214	99214	
2					
3					
4					
Diagnosis Codes					
1	185	185	185	185	
2	782.3	782.3	782.3	782.3	
3	401.1	401.1	401.1	401.1	
4	715.90		715.90		

Comments

The date of service on the medical record was not consistent with other supporting documents.	The fifth dx was for impotence 607.84

	Error Codes	
1	Not audited because of legibility	0
2	DOS, POS, or provider do not agree	1
3	History does not support E/M	0
4	PE does not support E/M	0
5	MDM does not support E/M	0
6	Documentation supports higher level	0
7	No code listed for this service	0
8	Consultation/coding guidelines not met	0
9	CPT codes unbundled	0
10	No separate documentation of procedure found	0
11	ICD-9 CM for lab not supported in MR	0
12	ICD-9 codes not consistent	0
13	Additional diagnoses codes needed	0
14	No Signature or initial found	0
	Total:	1

Tool 9-C: Sample Insurance Claims Filing Analysis Worksheet

XYZ Practice
Schedule I
Medicare EOB sample
June 2003

Patient	Provider #	Provider Name	Date of Service	CPT	Charged	Fee Schedule	Difference of Charged to Fee Schedule	Allowed	Paid	Date Paid	Batch Date	Date Posted	Denial Code	DOS to DOP	Date Paid to Batch Date	Batch Date to Date Posted	Collection % Allowed to Charged	Collection % Paid to Charged
Patient 1	1234561	Provider1	03/26/03	35475	1,350.00	1,427.00	(77.00)	-	-	05/30/02	06/03/02	06/11/02	CO-17	(296)	3	8		
	1234561	Provider1	03/26/03	75898	225.00	256.00	(31.00)	79.28	63.42	05/30/02	06/03/02	06/11/02	CO-42	(296)	3	8	35.2%	28.2%
	1234561	Provider1	03/26/03	75962	80.00	86.00	(6.00)	26.22	20.98	05/30/02	06/03/02	06/11/02	CO-42	(296)	3	8	32.8%	26.2%
Patient 2	1234561	Provider1	04/22/03	74160	180.00	197.00	(17.00)	60.44	48.35	06/05/02	06/11/02	06/12/02	CO-42	(317)	6	1	33.6%	26.9%
	1234561	Provider1	04/22/03	71260	190.00	196.00	(6.00)	58.85	47.08	06/05/02	06/11/02	06/12/02	CO-42	(317)	6	1	31.0%	24.8%
	1234561	Provider1	04/22/03	72193	150.00	169.00	(19.00)	55.37	44.30	06/05/02	06/11/02	06/12/02	CO-42	(317)	6	1	36.9%	29.5%
Patient 3	1234561	Provider1	04/27/03	71020	30.00	35.00	(5.00)	-	-	05/31/02	06/05/02	06/11/02	CO-18	(326)	5	6		
	1234561	Provider1	04/27/03	70210	25.00	29.00	(4.00)	-	-	05/31/02	06/05/02	06/11/02	CO-50	(326)	5	6		
	1234561	Provider1	04/27/03	70450	140.00	149.00	(9.00)	-	-	05/31/02	06/05/02	06/11/02	CO-18	(326)	5	6		
Patient 4	1234561	Provider1	05/20/03	78465	180.00	191.00	(11.00)	-	-	05/31/02	06/05/02	06/11/02	PR-28	(349)	5	6		
	1234561	Provider1	05/20/03	78478	70.00	81.00	(11.00)	-	-	05/31/02	06/05/02	06/11/02	PR-28	(349)	5	6		
	1234561	Provider1	05/20/03	78480	70.00	81.00	(11.00)	-	-	05/31/02	06/05/02	06/11/02	PR-28	(349)	5	6		
Patient 5	1234562	Provider2	03/21/03	70450	140.00	149.00	(9.00)	40.63	32.50	06/05/02	06/11/02	06/12/02	CO-42	(286)	6	1	29.0%	23.2%
	1234562	Provider2	03/21/03	71020	30.00	35.00	(5.00)	-	-	06/05/02	06/11/02	06/12/02	CO-50	(286)	6	1		
	1234562	Provider2	03/21/03	72050	50.00	49.00	1.00	14.95	11.96	06/05/02	06/11/02	06/12/02	CO-42	(286)	6	1	29.9%	23.9%
Patient 6	1234562	Provider2	03/27/03	76091	80.00	87.00	(7.00)	41.12	32.90	06/07/02	06/13/02	06/14/02	CO-42	(290)	6	1	51.4%	41.1%
	1234562	Provider2	03/27/03	76645	80.00	84.00	(4.00)	25.89	20.71	06/07/02	06/13/02	06/14/02	CO-42	(290)	6	1	32.4%	25.9%
Patient 7	1234562	Provider2	04/07/03	73060	25.00	27.00	(2.00)	-	-	06/07/02	06/13/02	06/14/02	CO-18	(300)	6	1		
	1234562	Provider2	04/07/03	73070	22.00	24.00	(2.00)	-	-	06/07/02	06/13/02	06/14/02	CO-18	(300)	6	1		
	1234562	Provider2	04/07/03	73070	22.00	24.00	(2.00)	-	-	06/07/02	06/13/02	06/14/02	CO-18	(300)	6	1		
Patient 8	1234562	Provider2	04/28/03	71020	30.00	35.00	(5.00)	-	-	05/31/02	06/05/02	06/11/02	CO-18	(327)	5	6		
	1234562	Provider2	04/29/03	32000	190.00	208.00	(18.00)	-	-	05/31/02	06/05/02	06/11/02	CO-18	(328)	5	6		
	1234562	Provider2	04/29/03	71010	20.00	28.00	(8.00)	-	-	05/31/02	06/05/02	06/11/02	CO-18	(328)	5	6		
	1234562	Provider2	04/29/03	76942	95.00	106.00	(11.00)	-	-	05/31/02	06/05/02	06/11/02	CO-18	(328)	5	6		
Patient 9	1234562	Provider2	05/04/03	74000	25.00	29.00	(4.00)	8.52	6.82	05/30/02	06/03/02	06/11/02	CO-42	(334)	3	8	34.1%	27.3%
	1234562	Provider2	05/04/03	70450	140.00	149.00	(9.00)	40.63	32.50	05/30/02	06/03/02	06/11/02	CO-42	(334)	3	8	29.0%	23.2%
	1234562	Provider2	05/04/03	71010	20.00	28.00	(8.00)	8.52	6.82	05/30/02	06/03/02	06/11/02	CO-42	(334)	3	8	42.6%	34.1%
Patient 10	1234563	Provider3	04/10/03	72125	170.00	179.00	(9.00)	55.37	44.30	05/30/02	06/03/02	06/11/02	CO-42	(310)	3	8	32.6%	26.1%
	1234563	Provider3	04/10/03	76375	20.00	22.00	(2.00)	7.82	6.25	05/30/02	06/03/02	06/11/02	CO-42	(310)	3	8	39.1%	31.3%
Patient 11	1234563	Provider3	05/05/03	70450	140.00	149.00	(9.00)	40.63	32.50	06/06/02	06/13/02	06/14/02	CO-42	(329)	7	1	29.0%	23.2%
	1234563	Provider3	05/05/03	62270	171.00	171.00	-	56.81	45.45	06/06/02	06/13/02	06/14/02	CO-B6	(329)	7	1	33.2%	26.6%
Patient 12	1234563	Provider3	05/05/03	70450	140.00	149.00	(9.00)	40.63	32.50	06/06/02	06/13/02	06/14/02	CO-42	(329)	7	1	29.0%	23.2%
	1234563	Provider3	05/05/03	72050	50.00	49.00	1.00	14.95	11.96	06/06/02	06/13/02	06/14/02	CO-42	(329)	7	1	29.9%	23.9%
	1234563	Provider3	05/05/03	72170	25.00	27.00	(2.00)	8.17	6.54	06/06/02	06/13/02	06/14/02	CO-42	(329)	7	1	32.7%	26.2%
	1234563	Provider3	05/05/03	76005	74.00	74.00	-	27.36	21.89	06/06/02	06/13/02	06/14/02	CO-42	(329)	7	1	37.0%	29.6%
Patient 13	1234563	Provider3	05/09/03	76091	80.00	87.00	(7.00)	41.12	32.90	06/05/02	06/11/02	06/12/02	CO-42	(334)	6	1	51.4%	41.1%
Patient 14	1234563	Provider3	05/28/03	93970	110.00	112.00	(2.00)	32.89	-	06/07/02	06/13/02	06/14/02	CO-42	(351)	6	1	29.9%	
													Averages:	(319)	5	4	31.9%	25.6%

XYZ Practice
Schedule I
Medicare EOB sample
June 2003

Legend

Denial Code	*Count*	*Percentage*	*Description*
CO-17	1	2.70%	Contractual obligation - Requested information was not provided or was incomplete
CO-18	9	24.32%	Contractual obligation - Duplicate claim/service
CO-42	21	56.76%	Contractual obligation - Charges exceed our fee schedule or maximum allowable amount
CO-50	2	5.41%	Contractual obligation - Not deemed "medical necesity"
CO-57	0	0.00%	Contractual obligation - Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or dosage
CO-59	0	0.00%	Contractual obligation - Charges are reduced based on multiple surgery rules or concurrent anesthesia rules
CO-B6	1	2.70%	Contractual obligation - This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty
PR-28	3	8.11%	Patient Responsibility - Coverage not in effect at the time service was provided
PR-31	0	0.00%	Patient Responsibility - Claim denied as patient cannot be identified as our insured
	37	100.00%	

Tool 9-D: Sample Practice Overhead Analysis

XYZ Practice
Operating Indicators Report
For the Twelve Months Ended December 31, 2003

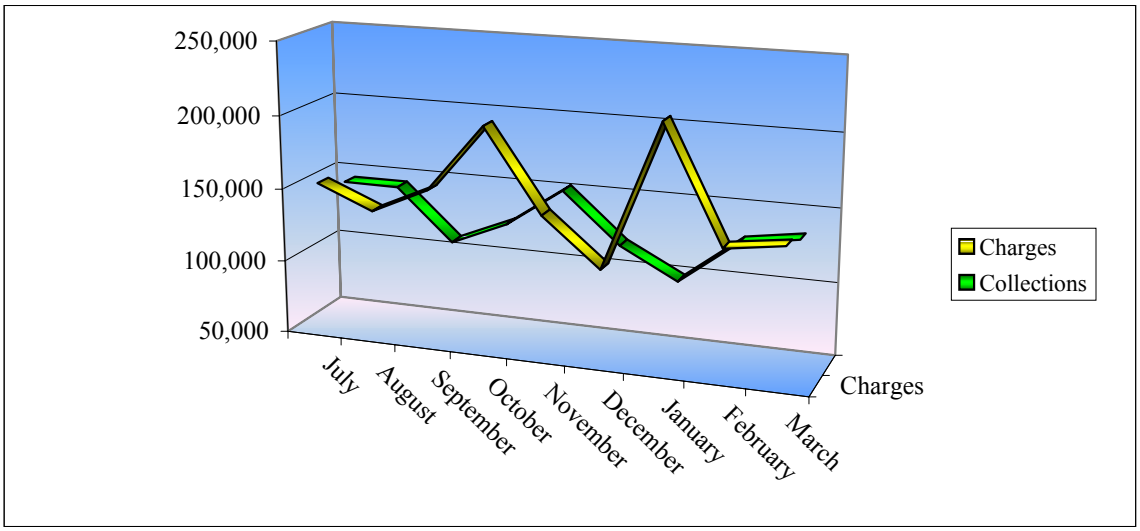
Current Month				Year to Date		
2003	MGMA*	2002		2003	MGMA*	2002
			Financial:			
141,439.56		163,653.06	Billed Charges	1,396,746.43		1,374,622.74
51,462.84		25,418.64	Adjustments	250,290.60		231,944.01
134,481.71		149,245.58	Cash Receipts	1,158,029.04		1,163,136.58
217.17		(1,538.00)	Untitled Income & Refunds	(265.57)		383.39
75,775.21		57,683.50	Operating Expenses	551,044.54		552,404.81
58,923.67		90,024.08	Operating Income (Loss)	606,984.50		611,115.16
43.74%	52.15%	60.95%	Operating Margin	52.43%	52.15%	52.52%
2003	MGMA*	2002		2003	MGMA*	2002
			Payor Mix:			
49.00%	56.02%	56.48%	Medicare	53.80%	56.02%	53.42%
5.30%	2.00%	3.63%	Medicaid/TennCare	3.90%	2.00%	4.28%
41.10%	31.60%	36.74%	Commercial	37.50%	31.60%	35.87%
4.70%	1.34%	3.15%	Self-Pay	4.80%	1.34%	6.43%
			Other Indicators:			
95.08%	57.42%	91.75%	Gross Collection Percentage	82.60%	57.42%	84.99%
149.46%	98.00%	108.62%	Adjusted Collection Percentage	100.64%	98.00%	102.24%
56.35%	55.37%	38.65%	Operating overhead	47.58%	55.37%	47.49%
21.10%	28.04%	17.10%	Total support staff salaries	21.20%	28.04%	22.43%
0.00%	1.37%	0.00%	Insurance - professional liability	3.60%	1.37%	2.79%
11.70%	6.30%	5.29%	Bldg. & occupancy	6.10%	6.30%	6.07%

* Based on 2002 MGMA Cost Survey Report Based on 2001 Data; Internal Medicine

Tool 10-A: Sample Graph for Presentation

Purpose of this Tool:

To demonstrate the gap between Charges and Collections that produces the gross collection percentage



Tool 14-A: Practice Valuation Questionnaire and Document Request List

1.) Legal name of practice _____

2.) Specialty: _____

3.) Type of entity: ____ Corporation ____ Partnership ____ Proprietorship ____ LLC
____ S Corporation ____ Non-profit Org. ____ Other _____

4.) List owners/stockholders/partners:

1 _____ 3 _____

2 _____ 4 _____

5.) List other physicians or providers (nurse practitioners, physicians' assistants, etc.):

1 _____ 2 _____

6.) Date practice began: _____

7.) Is/Are physician(s) board certified? ____ Yes ____ No

8.) Office hours: _____

9.) Charges and payments for the last five years (including current year):

	Charges	Payments	Adjustments
Current year from _____ to _____			
Year ending _____			
Year ending _____			
Year ending _____			
Year ending _____			

NOTE: Please provide this information per provider if available.

10.) Current payer mix (preferably based on gross charges):

Medicare	____ %
Medicaid (or similar state plan)	____ %
Medicaid - Capitation	____ %
Capitation (Non-Medicaid)	____ %
Commercial, private pay, etc.	____ %

12.) Average number of new patients per month _____

13.) Average hospital census _____

14.) Number of active patients _____

15.) List all fixed fee arrangements (i.e. Med. Directorships) or contractual relationships (Industry)

_____ _____

_____ _____

Billing System:

16.) What type of billing system is used by the practice? _____

17.) How often are charges posted and claims filed? _____

18.) Are claims filed electronically? _____

19.) How often do you send patient statements? _____

20.) How often do you increase fees? Date of last increase. _____

Medical Office Facilities:

21.) How long in present location? _____

22.) Square footage of medical office facilities _____

23.) Do you or another entity in which you're involved own the building? _____

24.) If so: What is your mortgage balance? _____
What are your monthly note or lease payments? _____

IMPORTANT:

25.) Do you have any pending or potential claims or litigation professionally either currently or in the last three years? If so, please attach a statement as to the outcome or status of the claim. Please also include whether you have been audited or have been notified that you will be audited by Medicare or any other regulatory authorities.

The following is a list of items needed at the time of your site visit. If you have any questions about what any of the items are, please let us know.

- Financial statements for the current period and prior four years.
- Depreciation schedule.
- Practice tax returns (corporate, partnership, or individual Schedule C) for the prior four years.
- Gross charge volume by charge code (CPT code) for current period and prior four years.
- Aged accounts receivable.
- Copy of bank notes payable and amount of accrued pension expense (if any).
- Current fee schedule.
- Inventory of furniture and equipment (if you do not have one, we will perform a physical inventory of equipment and furniture at the time of your site visit).
- Listing of employees, date of hire, current salary, job description (see attached form).
- Copies of all leases (building and equipment).
- Listing of all participation agreements (i.e. PPO's, Medicare, etc.). For capitated agreements, please include number of lives covered and pm/pm amount.
- If available, please provide a copy of all physician/owner CV's (curriculum vitae).
- A copy of the DEA certificate(s).
- A copy of each physician's current state license.
- A copy of the practice's current malpractice certificate of insurance.

NOTE: If possible, please also obtain some demographic data regarding your area. The best source for this may be from your local chamber of commerce. Most chamber offices will have a packet or brochure that gives information on population, industry, cost of living, etc.

If you have any questions about any of the items requested on this schedule, please do not hesitate to give us a call at (123) 456-7890. We will be happy to explain what type of information we are requesting.

Representation of Accuracy of Information:

All practice personnel providing information should sign the following representation.

The information provided by me on this questionnaire and the additional information (such as, but not limited to, the information listed on this page) supplied to representatives of [CPA firm] is true and correct to the best of my knowledge. In addition, I have not withheld any information that I believe would be relevant to the valuation of this medical practice.

Signature	Date	Signature	Date

Employee Name	Title	Date of Hire	Salary or Hourly Rate	Vacation Accrued	Eligible Benefits Code

Benefits Code:

1.) Pension and Profit Sharing
2.) Health Insurance
3.) Other _____
4.) Other _____
5.) Other _____
6.) Other _____

Tool 15-A: Sample Valuation Engagement Letter

Note to user: Explanatory endnotes follow this sample letter.

January 28, 20X0

Mr. Ray Cansela
Physician Acquisitions, Inc.
101 Main Street
Healthytown, TN 37200

Dear Ray:

This letter outlines our understanding of the terms and objectives of the valuation engagement.

We will perform a valuation of the assets of Internal Medicine Associates, P.C. as of December 31, 20X9.[1][2][3] We plan to start the engagement on or about February 15, 20X0, assuming receipt of the items listed in our questionnaire and document request form by that time and be completed by April 1, 20X0.

The objective of our valuation will be to estimate the fair market value of the assets of Internal Medicine Associates, P.C. to be used as the basis for an offering price by Physician Acquisitions, Inc. The term "fair market value" is defined as follows:[4]

> The price at which the property would change hands between a willing buyer and a willing seller, neither being under a compulsion to buy or sell and both having reasonable knowledge of relevant facts.

Although our valuation is intended to estimate fair market value, we assume no responsibility for the inability to transact an acquisition at that price.

In performing our valuation, we will be relying on the accuracy and reliability of your historical financial statements, forecasts of future operations, or other financial data of the subject company. We will not audit, review, or compile the financial statements, forecasts, or other data, and we will not express an opinion or any form of assurance on them. At the conclusion of the engagement, we may ask you to sign a representation letter on the accuracy and reliability of the financial information used in the engagement. Our engagement cannot be relied on to disclose errors, fraud, or other illegal acts that may exist.

Our valuation will be subject to the following assumptions and limiting conditions, which will be included as an appendix to our valuation report.[5]

1.) Information, estimates, and opinions contained in this report are obtained from sources considered reliable; however, no liability for such sources is assumed by the appraiser.

2.) Internal Medicine Associates, P.C. and its representatives warranted to us that the information supplied to us was complete and accurate to the best of their knowledge. Information supplied by management has been accepted without further verification as correctly reflecting the company's past results and current condition in accordance with generally accepted accounting principles.

3.) Possession of this report, or a copy thereof, does not carry with it the right of publication of all or part of it, nor may it be used for any purpose by anyone but Physician Acquisitions, Inc. without the previous written consent of Smith, Jones & Johnson, P.C. or Physician Acquisitions, Inc. and, in any event, only with proper attribution. Authorized copies of this report will be signed in ink by representatives of Smith, Jones & Johnson, P.C. Unsigned copies should be considered to be incomplete.

4.) None of the appraisers employed by Smith, Jones & Johnson, P.C. is required to give testimony in court, or be in attendance during any hearings or depositions, with reference to the practice being appraised, unless previous arrangements have been made.

5.) The various estimates of value presented in this report apply to this appraisal only and may not be used out of the context presented herein. This appraisal is valid only for the appraisal date or dates specified herein and only for the appraisal purpose or purposes specified herein.

6.) The appraised estimate of the fair market value reached in this report is necessarily based on the definition of fair market value as stated in the transmittal letter at the beginning of this report. An actual transaction for the assets of Internal Medicine Associates, P.C. may be concluded at a higher value or lower value, depending in the circumstances surrounding the practice and/or the motivations and knowledge of both the buyers and sellers at that time. Smith, Jones & Johnson, P.C. makes no guarantees as to what value individual buyers and sellers may reach in an actual transaction.

7.) Smith, Jones & Johnson, P.C. has not been engaged to apply and therefore has not applied, procedures prescribed by the American Institute of Certified Public Accountants or the Auditing Standards Board, to any historical or forecasted financial statement included or incorporated in this report. Accordingly, we are not assuming the role of reporting Certified Public Accountants and are not separately reporting on the financial statements or forecasts by virtue of their incorporation into the valuation of the practice.

At our discretion, we may include additional assumptions and limiting conditions in our report as a result of performing the valuation.

We will document the results of the engagement in a formal report.[6] We understand that our conclusion will be used as the basis for an offering price for the assets of Internal Medicine Associates, P.C.,[7] and that the distribution of the report is restricted to the internal use of the management of Physician Acquisitions, Inc., and accordingly, will not be distributed to outside parties to obtain credit or for any other purposes. If for any reason we are unable to complete the valuation engagement, we will not issue a report as a result of the engagement.

We have no responsibility to update our valuation report for events and circumstances that occur after the date of its issuance.

We estimate that our fees for this service will be _____. If we encounter unusual circumstances that would require us to perform additional work, we will discuss them with you before incurring any additional time. We will require a retainer of _____, at the execution of this agreement. The remainder of our fees will be billed to you on the 15th and the last day of each month and are payable within 10 days. Balances which remain unpaid 30 days from dates of invoices will incur a finance charge of 1.5% per month (18% annual percentage rate). Our valuation report will state that our fee is not contingent on the value determined by this engagement.[8]

The fee estimate is for the valuation only and does not include any services that may be required defending the report in litigation, including conferences, depositions, court appearances, and testimony. Fees for such services, if required, will be billed at our standard hourly rates. [9]

We appreciate the opportunity to assist you. If you agree with the foregoing terms, please sign the copy of this letter in the space provided and return it to us.

Sincerely,

Smith, Jones & Johnson, P.C.
Robert A. Johnson, CPA/ABV
Vice President

RESPONSE:

This letter correctly sets forth the understanding of Physician Acquisitions, Inc.

Signature _____

Title _____

Date _____

Endnotes: Items to Include in the Engagement Letter

1. **Identification of the property to be valued.** Will intangible assets be included? Is the subject of the appraisal the practice assets or the corporation's stock? Is real estate owned by the practice or the physicians to be included in the engagement?
2. **Effective valuation date.** Depending on the reason for the engagement, it is usually best to let the client's legal counsel determine the date of the valuation.
3. **Relevant ownership characteristics.** This section can "dovetail" with the section on the identification of the subject property.
4. **Definition (standard) of value.** Is the standard of value "fair market value" or some other standard? In many instances, the client requesting the valuation will not know what standard of value they want. It is important to listen and clearly understand the objectives of the appraisal to adequately assist the client with determining the proper standard of value to use. This will be an opportunity to educate the client on the outcome of the engagement.
5. **Access to information sources and any known limiting conditions.** Defines the information necessary to perform a complete valuation of the practice. If access to certain documents is limited during the engagement, this can become an important section of the letter.
6. **Scope of written and/or oral report.** This part of the letter is merely to define the expected outcome (not in terms of final value) of the report and to assist the appraiser in adequately meeting the expectations of the client.
7. **Intended use or uses of the appraisal.** As the appraiser, knowing the intended use of the appraisal is crucial to meeting the client's expectations. Additionally, you will

want to limit the use of the report to the intentions stated to you by the client so that you do not unknowingly accept additional liability. For example, if you are requested to perform a valuation for acquisition purposes that never come to fruition, you don't want the client also using the report for obtaining credit without your knowledge or approval.

8. **Contractual relationship with the client.** How much will the engagement cost? If this is a new client, how much of a retainer will be required before undertaking the engagement? (Retainers are standard operating procedure for most professional appraisers. Don't be afraid to ask for it.) When are payments expected?
9. **Insert ny special instructions from the client or attorney.** Section for standard language deemed necessary by the firm or other areas deemed necessary by any of the parties involved in the engagement (appraiser, client, or attorney).

Tool 15-B: Sample Valuation Report

Date

Mr. Jeff Bones
Music City Memorial Hospital
9999 Old Hickory Blvd.
Suite 30000
Nashville, TN 99999

Dear Mr. Bones:

In accordance with your request, I have made an estimation of the fair market value of the assets of the internal medicine practice of **Eddie Titan, M.D., P.C.** as of July 31, 1997. Assets included in the valuation of the subject company are comprised of accounts receivable, supply inventory, equipment and furnishings, intangible assets, and any debt obligations related to the previously mentioned assets. Intangible assets include, but are not limited to, items such as patient charts, assembled workforce, and goodwill.

I understand that the function of my appraisal is to assist in determining an offering price in a proposed acquisition by Music City Memorial Hospital. However, no responsibility is assumed for the inability of the buyer and seller to negotiate a purchase at that price. The purpose of my valuation has been to estimate the current fair market value of the above mentioned assets. The term "fair market value" is defined as follows:

> The price at which the property would change hands between a willing buyer and a willing seller, neither being under a compulsion to buy or sell and both having reasonable knowledge of relevant facts. (Treas. Reg. 20.2031-(b); Rev. Rul. 59-60, 1959-1 C.B. 237.)

Our valuation has considered the following factors enumerated in Revenue Ruling 59-60 for the valuation of a closely-held business interest:

- The nature of the practice and its history.
- The economic outlook in general and the condition of the practice.
- The book value of the practice and the financial condition.
- The earning capacity of the practice.
- Whether or not the practice has intangible value.
- The market price of practices in the same specialty.

The historical financial data used in our valuation engagement is taken from the compiled financial statements of Eddie Titan, M.D., P.C. for the years ended December 31, 1996, 1995, and 1994 and an interim compiled statement for the six months ended June 30,

1997. I have not audited, reviewed, or compiled the financial data and I neither express an opinion nor offer any other form of assurance regarding them.

Legislation at all levels of government has affected and may continue to affect revenue and costs of healthcare facilities. The projections in this report are based upon legislation currently in effect. If legislation related to healthcare facility operations is subsequently enacted, this legislation could have a material effect on future operations.

I have no responsibility to update this report for events and circumstances occurring after the date of this report.

Based on the facts, assumptions, and procedures described in the following report, I estimate the fair market value of the assets of the internal medicine practice of **Eddie Titan, M.D., P.C.** as of July 31, 1997, to be:

THREE HUNDRED TWENTY-SEVEN THOUSAND DOLLARS ($327,000).

I appreciate the opportunity to assist Music City Memorial Hospital in this important endeavor.

Sincerely,

DOYLE & ASSOCIATES, P.C.

Joe B. Appraiser, CPA/ABV, CBA

EDDIE TITAN, M.D., P.C.

PRACTICE VALUATION

TABLE OF CONTENTS

I. NATURE AND HISTORY OF THE PRACTICE

Background:
Eddie Titan, M.D., P.C. (the "Practice") is a professional corporation (PC) chartered under the laws of the State of Tennessee in September, 1980. The common stock of the corporation is owned 100% by Eddie Titan, M.D. The practice is located in Hendersonville, Tennessee.

Dr. Titan is board certified by the American Board of Internal Medicine and is licensed to practice in Tennessee. He has been practicing medicine in the Madison/Hendersonville area since 1979. Dr. Titan graduated from Ohio State University School of Medicine in 1975. Prior to medical school, he received his undergraduate degree from Ohio State University in 1968. He performed his internship and residency in internal medicine at Liberty Bowl Medical Center in Memphis, Tennessee. After finishing his residency, he was recruited to Nashville by Tennessee Medical Center in 1979.

Dr. Titan has attending staff privileges at Volunteer Memorial Hospital and Tennessee Medical Center. He is a member of the American Society of Internal Medicine, the Tennessee Medical Association, and the Southern Medical Association. He is also currently the Chairman of the Diet and Nutrition Committee at Nashville Volunteer Hospital.

In addition to Dr. Titan, the practice employs a nurse practitioner, Sandra M. Nightengale, RN, CS. Ms. Nightengale started employment on July 28, 1997, and will work only three days per week for the first few months. Dr. Titan believes she will become a full-time employee within several months.

Location:
The Practice's office is located at 999 Main St., Hendersonville, Tennessee, across the street from Hendersonville Hospital. The building is owned by three physicians who occupy most of the building. Dr. Titan is not a part of the building ownership. Tennessee Medical Center (TMC) leases the office space from the partnership and sublets it to Dr. Titan. The Practice leases approximately 2,680 square feet of medical office space from TMC. Dr. Titan has only been leasing the office space for six months. During that period the corporation paid $10,772 ($8.39/sq.ft.) in lease payments.

Management's Analysis:
Dr. Titan has not been accepting new patients for the last three years. He has felt that attempting to see any more patients during his normal office hours could weaken the quality of healthcare. Accordingly, he believes that by hiring Ms. Nightengale, he can accommodate the continuing demand to see new patients without incurring a proportionate amount of expenses. It is Dr. Titan's contention that although variable expenses would increase with production, fixed expenses would remain relatively stable.

Until early 1996, there had been little medical practice acquisition activity in the Hendersonville area. However, the local hospital has begun to buy local primary care

practices along with a large family practice group that was acquired in 1996 by a non-profit hospital in Nashville. Both hospitals are upgrading facilities and are searching for partners for their primary care network. Therefore, acquisition activity in the Hendersonville area is expected to continue for the next two to three years as various payers and hospitals attempt to form local alliances. The two hospitals mentioned above have both recruited new physicians to the Hendersonville area, but they have all been "specialists" such as orthopedic surgeons and cardiologists. No new primary care physicians have been recruited to the Hendersonville area.

Management's Future Expectations:
Management also believes that capitation in the Hendersonville area will remain minor. Primary care providers in Tennessee (other than pediatrics) have resisted participating with capitated payment plans. Even though Dr. Titan participates with a small amount of managed care products, including capitation products, the need for certain providers in the area to participate is strong. Thus far, Dr. Titan has been able to negotiate per member/per month (pm/pm) payments that are at favorable rates. Neither management nor the appraiser believes that capitation or managed care products will have a significant long-term impact in Tennessee. Local employers who have participated with HMOs and PPOs are heeding employees' wishes to return to traditional insurance plans.

Additional Investments in Business:
Dr. Titan believes that the only short-term additional investment needed to operate the practice has been fulfilled with the addition of the nurse practitioner. He appears to have an office that is more than adequate for providing quality services to patients. In addition, it is large enough with enough exam rooms to facilitate the addition of Ms. Nightengale to the practice. Management does not believe that any significant equipment investments will be necessary in the next several years.

II. SOURCES OF INFORMATION

On August 6, 1997, I met with Dr. Titan, Veronica Titan (his wife), and Paula Smith (billing supervisor) and toured the medical office location in Hendersonville, Tennessee. Ms. Titan and Ms. Smith provided much of the information in the following list and also provided a great deal of the Practice's history and business statistics. The sources of information used in this appraisal included the following:

- Corporate tax returns (Form 1120) for the years ended December 31, 1994-1996.
- Compiled financial statements for the years ended December 31, 1994-1996 and the six months ended June 30, 1997.
- Practice charges and collections for the years ended December 31, 1994-1996 and the seven months ended July 31, 1997.
- Aging of accounts receivable as of July 31, 1997.
- Production report of charges by physician by type of service for 1994-1997.
- Payer mix for the Practice for 1997.
- Current practice fee schedule.
- Listing of all employees.
- Listing of all participation agreements (that is, PPOs, Medicare, Medicaid, and so on).
- Curriculum Vitae for Dr. Titan.
- Copy of DEA certificate.
- Copy of physician's state license.
- Copy of the Practice's current malpractice certificate of insurance.
- Industry information from the Medical Group Management Association (MGMA) Cost Survey: 1996 Report Based on 1995 Data and the MGMA Physicians Compensation and Production Survey: 1996 Report Based on 1995 Data.
- Economic information on the U.S. economy from PPC's *Guide to Business Valuations*, the Bureau of Labor Statistics May, 1996 Report, Dun & Bradstreet's "U.S. Survey of Business Expectations," Reuters NewMedia, Health Wire, February, 1997, Year-End Summary Report 1996 from Ibbotson Associates, and *Environmental Assessment of the Health Care Industry in the United States* by Deloitte & Touche, L.L.P. and VHA, Inc.
- Information on the Hendersonville, Tennessee economy from the Hendersonville Area Chamber of Commerce.
- Information regarding intangible values from *The Goodwill Registry 1997* published by The Health Care Group, Inc.
- Information regarding equity risk premia from *Stocks, Bonds, Bills, and Inflation 1997 Yearbook* from Ibbotson Associates.
- Information regarding fees for the Hendersonville/Nashville, Tennessee area is provided by the *Physicians Fee and Coding Guide* from HealthCare Consultants of America, Inc.

III. ECONOMIC OUTLOOK

In the appraisal of any company, the general economic factors prevailing at the date of the appraisal must be considered in order to gain insight into the economic climate in which investors are dealing. Although individual factors may or may not have a direct impact on a particular industry, the overall economy and outlook strongly influence how investors perceive the investment opportunities in all industries. In my analysis of the medical practice of Eddie Titan, M.D., P.C., I have focused on the general economic climate that prevailed in July, 1997 as well as the outlook for the future. In particular, I have focused on the outlook for physician practices, since this aspect of the economy is most directly related to Eddie Titan, M.D., P.C.

Overview

In 1996, the U.S. economy continued the strong growth pattern that began during the second half of 1995. In a survey performed by Reuters NewMedia, economists estimated the Gross Domestic Product (GDP) for the fourth quarter grew at an annual rate of 3.6%. Domestic stocks continued to perform well throughout 1996, though returns were down from 1995 levels. Bond returns dropped in the first half of 1996 as yields increased, creating an abrupt turnaround from the 1995 bond market. In January of 1996, the Federal Reserve Board (the "Fed") continued its policy of lowering interest rates with its third successive rate decrease. As inflationary indicators began to point upwards in the first half of 1996, the stock and bond markets awaited word from the Fed. The Fed did not react with an increase in rates since inflation remained moderate for the remainder of the year.

The market for U.S. large company stocks is represented by the total return on the S&P 500®. In 1996, the large company stock return of 23.07% was substantially above the long-term average return (1926-1996) of 10.71% and the compound annual return for the last five years of 15.2%.[1] The above average rate of return tends to indicate a strong growth pattern for large company stocks. Small company stocks once again trailed the equities of larger companies and returned 17.62% in 1996. This return for small company stocks ranks as the 37th best of the 71 years in the 1926-1996 period, and compares slightly less than favorably to the compound annual return for the last five years of 19.47%.[2] Bond prices fell as yields on all categories of bonds rose in 1996. Intermediate-term interest rates rose less than long-term rates. Short-term rates experienced a relatively modest increase. After spectacular performance in 1995, long-term government bonds returned -0.93% in 1996. This return ranks as the 16th largest loss over the past 71 years. The yield on the bonds rose over the first part of the year, reaching a peak of 7.26% in August. By December, the yield had fallen only to 6.73%.

The Consumer Price Index (CPI) rose 3.3% in 1996, an increase from the 1995 rate of 2.5%. Thus inflation has remained in the range of 2%-5% for 13 of the last 15 years. The

[1] Ibbotson Associates, *Stocks Bonds Bills and Inflation 1997 Yearbook* (Chicago, IL: Ibbotson Associates, 1997), p.44.
[2] Ibid, p.44.

rate was slightly above the 71-year average of 3.12%. In addition, according to Reuters NewMedia, consumers' income rose sharply as 1996 ended. The Commerce Department said incomes from wages, salaries, and all other sources rose a solid 5.5% for all of 1996, although that was down from the 6.3% rise in 1995.

Outlook

Based on the results of the survey mentioned previously, the economic outlook for 1997 and 1998 appears to indicate a period of moderate, slowing economic growth. While no one in the survey forecast a recession, the experts did project a marked slowdown in the expansion rate of the economy. On average, economists surveyed estimated the GDP should slow to about 2% by the end of 1997. In mid-1998, GDP growth should bottom out at about 1.8%, those surveyed said. Chief among the factors expected to drain vitality from the economy will be a series of interest rate hikes by the Fed.

In regards to inflation, the experts projected prices of most consumer goods, excluding food and energy, would grow at about 3% per year in 1997 and 1998. Furthermore, in another part of the survey, most economists are projecting the unemployment rate to rise to approximately 5.5% (considered full employment) by the fourth-quarter 1998 from about 5.25 percent during the first quarter of 1997. In the summary of the report, economists believe a labor market operating at 5.5% unemployment coupled with inflation near 3% would not throw the economy out of balance.

Economic Outlook for Hendersonville, Tennessee and the Middle Tennessee Area

Hendersonville, Tennessee, in Sumner County, is located approximately 20 miles northeast of Nashville. The county had a population of approximately 113,560 in 1994 with Hendersonville constituting approximately 39,200 of that number. The median household income for Sumner County is above the average of other adjacent counties. The unemployment rate for the county in 1994 was 3.7% as opposed to 4.9% in the surrounding area. The city has one hospital (Columbia Hendersonville Hospital) with 120 beds. In addition, Hendersonville has approximately 71 physicians, seven home healthcare companies, four clinics, and two nursing homes.

Hendersonville has several large manufacturers. Large area employers include Globe Business Furniture, BOSCH/GE (automotive motors), Fire Protection Systems (industrial sprinkler systems), Ferguson Habour (environmental services), and ITW Dynatec (adhesive applicators).

Healthcare and Physician Practice Industry

An understanding of the outlook for the healthcare and physician practice industry, as well as its nature, is very important for an appraisal of the medical practice of Eddie Titan, M.D., P.C., since it is necessary to evaluate a company in the context of the industry and markets in which it participates. Therefore, I considered the outlook for the healthcare and physician practice industry as of July, 1997 in my valuation of the medical practice of Eddie Titan, M.D., P.C.

The Bureau of Labor Statistics (BLS) reports that the physician services component of the Consumer Price Index (CPI) has risen 21.3% over the last four years as opposed to the rest of the U.S. economy which has increased 11.7%. This results in an average annual increase of 5.3%. The BLS projects spending on physician services to increase by 4.1% for 1997 and 1998, as opposed to the rest of the economy which is projected to grow by 3.1% and 3.2% (according to BLS projections) in 1997 and 1998 respectively. The BLS believes that consumer confidence is strong. In its report, it states that this confidence should lead to a release of pent-up demand for medical services. This is projected to create an upswing in utilization of medical services.

The healthcare industry has become a fast-changing industry due to regulatory and economic pressures. The advent of managed care has precipitated the pooling of forces among healthcare providers whether it be through mergers and acquisitions, or formation of professional alliances. Most of these entities have been formed to strengthen bargaining positions of the individuals (physicians and others) involved in the entities. Practices who fail to recognize the proper alliances in their communities may find revenues decreasing in the future.

According to a report released in February, 1997 by Deloitte & Touche, LLP and VHA, Inc. entitled the 1997 *Environmental Assessment of the Health Care Industry in the United States*, "To maintain a competitive stronghold in an increasingly mature industry, healthcare organizations must: (1) meet and manage customer demand, (2) develop flexible and nimble organizational structures, (3) embrace information technology as a competitive necessity, and (4) accommodate the new roles of physicians. It is clear from this year's Environmental Assessment, Redesigning Health Care for the Millennium, that strategic planners must prepare their organizations to manage simultaneously short-term market fluctuations and long-term planning and investment requirements."

The report also goes on to state, "Community-focused organizations will be in the best position. Organizations should adopt a population-based health focus and develop community-based services. To do so, they will need to (1) embrace a systematic definition and understanding of health, (2) manage care through early intervention, health promotion and disease prevention, (3) develop community partnerships to share resources and responsibility, and (4) in essence, accept stewardship for community health."

In the short term, revenues for physician practices are promising, especially in the Hendersonville area. Tennessee has yet to be absorbed completely by managed care,

particularly capitation. In addition, Medicare increased reimbursement for 1997 for office based evaluation and management services. Primary care physicians such as pediatricians, family physicians, and internists realized increases in benefit reimbursement in 1997 of approximately 6%. Early estimates for 1998 changes in reimbursement rates indicate an increase for primary care physicians (includes internal medicine) of 6% to 8%.

Summary

Clearly, the general economic outlook in July 1997 is optimistic for the practice. The volatility in the market, however, suggests some uncertainty. Small business owners, although optimistic about 1997 growth, realize that caution must be exercised to remain aware of local alliances and movement by healthcare providers in the Hendersonville area.

The changes in the industry will have a direct impact on the way the medical practice of Eddie Titan, M.D., P.C. operates in the future. Within this swirling continuum of change are physicians, who remain the industry's primary caregivers. Market changes have produced both new options and new risks for physicians as they increasingly join group practices and independent physician associations. In the areas with the greatest managed care penetration, solo-practice, self-employed physicians are rapidly disappearing, and increasingly healthcare delivery systems expect and encourage a higher degree of primary care physician involvement in management.

To maintain market share, the practice will need to remain cognizant of local healthcare alliances and will be forced to continuously analyze new opportunities and regulatory changes in the healthcare industry.

Based on the economic outlook, the internal medicine practice of Eddie Titan, M.D., P.C. should anticipate growth that is above the projected spending by the BLS in 1997 due to expected short-term increases in reimbursement. Primary care physicians (includes internal medicine practice) should anticipate the continued concentration of increases in reimbursement which makes the outlook for primary care physicians encouraging.

IV. BOOK VALUE AND CONDITION OF THE PRACTICE

Patient Information and Office Hours:
According to management, Dr. Titan has approximately 3,500 active patients. He averages approximately 30 patient encounters per day. Management estimates that he sees approximately 25 new patients per month. Patients reside mainly in the Hendersonville/Madison area. The office is open Monday through Friday from 7:30am to 5:00pm. Dr. Titan takes Wednesday afternoons off.

Dr. Titan is also involved in managing a weight loss program. Management estimates that currently he only has about 12 patients in this program.

Medical Directorships/Contractual Relationships:
Management stated that Dr. Titan had no medical directorships.

Litigation:
Management represented that Dr. Titan does not have any pending claims or potential litigation regarding medical services provided, nor has he had any claims in the last three years.

Participation Agreements:
Dr. Titan currently participates with Medicare, Aetna, Blue Cross and Blue Shield, CIGNA, Champus, Columbia HealthCare Network, Health 1·2·3 (Platinum/Medicare/ Tripoint), HealthNet, Healthwise, MetraHealth, PHCS, Signature Health Alliance, United Healthcare/Complete Health, and Willis Corroon. The corporation receives a capitated payment from HealthNet for approximately 80 lives for approximately $7.03 per member/per month (pm/pm). The corporation will also start receiving a capitation payment from United Healthcare beginning August 1, 1997. Management negotiated a payment of $13 pm/pm from United Healthcare. They will be assigned approximately 60 lives in August.

Accounts Receivable System and Information:
The Medic system is used for billing and medical information management. Employees file claims electronically. Practice employees post charges and payments daily and file claims with payers weekly. Employees send patient statements on a monthly basis. However, for a period of time during the second half of 1996, the employee responsible for billing did not send patient statements. Nevertheless, this procedure has been corrected. The new billing supervisor sends patient statements every month.

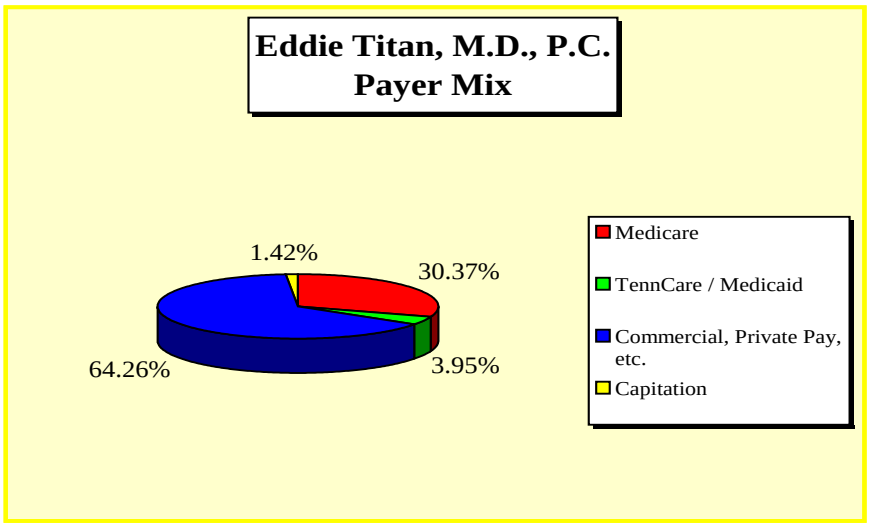
The collection rate has remained fairly stable from 1994-1995 (84.2%-86.5%). However, the collection rate dropped to 73.78% in 1996 and increased to 103.85% through June 30, 1997. These rates compare to the median of 72.09%.[3] As mentioned in the preceding paragraph, the employee in charge of billing in 1996 did not send patient statements. Therefore, a large amount of patient balances remained uncollected. Accordingly, a new

[3] Medical Group Management Association. *Cost Survey: 1996 Report Based on 1995 Data*, Internal Medicine Section. Englewood, CO.

billing supervisor was hired to ensure that statements were mailed monthly. In 1997, a large portion of the 1996 charges were collected which created the unusually high collection rate for 1997. When 1996 and the first six months of 1997 are combined, they result in a collection rate of 83.18% which approximates historical levels.

	1997	1996	1995	1994
Charges	$ 288,679	$ 634,665	$ 626,144	$ 700,537
Collections	$ 299,792	$ 468,244	$ 541,994	$ 590,008
Percentage of charges collected	103.85%	73.78%	86.56%	84.22%

The payer mix compares similarly to the median[4] in regards to the level of Medicare and Medicaid (TennCare). The capitation revenues are somewhat less than the median and the commercial insurance and self-pay revenues are substantially higher than the median. Even though the payer mix is similar to the median, the historical collection percentage is well above the median. This is due to the office's procedure for only billing Medicare the reimbursable amount, which understates both charges and adjustments and overstates the applicable collection percentage.



[4] Medical Group Management Association. *Cost Survey: 1996 Report Based on 1995 Data*, Internal Medicine Section. Englewood, CO.

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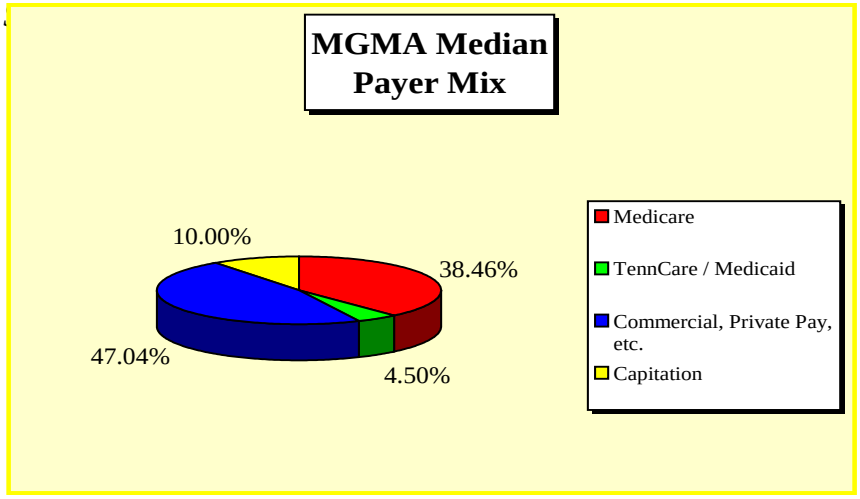
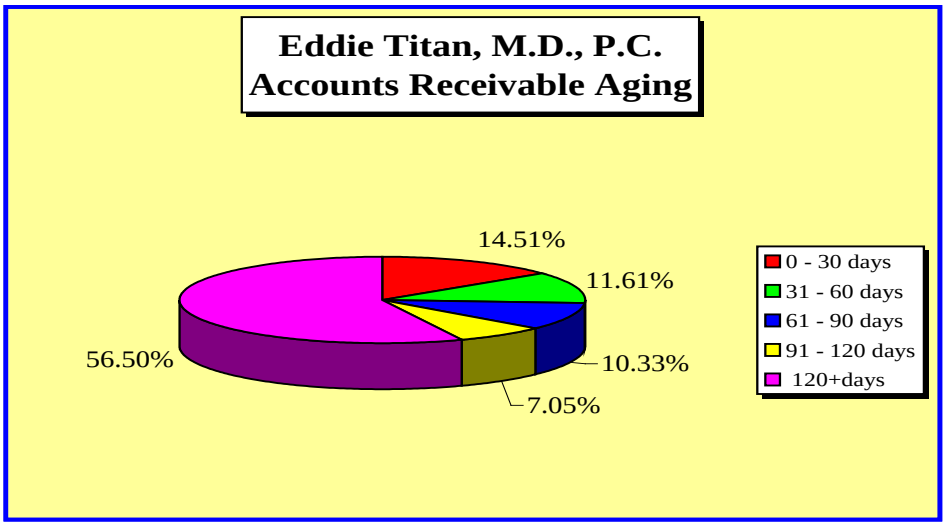
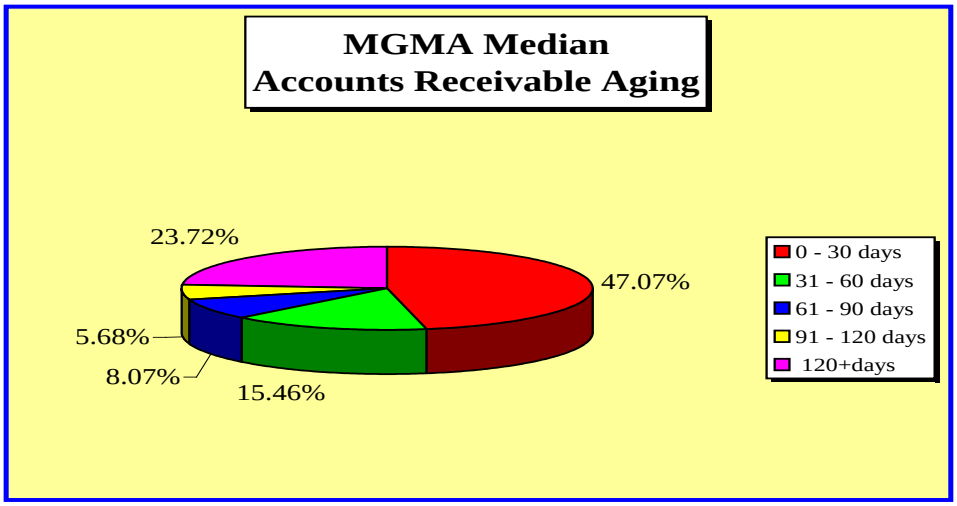


	Actual	MGMA
Medicare	30.37%	38.46%
TennCare / Medicaid	3.95%	4.50%
Commercial, Private Pay, etc.	64.26%	47.04%
Capitation	1.42%	10.00%

The ratio of accounts receivable to average monthly charges compares less than favorably to the median (3.35 vs. the median of 1.74). This would equate to approximately 102.18 days charges in accounts receivable vs. the MGMA median of 53.07. An aging of receivables obtained from management reported that 56.50% of the accounts were over 120 days old as compared to the MGMA Survey median of 23.72%.



	Actual	MGMA
0 - 30 days	14.51%	47.07%
31 - 60 days	11.61%	15.46%
61 - 90 days	10.33%	8.07%
91 - 120 days	7.05%	5.68%
120+days	56.50%	23.72%

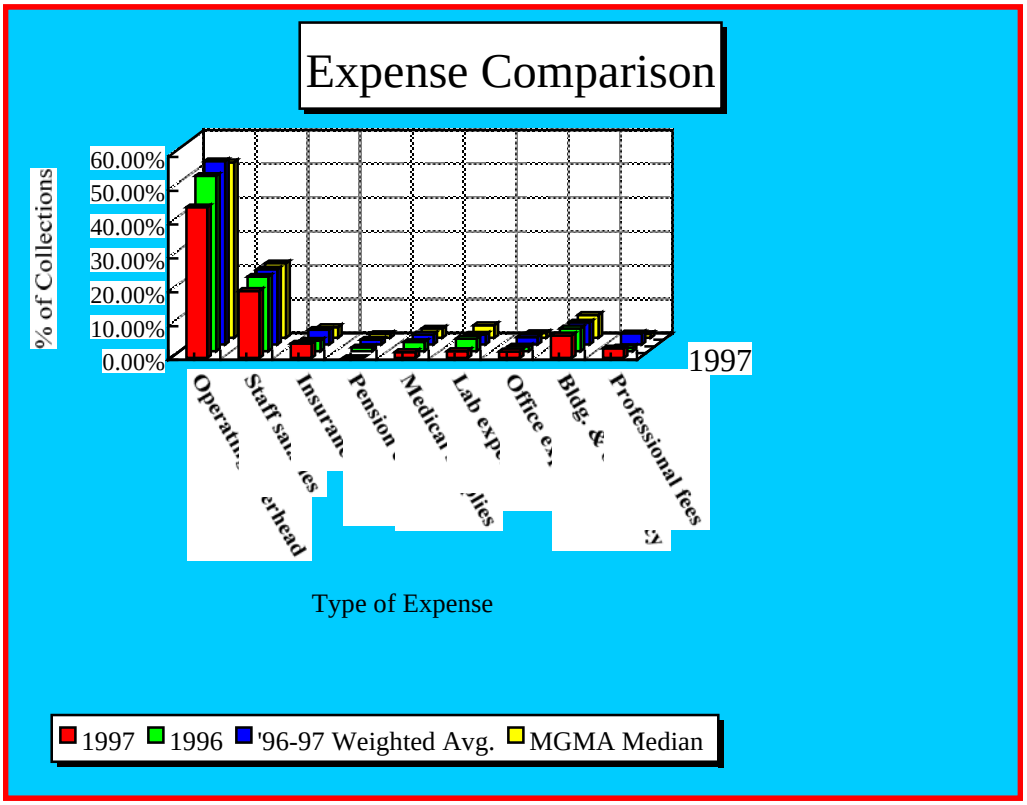


Practice Charges and Collections:
Based on a review of charges, it would appear that gross charges for 1996 increased slightly over 1995 (1.36%). However, the 1997 annualized charges of 577,358 report a decrease of 9.03%. However, Dr. Titan took a one month sabbatical in early 1997 with his wife for their 25th anniversary. This would tend to indicate that daily or monthly charges are equal to or greater than 1996, not less. The 1996 charges of $634,665 were well above the median for internal medicine of $487,671.

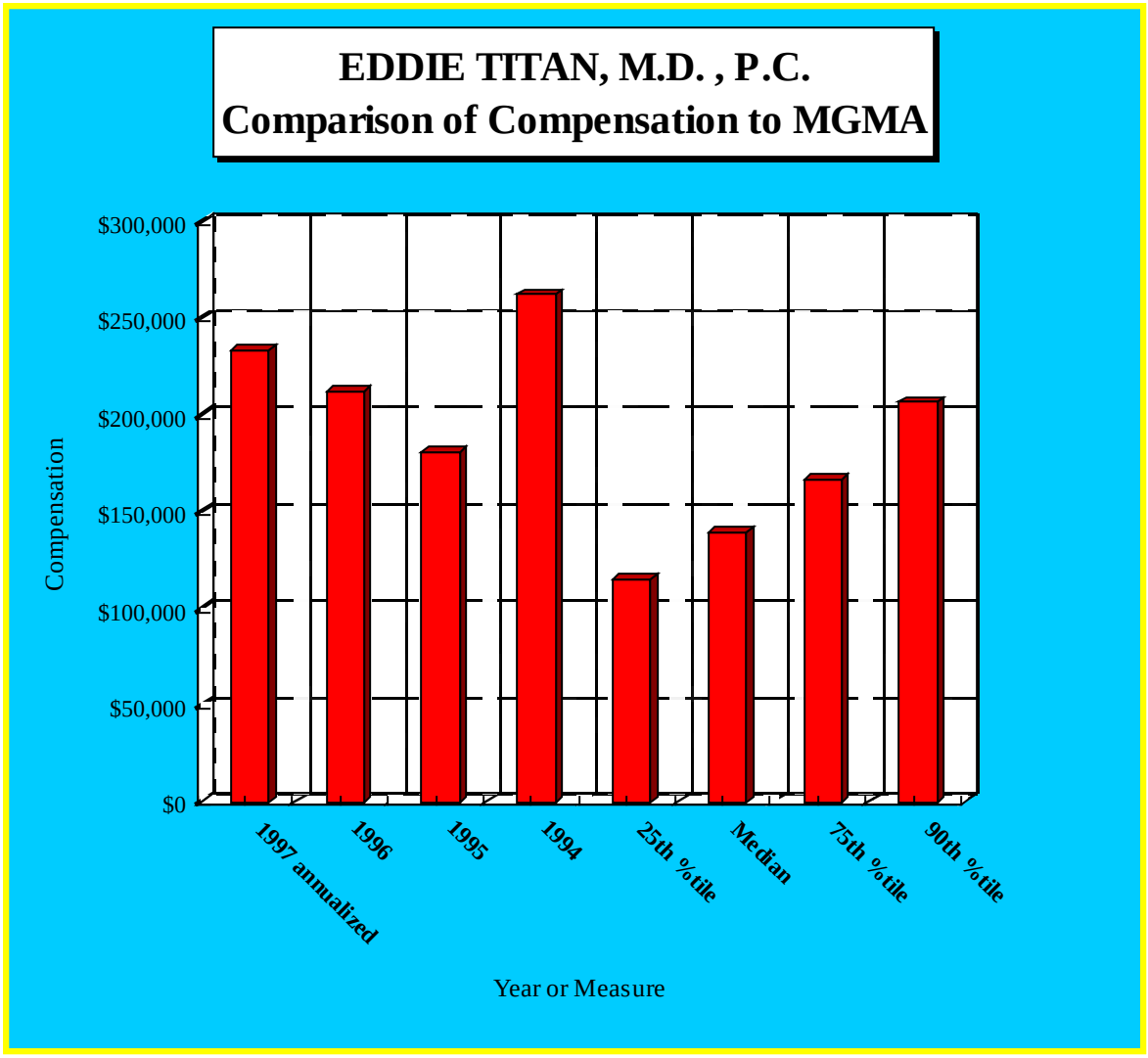
It is difficult, at best, to determine any type of growth pattern for collections. Due to the omission of patient statements in 1996, the collections decreased substantially. However, 1997 annualized collections report a substantial increase over 1996. Even so, the understated collections for 1996 of $465,772 are still well above the MGMA median for an internal medicine practice of $344,521.

Overhead:
Based on an analysis of overhead, it appears that the Practice compares slightly less than favorably to the median for internal medicine for 1996 and 1997 (60.28% in 1996 and 44.54% in 1997 vs. median of 51.81%). However, the amounts in 1996 and 1997 are affected by the collection matter mentioned in the previous paragraphs. The overall overhead rate for the eighteen months ended June 30, 1997 was 54.14%, which is slightly higher than the median. The Practice compares similarly to the median in regards to most expenses. Insurance, office expense, and professional fees were slightly higher than the median while occupancy and lab expenses were slightly lower than the median.

	1997	1996	96-97 Weighted Average	MGMA*
Operating overhead	44.54%	60.28%	54.14%	51.81%
Staff salaries	19.79%	23.73%	22.22%	22.03%
Insurance	4.25%	4.39%	4.34%	3.13%
Pension expense	0.00%	2.28%	1.41%	1.10%
Medical supplies	1.76%	3.69%	2.95%	2.71%
Lab expense	2.01%	3.45%	2.90%	3.71%
Office expense	1.91%	2.35%	2.19%	1.38%
Bldg. & occupancy	6.66%	6.42%	6.51%	6.74%
Professional fees	2.83%	3.59%	3.30%	1.09%



Physician's Compensation:
Physicians' compensation is measured as a product of W-2 wages for Dr. Titan. His wages have ranged from a low in 1995 of $180,785 to a high for 1997 annualized of $233,176 ($263,176 less pension contribution of $30,000). The MGMA Physician Compensation and Production Survey: 1996 Report Based on 1995 Data reports the median for internal medicine is $139,320. It should be noted that the MGMA defines compensation as payments excluding retirement plan contributions and fringe benefits. Dr. Titan's wages more closely resemble the 90th percentile for internal medicine of $206,731.



Employees and Benefits:
The Practice has 9 FTE employees (8 full-time and 2 part-time including the new nurse practitioner) which is somewhat higher than the median for internal medicine of 3.73. However, as noted previously, the corporation is staffed to support two providers. Employees receive one to three weeks of paid vacation, and five days personal leave.

Employees also receive a retirement contribution to the Money Purchase and Profit Sharing Plans when they become eligible. Additionally, employees receive an $108 monthly health insurance allowance. A list of employees is as follows:

Name	Title	Hire date	Rate of Pay
Employee A	Computer Supp. \Billing	01/01/92	$14.50/hr
Employee B	Nurse	05/09/97	$10.00/hr.
Employee C	Summer/Office Help	01/01/95	$6.50/hr.
Employee D	Transcription	01/01/95	$10.00/hr.
Employee E	Check-In	05/24/97	$9.00/hr.
Employee F	Check-Out	09/11/95	$8.48/hr.
Employee G	Billing Sup.	03/01/97	$13.00/hr.
Employee H	Transcription	01/01/95	$11.66/hr.
Employee I	Office Manager	12/01/79	$26,250/year
Sandra Nightengale	Nurse Practitioner	07/28/97	$24.50/hr.
Eddie Titan	Physician	12/01/79	$ 233,176

As mentioned in Section I of this report, the corporation hired a nurse practitioner on July 28, 1997. Per corporate management, Ms. Nightengale will begin working three days per week for $24.50 per hour. It is the intention of both parties for Ms. Nightengale to shift to a 36 hour week as she acclimates herself to the practice and the patients.

Fee Schedule:
An analysis of the fee schedule revealed that the Practice is approximately at the upper range of fees computed for most patient procedures based on the 1997 Physician's Fee and Coding Guide for the Nashville area (see exhibit of fee comparison on next page). The Practice reviews fees annually in January. The last fee increase was implemented in January, 1997.

FEE ANALYSIS

Code	Description	Actual	Lower Range*	Upper Range*	Percentage of charges
99201	Level 1 New patient	54	45	56	0.00%
99202	Level 2 New patient	67	55	70	0.17%
99203	Level 3 New patient	90	76	95	0.48%
99204	Level 4 New patient	128	110	136	1.16%
99205	Level 5 New patient	162	142	183	3.88%
99211	Level 1 Established	29	24	34	0.82%
99212	Level 2 Established	47	37	45	9.46%
99213	Level 3 Established	60	48	61	16.63%
99214	Level 4 Established	95	71	87	1.08%
99215	Level 5 Established	140	115	147	15.88%
99217	Observation care discharge	110	74	96	0.00%
99218	Level 1 Initial observation	90	102	127	0.00%
99219	Level 2 Initial observation	120	132	173	0.00%
99220	Level 3 Initial observation	151	166	225	0.08%
99221	Level 1 Initial hospital	120	105	137	0.01%
99222	Level 2 Initial hospital	150	136	175	0.15%
99223	Level 3 Initial hospital	201	167	216	1.88%
99231	Level 1 Subs. hospital	62	56	73	0.00%
99232	Level 2 Subs. hospital	83	75	93	2.10%
99233	Level 3 Subs. hospital	120	113	144	1.00%
99238	Hospital discharge	92	72	92	0.71%
99291	Critical care, first hour	265	262	324	0.07%
99292	Critical care, each add. thirty min	120	132	166	0.04%
99302	SNF	150	103	133	0.08%
99303	SNF	190	135	172	0.11%
99311	SNF	53	45	56	0.00%
99312	SNF	80	66	83	0.08%
99313	SNF	97	82	103	0.12%
93000	EKG	56	52	62	0.00%
93005	EKG tracing only	50	32	39	0.00%

* 1997 Physician's Fee Coding Guide

Production Analysis:
A production analysis for 1996 reported the following concentrations of patient procedures as a percentage of gross charges. Ancillary services include lab, EKG, and x-ray.

Type of Service	Percentage
Office Visits	57.58%
In-patient Hospital	6.31%
Skilled Nursing Facility.	0.29%
Endoscopies	2.50%
Ancillaries	24.76%
Other	8.56%

Insurance:
The corporation has professional liability insurance for Dr. Titan with State Volunteer Mutual Insurance Company. Dr. Titan is covered for $3,000,000 for each medical incident and $5,000,000 in the annual aggregate. The current policy expires on January 22, 1998.

Book Value:
Due to financial reporting requirements for tax purposes, the corporation accounts for its income and expenses on the modified cash basis of accounting (income tax basis). Under this method, neither receivables nor payables are recognized on the corporate balance sheet. The book value for any of the years is mostly comprised of the net fixed assets and the company's cash balance. Financial statements for the practice are on the following two pages.

EDDIE TITAN, M.D. , P.C.
STATEMENTS OF REVENUE AND EXPENSE
FOR THE SIX MONTHS ENDED JUNE 30, 1997 AND
THE YEARS ENDED DECEMBER 31, 1996, 1995 AND 1994

	1997	1996	1995	1994
Charges	$288,679	$634,665	$626,144	$700,537
Collections	$299,792	$468,244	$541,994	$590,008
Percentage of charges collected	**103.85%**	**73.78%**	**86.56%**	**84.22%**
Less refunds	382	307	1,900	7,506
Misc. income	0	13,290	2,087	633
Total income	299,410	481,227	542,181	583,135
Salaries & wages	59,260	114,189	150,980	75,369
Medical supplies	5,272	17,752	10,378	15,510
Lab expense	6,025	16,603	14,021	27,773
Advertising- Flowers/ Relations	0	80	108	711
Auto Expense	19	2,413	1,360	4,633
Bank charges	539	1,174	748	498
Computer Expense	0	2,411	2,306	2,438
Contract labor (outside services)	0	11,003	28,144	19,398
Depreciation	3,604	6,067	10,405	20,920
Dues and Subscriptions	105	313	1,611	1,139
Insurance	12,733	21,125	11,758	13,899
Interest	0	0	0	185
Meals & entertainment	12	30	243	416
Meetings	0	199	189	0
Pension Expense	0	10,993	4,882	3,739
Office expense	5,733	11,324	8,136	5,785
Postage	605	1,955	1,339	1,874
Professional Fees	8,475	17,280	6,414	15,147
Training and seminars	120	110	343	97
Rents	10,772	12,034	0	1,346
Repairs and maintenance	4,028	7,967	7,920	8,922
Taxes and licenses	11,084	16,045	14,549	9,604
Uniforms	0	293	227	152
Utilities	5,145	10,898	10,777	8,582
Operating expenses	133,531	282,258	286,838	238,137
Overhead percentage	**44.54%**	**60.28%**	**52.92%**	**40.36%**
Net income before physicians compensation	165,879	198,969	255,343	344,998
Physician's compensation:				
Salaries and wages	131,588	212,453	180,785	262,445
Payroll taxes	5,981	6,968	6,441	7,563
Insurance	6,112	12,000	12,000	12,000
Pension	0	30,000	30,000	30,000
Total physician's compensation	143,681	261,421	229,226	312,008
Net income	$22,198	($62,452)	$26,117	$32,990

EDDIE TITAN, M.D., P.C.

SCHEDULE OF ASSETS, LIABILITIES, AND EQUITY
JUNE 30, 1997 AND DECEMBER 31, 1996, 1995, AND 1994

	1997	1996	1995	1994
ASSETS				
Current assets:				
Cash	$64,267	$150	$72,240	$51,985
Investments	0	0	0	10,423
Other current assets	0	20,468	2,614	0
Total current assets	64,267	20,618	74,854	62,408
Fixed assets, net	11,596	15,200	12,911	67,758
Other assets:				
Organizational costs (net of amort.)	0	0	0	0
Total assets	$75,863	$35,818	$87,765	$130,166
LIABILITIES AND EQUITY				
Current liabilities:				
Payroll taxes payable	$17,135	$0	$0	$0
Loans from stockholders	14,604	0	0	38,061
Retirement plan payable	40,179	40,179	34,882	33,739
Bank overdraft	0	12,238	0	0
Total current liabilities	71,918	52,417	34,882	71,800
Long-term debt, net of current	0	0	0	12,883
Equity:				
Common stock	19,093	19,093	19,093	19,093
Retained earnings	(15,148)	(35,692)	33,790	26,390
Total equity	3,945	(16,599)	52,883	45,483
Total liabilities and equity	$75,863	$35,818	$87,765	$130,166

V. APPROACHES TO VALUE

Different approaches must be considered by the appraiser to determine the value of a business or its assets as a going concern. Going concern value is based upon the Practice's earnings power and cash generation capability as it continues in business. The three basic approaches to determine value as a going concern are:

- The cost approach.
- The income approach.
- The market comparison approach.

Cost Approach:
With this approach, each component of a business (including the liabilities) is valued separately. The values are totaled and the liabilities are subtracted to derive the total value of the Practice. Estimates are made as to the fair market value of the individual assets and liabilities.

Income Approach:
The income approach to valuation is based on the assumption that an investor would invest in a property with similar investment characteristics, but not necessarily the same business. The computations used with the income approach generally determine the value of the business to be equal to the expected future benefits divided by a rate of return. This approach involves capitalization, which is the process of converting a benefit stream into value. The value derived is the value of the operating assets and liabilities of the entity.

Market Comparison Approach:
The market comparison approach uses various methods such as comparable sales method, the public companies method, and various industry methods or rules of thumb. These methods are used to determine the value of the entire business enterprise rather than only components thereof. Since medical practices do not normally have any comparable public companies, in this valuation a method utilizing private company transactions has been used.

COST APPROACH

Within the cost approach, underlying asset methods determine a value for a business on individual asset values. To apply these methods, the assets and related liabilities have been adjusted to fair market value under the Net Asset Value (NAV) Method. This method assumes that the value of the business will be realized as part of a going concern.

This method applies not only to the tangible assets, but also to the intangible assets as well. In my experience with medical practice acquisitions, a large portion of the ultimate purchase price has been related to intangible assets. Within the NAV method, I have attempted to identify the fair market value of those intangible assets using a replacement cost method which attempts to determine the value based on the cost to reproduce the assets being valued.

Some appraisers utilize the Excess Earnings Method (also known as "the formula method") as a means of determining value of intangible assets under the cost approach. Due to the subject company's operation in a industry regulated by the Office of the Inspector General (OIG), I have attempted to avoid such a method if at all possible. The OIG utilizes the appraisal experts of the Internal Revenue Service. The IRS has opined in Revenue Ruling 68-609 that the "formula method" should used only if no other method is available.

Accounts Receivable

The balance in patients accounts receivable on July 31, 1997 was $177,156. Management stated that the amounts in the aging buckets had become somewhat stable in the last two months. It would appear that the "catch up" of 1996 collections is almost complete. Dr. Titan could not provide information regarding what percentage of accounts are collected after reaching the 120 day category. I have estimated the percentage based on my experience with other similar practices. Based on historical and anticipated collection percentages, collectible accounts have been estimated as follows:

Accounts receivable less than 120 days	$ 77,071
Anticipated collection percentage	83.00%
Estimated collectible portion	63,969
Accounts receivable greater than 120 days	$ 100,085
Estimated collection percentage	15.00%
Estimated collectible portion	15,013
Total estimated collectible accounts receivable	$ 78,982
Estimated collectible accounts receivable - ROUNDED	$ 79,000

Supplies

The supply inventory was valued using an estimate based on two months average supplies for the year ended December 31, 1996. Therefore, supplies were estimated as follows:

Two months' average medical supplies	$ 2,959
Two months' average office supplies	1,887
Two months' average supplies	$ 4,846
Total - ROUNDED	$ 5,000

Equipment and Furniture

The equipment was observed as of the time of my site visit. As of June 30, 1997, the corporate balance sheet reported equipment and furniture with a cost of $131,512 and a net book value of $11,596. As of the date of our site visit, the equipment and furnishings appeared to be in good working order.

A listing of the practice equipment and furniture inventory is included in Appendix B following this report. Based on the age, condition, and our experience in over 200 similar such engagements, I have estimated the value of practice equipment and furnishings to be $61,000.

Intangible Assets

For a healthcare-related intangible asset to have a quantifiable value from an economic analysis or appraisal perspective, it must possess certain attributes. Some of these requisite attributes include the following:

- It must generate some measurable amount of economic benefit to its owner and this benefit could be in the form of an income increment or of a cost decrement.
- The economic benefit may be measured in any of several ways.
- The benefit must be able to enhance the value of the other assets with which it is associated.

Generally, appraisers and economists will categorize individual healthcare-related intangible assets into several distinct categories. This categorization of intangible assets is used for general asset identification and classification purposes. A common categorization of healthcare-related intangible assets is (1) technology, (2) patients, (3) contracts, (4) data processing, (5) human capital, (6) marketing, (7) location, and (8) goodwill. I have identified two specific categories in which I believe the practice has an indicated intangible value.

Patients: Patient Charts
I have estimated the cost to reproduce an exact replica of patient charts. This tends to produce a Cost to Create Approach which author Raymond C. Miles, in his book *Basic Business Appraisal*, indicates "is generally not recognized as an acceptable appraisal method." However, Mr. Miles also goes on to state that "there sometimes can arise situations in which the cost to create approach may have legitimate applications in appraising." He also states that "Such situations are more likely to involve intangible assets, whose value is difficult to estimate under the best of circumstances, as compared to tangible assets whose value usually can be estimated by one of the other methods such as the replacement cost approach or the market data approach."

As mentioned previously in this report, regulators of the healthcare industry (IRS for business appraisal issues) prefer that the excess earnings method for determining goodwill not be used. Accordingly, I have resolved to use a cost to create method for the value of patient charts. Including the costs of supplies, paper, photo copiers, and labor, it is estimated the cost to reproduce patient files would be approximately $9 per chart. Therefore, the value of the patient charts is estimated to be $32,000 (3,500 active patients X $9, rounded).

Human Capital: Value of Assembled Workforce
I have estimated the value of the assembled workforce by contemplating the cost to replace the assembled workforce. This value is based on an estimate of the cost to recruit, hire, and train new employees of comparable experience and expertise to the subject workforce. This cost was estimated as a percent of total compensation for various levels of employees.[5] Based on these estimated costs, the total cost to recruit, hire, and train the assembled workforce, or the indicated fair market value of the workforce based on the replacement cost method of the cost approach is as follows:

Employee Levels	Total Annual Compensation	Cost to Recruit, Hire, & Train	Estimated Cost
Clerical (admin.)	95,874	10%	$ 9,587
Nursing	20,800	15%	3,120
Office Mgr.	26,250	20%	5,250
Nurse Pract.	30,500	25%	7,625
Physicians	233,176	30%	69,953
		Total	$ 95,535
		Total - ROUNDED	$ 96,000

[5] Based on information obtained from John Jenkins, a healthcare recruiting specialist for Medical Solutions, Inc. in Nashville, Tennessee.

The wages shown above are less than the amount reflected in the schedule on page 17. However, two of the administrative employees were hired in the spring of 1997. In addition, the nurse practitioner began three days prior to the valuation date and had not yet received any pay.

Debt Obligations

Management represents that there are no debt obligations. Therefore, debt is estimated to be $0.

Summary of the Cost Approach:

The estimated fair market value of the assets based on the cost approach is as follows:

Accounts receivable	$ 79,000
Supply inventory	5,000
Furniture and equipment	61,000
Practice patient charts	32,000
Assembled workforce	96,000
TOTAL	$ 273,000

INCOME APPROACH

Theoretically, an investment in a business is worth the present value of all future benefits it will produce for its owner(s), with each expected future benefit discounted back to present value at a discount rate that reflects the risk (degree of uncertainty) that those benefits will not be realized.

The measurement of future benefits on which financial analysts and business valuers most frequently focus is net cash flow. Therefore, I have developed an indication of value based on a forecast using the Discounted Cash Flow (DCF) Method. This forecast of future cash flow and the underlying assumptions are included in the supplementary information.

The rate used to discount the expected cash flows to present value is the estimated rate of return currently available in the market on alternative investments with comparable risk. Our estimate of the discount rate (required rate of return) is derived from market evidence and is the sum of the following components:

1. Risk free rate (20 year Treasury bond yield)
2. General risk premia (Ibbotson & Associates 1997 Yearbook)
3. Company specific risk premia:
    - Industry risk
    - Business risk
    - Management risk
    - Financial risk
    - Valuation risk (risk associated with forecasted data)

Based on the factors listed above, the company specific risk premium rate for purposes of this valuation are computed as follows:

Industry risk:
Absent of reform, the healthcare industry continues to grow at a rate in excess of the gross domestic product. Expenditures for services of physicians have grown at an average rate of 5.3% per year (1992 - 1995). The Bureau of Labor Statistics predicts an annual growth of 4.1% over the next two years. Growth should continue with the addition of Ms. Nightengale in July, 1997. Revenue in 1998 for Dr. Titan's production is assumed to increase by 7% for expected increases in reimbursement from payers. His revenue is expected to grow by 3% per year thereafter.

Ms. Nightengale has been included with her working 3 days per week (0.6 FTE) for her current rate of pay. Her revenue in 1998 has been assumed to approximate 60% of the MGMA 25th percentile revenue for a nurse practitioner, adjusted for an expected 7% increase in reimbursement. In 1999 her production has been estimated to 60% of the MGMA median. Subsequent to 1999, her revenue growth is estimated to be 3% per year to keep pace with historical inflationary increases even though recent increases in reimbursement tend to indicate that growth could be higher. The practice collection

percentage is anticipated to approximate the January 1, 1996 to June 30, 1997 rate of 83%. Therefore, industry risk is assumed to be moderate.

Business risk:
Based on the comparisons to industry medians, the age of the practice, the experience of the new nurse practitioner, and the prior problems with the practice's billing system, the business risk factor is estimated to be moderately high.

Management risk:
Based on management's experience in operating a practice, it appears that the practice will benefit from corporate management, therefore, management risk is assumed to be moderately low.

Financial risk:
The practice has no debt. Therefore financial risk is considered to be nonexistent.

Valuation purpose risk:
Obviously, the use of forecasted data increases risk. Based on the uncertainty of forecasted events and in light of the assumptions, the valuation risk is estimated to be moderate.

Based on the factors enumerated above, I have estimated the after-tax discount rate to be as follows:

Component		Rate
20 year Treasury Bond yield on July 31, 1997 (rounded)		6.5%
Long-term equity risk premium (Ibbotson Associates)		7.5%
Micro-capitalization equity risk premium (Ibbotson Assoc.)		3.5%
Company specific risk premium:		
Industry risk	1.00%	
Business risk	1.50%	
Management risk	0.50%	
Financial risk	0.00%	
Valuation risk	1.50%	4.5%
Estimated applicable after-tax discount rate		22.0%

The enterprise value based on the DCF Method indicates an estimated fair market value for the practice assets, including intangibles, of $351,000. Assumptions regarding the revenues and expenses associated with the discounted cash flows are included immediately following the DCF Schedule.

EDDIE TITAN, M.D., P.C.

Discounted Cash Flows

		1998	1999	2000
Dr. Titan		+7%	+3%	+3%
Prior year gross charges		$615,563	$659,000	$679,000
Estimated growth (reimbursement)		107.00%	103.00%	103.00%
Estimated gross charges		$659,000	$679,000	$699,000
		0.6 FTE	0.6 FTE	0.6 FTE
Ms. Nightengale		25th %tile	MGMA Med.	+3%
Prior year gross charges or MGMA		$60,898	$82,078	$85,000
Estimated growth (reimbursement)		107.00%	103.00%	103.00%
Estimated gross charges		$65,000	$85,000	$88,000
Total Gross Charges		$724,000	$764,000	$787,000
Estimated Collection %		83.0%	83.0%	83.0%
Estimated Gross Collections		600,920	634,120	653,210
Less Overhead (18 month historical rate of 54%)		(324,500)	(342,400)	(352,700)
Net Income from Operations before Providers' Comp.		276,420	291,720	300,510
Providers' Compensation		(203,900)	(210,000)	(216,300)
Net Income Before Income Taxes		72,520	81,720	84,210
Provision for Income Taxes	- Federal	13,130	16,035	16,881
	- State	4,351	4,903	5,053
Net Income		55,039	60,782	62,276
Depreciation		2,320	2,320	2,320
Net Cash Flow		57,359	63,102	64,596
Discount Factor (mid-year discounting factor)		0.905357	0.742096	0.608276
Discounted Cash Flows		$51,930	$46,828	$39,292

Discount Rate	**22.0%**
Growth Rate	**3.0%**

Total Discounted Cash Flows	**$ 138,050**
Terminal Value	**213,005**
Enterprise Value	**$ 351,055**
Enterprise Value - ROUNDED	**$ 351,000**

Prepared using Microsoft Excel 97

SUMMARY OF SIGNIFICANT ASSUMPTIONS TO DISCOUNTED CASH FLOWS

Revenue:

Management has estimated that gross charges in Year 1998 are assumed to approximate annualized charges for the preceding eighteen month period, adjusted for an increase of 7% for anticipated increases in reimbursement from payers. Management believes that production for Dr. Titan in 1999 and 2000 will increase by 3% to keep pace with historical inflationary increases.

In addition, as mentioned previously in this report, management hired a nurse practitioner in July, 1997. She is beginning by working only three days per week. Therefore, in Year 1998, her production has been estimated to be 60% of the 25th percentile of charges for a nurse practitioner as reported by the MGMA Physician Compensation and Production Survey: 1996 Report Based on 1995 Data. Management has estimated it to increase to 60% of the median in Year 1999 and subsequently increase 3% in 2000 to keep pace with inflation.

Collections have been assumed to be at the January 1, 1996 - June 30, 1997 collection percentage of 83% for years 1998 through 2000.

Overhead:

Management has estimated that overhead in Year 1998 will approximate annualized overhead for the eighteen months ended June 30, 1997. Overhead in 1995 was approximately 52%. Therefore, the use of the 54% rate realized for the eighteen months ended June 30, 1997 would appear to be consistent with historical rates. Based on the reconciliation above, overhead is assumed to be 54% in all years.

Providers' Compensation:

Providers' compensation has been normalized to the median compensation as reported by the MGMA Physician Compensation and Production Survey: 1996 Report Based on 1995 Data. Additionally, Ms. Nightengale's compensation has been normalized to 60% of the MGMA median for a nurse practitioner. Management anticipates that Ms. Nightengale will work 3 days per week. Working 3 days out of a 5 day work week makes her a 0.6 FTE.

	Dr. Titan	Ms. Nightengale	Total
Wages	$ 139,300	$ 30,600	$ 169,900
Fringe benefits (20% of wages)	27,900	6,100	34,000
Total	$ 167,200	$ 36,700	$ 203,900

Management has assumed that the wages for Dr. Titan and Ms. Nightengale will increase by 3% per year to keep pace with inflation. In addition, management has estimated that fringe benefits are approximately 20% of annual wages. Therefore, they have been estimated at 20% for all three years.

MARKET COMPARISON APPROACH

Since medical practices are not actively traded on the stock exchange, comparable sales are difficult to determine through public transactions. The *Goodwill Registry 1997*, published by The Health Care Group, compiles data on purchases of medical practices by specialty, geographical area, and reason for the sale. Although the purchase price may have been determined based on a variety of valuation methods, the information is summarized and the value assigned for intangibles is represented as a percentage of annual collections. According to *The Goodwill Registry*:

> Intangible values are an increasingly important part of a practice's worth and *The Goodwill Registry* compiles assessments of the intangible elements of medical and dental practice transactions. *The Goodwill Registry* for 1997 contains over 3,000 reports from transactions during the years 1987 to 1997.
>
> Using a "comparable sales" methodology, *The Goodwill Registry* for 1997 assists accountants, appraisers, attorneys and other advisors in determining the intangible worth of a practice.

For the years 1987 - 1997, the median price paid for intangibles for internal medicine practices (ongoing business value) was 30.15% (mean was 34.66%) of gross collections. However, due to various levels of overhead, some practices are more or less profitable than others with the same level of collections. In theory, a lower rate of overhead would indicate a higher level of profitability. Hence, this would tend to indicate a higher goodwill value.

Eddie Titan, M.D., P.C. had an overhead rate for the eighteen months ended June 30, 1997 of approximately 54%. *The Goodwill Registry* for 1997 reported 31 transactions of internal medicine practices since the beginning of 1992 with an overhead rate that ranged from 51%-57%. The range chosen included all transactions for internal medicine practices since 1992 with an overhead rate of not more than three basis points higher or lower than Dr. Titan's practice. Within this group, the median price paid for intangibles was 30.79% of gross collections. The mean price was 35.79%.

After analyzing both the mean and median for internal medicine. The median price/ percentage appeared to be better than the mean so that large fluctuations in value (high or low) do not affect the most probable value of a medical practice.

Based on the valuation of fair market value under the cost approach, the indicated value of the practice based on the market comparison approach would be computed as follows:

Annualized practice collections for last 18 mos.	$512,024
Median intangible percentage	30.79%
Estimated value of intangibles	$157,652
Estimated value of intangibles - ROUNDED	$158,000
Estimated value of tangible net assets - Cost Approach	145,000
Estimated value of practice - Market Comparison Approach	$303,000

NOTE:
Normally when using The Goodwill Registry for the calculation of medical practice goodwill, the most recent twelve month fiscal year's collections are used for the application of the goodwill multiple. In this particular case however, because the billing supervisor elected in 1996 not to send any patient statements, the collections for 1996 and year-to-date 1997 are skewed. The collections for 1996 appear to be understated because no patient statements were mailed. The collections for the first six months of 1997 appear to be overstated because once statements were mailed, some of the 1996 charges were collected. Therefore, using an annual average for the 18 month period from January 1, 1996 to June 30, 1997 appears to give the best indication of the correct practice collections for a 12 month period.

As mentioned above, *The Goodwill Registry* for 1997 compiles data from assessments of intangible value in a medical practice. Since *The Goodwill Registry* only addresses the intangible value of a medical practice, the value calculated above for intangible assets is added to the values for tangible assets derived from the Cost Approach to arrive at an enterprise value for the entire practice.

Institute of Business Appraisers Database

A listing of transactions for medical practices was obtained from the Institute of Business Appraisers (IBA). However, the listing of transactions, especially when separated by specialty (where available), was not as comprehensive as the listing produced by *The Goodwill Registry 1997*. Five transactions for SIC #8011 were reported by the IBA. Three of the transactions were for practices that were much smaller than Dr. Titan's practice. Additionally, they were transactions from 1989.

Of the two remaining internal medicine transactions, one was for a practice with $2,900,000 in revenues, which is much larger than Dr. Titan's practice. The other transaction was for a practice with gross collections of $510,000, which is similar to the subject company. Using a price/revenue multiple reported for the one similar transaction of 0.69, results in a value for Dr. Titan's practice of $353,000 ($512,024 x 0.69), which is similar to the range of prices derived from some of the other methods. However, basing a value for a practice on the comparison to only one other transaction does not provide a great deal of confidence.

Therefore, since we have already arrived at a value under the market approach using the list of transactions from *The Goodwill Registry 1997,* it was not deemed as critical to place any reliance on the a comparison to one additional transaction on a "stand alone" basis.

Doyle & Associates, P.C. Database

As mentioned previously in this report, our firm has been involved in over 200 appraisals of medical practices. A list of the actual transactions that resulted from the appraisals performed was compiled. It was determined that a methodology similar to that used with *The Goodwill Registry* would be appropriate due to the wide variance in tangible assets on a practice by practice basis. The transactions in the database were sorted by specialty and gross collections.

In searching the firm's database for actual transactions of internal medicine practices, a total of 37 transactions were found. Seven of those transactions were found to be practices that had gross collections similar to Dr. Titan's practice. The median intangible percentage of gross collections was 32.97%. Based on the median multiple from the Doyle & Associates Database, the estimated value is as follows:

Annualized practice collections for last 18 mos.	$512,024
Median intangible percentage	32.97%
Estimated value of intangibles	$168,814
Estimated value of intangibles - ROUNDED	$169,000
Estimated value of tangible net assets - Cost Approach	145,000
Estimated value of practice - Internal Database	$314,000

VI. SUMMARY OF VALUATION AND CERTIFICATION

Based on the three different approaches to value (cost, income, and market comparison) I have arrived at the following indications of value for the assets of Eddie Titan, M.D., P.C. as of July 31, 1997:

Cost Approach	$ 273,000
Income Approach	$ 351,000
Market Comparison Approach	
The Goodwill Registry	$ 303,000
Carter, Young, Lankford & Roach Database	$ 314,000

In concluding the relative weights to be accorded the various approaches, one must consider the mandates of Revenue Ruling 59-60, generally accepted appraisal practices, and the appraiser's experience. Revenue Ruling 59-60 discusses weighting to be accorded various approaches as follows:

> Earnings may be the most important criterion of value in some cases, whereas asset value will receive primary consideration in others. In general, the appraiser will accord primary consideration to earnings when valuing stocks of companies which sell products or services to the public; conversely, in the investment or holding type company, the appraiser may accord the greatest weight to the assets underlying the security to be valued.

Clearly, the medical practice of Eddie Titan, M.D., P.C. is a service company and not an investment company, so the values indicated by the discounted cash flows and the market comparison should be accorded the primary consideration since they are both a product of operations (cash flow and collections). This weighting is also consistent with generally accepted practices in business appraisals in other contexts.

Of the two methods dealing with a function of operations, I accorded an equal amount of the weight to the income (DCF Method) and market (*Goodwill Registry 1997*) approaches. The market comparison is based on the median internal medicine practice. As analyzed previously in this report, Dr. Titan's production is better than the median. However, overhead approximates the median for internal medicine. An overhead rate similar to Dr. Titan's practice would tend to indicate a level of profitability that is also similar. *The Goodwill Registry 1997* purports to reveal actual transaction prices for similar practices within the same specialty. Additionally, the value derived using the same approach with the transactions from the Doyle & Associates, P.C. Database resulted in a value that was similar to *The Goodwill Registry*.

Furthermore, the income approach defines the value an investor would be willing to pay for specific future benefits that reflect a risk that those benefits will not be realized. There appears to be excellent reasons for relying on both methods as an indication of value.

Accordingly, I have weighted my value 50% towards the income approach and 50% towards the market comparison approaches. However, according to the authors of *PPC's Guide to Business Valuations*:

> The weighting of valuation methods is not an exact science and is presented in mathematical terms only to assist the reader in interpreting the valuer's thinking as to the relative emphasis given to each method. The factors that influence the appropriate degree of emphasis for different methods may change over time and thus the methods used and the weightings to be applied to each may be different in valuing the same company at a different time and/or under different circumstances.

In conclusion, **the estimated fair market value of the assets of Eddie Titan, M.D., P.C. as of July 31, 1997 is**

THREE HUNDRED TWENTY-SEVEN THOUSAND DOLLARS ($327,000).

CERTIFICATION OF APPRAISER:

I certify to the best of my knowledge and belief:

- The statements of fact contained in this report are true and correct.
- The reported analysis, opinions, and conclusions are limited only by the reported assumptions and limiting conditions and are my personal, unbiased analysis, opinions, and conclusions.
- I have no present or prospective interest in the property that is the subject of this report, and I have no personal interest or bias with respect to the parties involved.
- My compensation is not contingent on an action or event resulting from the analysis, opinions, or conclusions in, or the use of this report.
- My analysis, opinions, and conclusions were developed and this report has been prepared in conformity with the Uniform Standards of Professional Appraisal Practice (USPAP) and the Institute of Business Appraisers, Inc.'s Business Appraisal Standards.
- Unless acknowledged in this report, no one provided significant professional assistance to me.

DOYLE & ASSOCIATES, P.C.

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Joe B. Appraiser, CPA/ABV, CBA

SUPPLEMENTARY INFORMATION

APPENDIX A

ASSUMPTIONS AND LIMITING CONDITIONS

This appraisal of the assets of Eddie Titan, M.D., P.C. is subject to the following assumptions and limiting conditions:

1.) Information, estimates, and opinions contained in this report are obtained from sources considered reliable; however, no liability for such sources is assumed by the appraiser.

2.) Eddie Titan, M.D., P.C. and its representatives warranted to us that the information supplied to us was complete and accurate to the best of their knowledge. Information supplied by management has been accepted without further verification as correctly reflecting the company's past results and current condition in accordance with financial statements prepared on the tax basis of accounting. The tax basis of accounting is the method used by the company for federal income tax purposes and is a comprehensive basis of accounting other than generally accepted accounting principles.

3.) Possession of this report, or a copy thereof, does not carry with it the right of publication of all or part of it, nor may it be used for any purpose by anyone but Music City Memorial Hospital without the previous written consent of Doyle & Associates, P.C. or Music City Memorial Hospital and, in any event, only with proper authorization. Authorized copies of this report will be signed in ink by representatives of Doyle & Associates, P.C. Unsigned copies should be considered to be incomplete.

4.) None of the appraisers employed by Doyle & Associates, P.C. is required to give testimony in court, or be in attendance during any hearings or depositions, with reference to the practice being appraised, unless previous arrangements have been made.

5.) The various estimates of value presented in this report apply to this appraisal only and may not be used out of the context presented herein. This appraisal is valid only for the appraisal date or dates specified herein and only for the appraisal purpose or purposes specified herein.

6.) The appraised estimate of the fair market value reached in this report is necessarily based on the definition of fair market value as stated in the transmittal letter at the beginning of this report. An actual transaction for the assets of Eddie Titan, M.D., P.C. may be concluded at a higher value or lower value, depending in the circumstances surrounding the practice and/or the motivations and knowledge of both the buyers and sellers at that time. Doyle & Associates, P.C. makes no guarantees as to what value individual buyers and sellers may reach in an actual transaction.

7.) Doyle & Associates, P.C. has not been engaged to apply and therefore has not applied, procedures prescribed by the American Institute of Certified Public Accountants or the Auditing Standards Board, to any historical or forecasted financial statement included or incorporated in this report. Accordingly, Doyle & Associates, P.C. is not assuming the role of reporting Certified Public Accountant and is not separately reporting on the financial statements or forecasts by virtue of their incorporation into the valuation of the practice.

EQUIPMENT INVENTORY

EXAM ROOM 1
Exam Table- Ritter- #104
Wooden Armchair
Secretarial Table
Wallmount BP
Oto

EXAM ROOM 2
Exam Table
Secretarial Chair
Wooden Armchair
Wallmount BP
Oto

EXAM ROOM 3
Exam Table- Ritter
Glass-Top End Table
Wooden Armchair
Secretarial Chair
Wallmount BP
Oto

EXAM ROOM 4
Exam Table
Wooden Armchair
Secretarial Chair
Wallmount BP
Oto
Supply/ Stand cabinet

DR. TITAN'S OFFICE
Wooden Desk
Executive Chair
Armchair
Wing-Back Chairs (2)
2 Door met. Filing cabinet
Night Stand
Lamp
Bookshelf- Wooden

PROCEDURE ROOM
Armchair
Exam Table
Secretarial Chair
2 Door met. Filing Cabinet (2)
Cryo- Surgical Unit- Wallach- #LL-100
Pulmonary Function w/ printer- Pulmo- Aide
Holter Monitor w/ printer- Qmed
Wallmount BP

BUSINESS OFFICE
Wooden Desk
Secretarial Chairs (2)
Calculator
Printer- Okidata- Microline 320
Tables (2)
Laser Printer- Okidata- #OL-400e
High Speed Printer- TI- # Omni 800/880 DP
1 Door met filing Cabinet on wheels
4 Door met filing cabinet (4)
2 Door met filing cabinet

FRONT OFFICE
Metal Chart Shelves (6)
Step Stool
Secretarial Chairs (4)
Laser Printer- HP Laserjet 4P
Printer w/ Stand- TI Omni 800/830
typing Desk- Wooden
2 Door met Filing cabinet
Large wooden Bookshelf
Wooden Printer Stand
Table
paper Cutter
Copier - Panasonic- #FP-1780
2 Door met filing cabinet on Rollers
Fax (plain paper) - Panasonic - #VF-733
Typewriter- IBM Wheelwriter
Calculator

- CONTINUED -

EQUIPMENT INVENTORY (CONTINUED)

CLOSET TO EXAM 1
3 Shelf Cart
Sigmoidoscope- Olympus

LOBBY
Armchairs (12)
Glasstop End Tables (3)
Sofa
Lamps (3)

KITCHEN
Coffee Maker
Microwave
Refrigerator
Small Table
Chairs (2)
Bamboo Coat Rack

HALLWAY
BP Cuffs
3 Shelf cart
EKG - Burdick- Model#E320
Air Purifer-NSA
Supply Stand / cabinet
Tri-View X-ray viewbox
3 Shelf chart shelf on rollers
Wooden Armchair
Wooden Endtable

EXTRA EXAM ROOM
Wooden Exam Table
Arm Chair
Exam Stool
Supply Stand/ Cabinet
BP cuffs
Step Stool

NURSE'S STATION
Blood Drawing Chair
Exam Stool
Scales- Healthometer
Centrifuge
1/4 size Refrigerator
Secretarial chairs (2)

OTHER
Computer System- 8 term & 1 PC*
Phone System -3yrs. old
*PC- SONY 486

AT DR'S HOME
Treadmill& computer- Circadian

QUALIFICATIONS OF APPRAISER

This appraisal report was prepared by Doyle & Associates, P.C., a CPA firm that specializes in consulting for the Healthcare industry, specifically physicians' practices. Members of Doyle & Associates, P.C. have been performed over 200 valuations of medical practices and other businesses over the last several years. Valuations have been performed for acquisitions, mergers, divorces, and federal gift and estate tax cases.

Joe B. Appraiser, CPA/ABV, CBA is a vice president with Doyle & Associates, P.C. Mr. Appraiser is also a Certified Business Appraiser designation with the Institute of Business Appraisers, Inc. He has his B.B.A. from Belmont University with a major in accounting. Mr. Appraiser has been practicing public accounting in Tennessee for 11 years.

A complete resume for Mr. Appraiser is exhibited immediately following this page.

JOE B. APPRAISER, CPA/ABV, CBA

Educational Background

Certified Public Accountant - Tennessee
B.B.A. in Accounting - Belmont University, Nashville, Tennessee
Accredited in Business Valuation (ABV) designation with the American Institute of Certified Public Accountants.
Certified Business Appraiser (CBA) designation with the Institute of Business Appraisers, Inc.

Career Experience

Doyle & Associates, P.C. - Vice President – Audit, Accounting, & Valuation Services, 1995 - Present
Doyle & Associates, P.C. - Manager - Audit and Accounting Services, 1990 - 1995
Doyle & Associates, P.C. - Staff Accountant, 1988 - 1990
State of Tennessee, Comptroller of the Treasury, Division of State Audit - Staff Auditor

Professional Associations

Institute of Business Appraisers, Inc. - Member
American Institute of Certified Public Accountants
- *Journal of Accountancy* - Editorial Advisor, 1992 - 1995

Tennessee Society of Certified Public Accountants
- Editorial Committee, Chairman - responsible for publication of the *Tennessee CPA* - 1990 - 1994
- Accounting Careers Committee, Chairman, 1995
- Healthcare Committee, 1997

Civic Associations

Belmont University National Alumni Advancement Board - Member
Music City Area Chamber of Commerce
- Treasurer, 1993
- Board of Directors, 1993 - 1995

Publications and Speeches

Featured articles in the following publications:
Tennessee CPA
Granite State CPA
Nashville Medical News
Dallas Medical News

APPENDIX C

Valuation Related Education

American Society of Appraisers, Inc. - BV205
AICPA - National Business Valuation Conference – 1996 & 1997
AICPA – BV Exam Review Course
Health Care Advisors Association - Medical Practice Valuations, Intermediate
- Medical Practice Valuations, Advanced

Tool 15-C: Valuation Checklist and Processing Form

Name of entity being valued: _____

Form of ownership:

_____ C corporation
_____ S corporation
_____ General partnership
_____ Limited partnership
_____ Limited liability company
_____ Sole proprietorship
_____ Other (specify)

State in which incorporated or registered: _____

Valuation being done on: _____ Stock basis _____ Asset basis
(If asset basis, list assets & liabilities to be included)

Proportion of total entity being valued: _____

Any restrictions on transfer? _____

Purpose of valuation: _____

Valuation date: _____

Does the report contain the following items?	Yes	No	N/A
Business name, description of entity, and securities or assets being valued.			
Form of organization and description of equity composition.			
Purpose (standard of value) of the appraisal.			
The function (use) of the appraisal.			
Definition of the standard of value used.			
The effective date of the appraisal.			
The date the appraisal report was prepared.			
The report's assumptions and limiting conditions.			
The principal sources and references used in the appraisal.			
The consideration of all relevant data available.			
A certification signed by all appraisers involved.			

	Copies	Initial	Date
Schedules prepared			
Report written			
Report reviewed			
Preliminary report copied			
Preliminary report issued			
Final report copied			
Final report signed			
Final report issued			

Tool 15-D: Valuation Engagement Work Program Checklist

Client Name[1]:_____ Valuation Date:_____

Completed By:_____ Date Completed:_____

Work Program Step:	Initials or N/A	Date
1. Has the interest to be valued been defined and documented in the workpapers?		
2. Has an engagement letter been prepared? It is firm policy that an engagement letter be prepared for all valuation engagements.		
3. Send the client or his representative a copy of the firm's physician practice valuation questionnaire/checklist along with a document request list for any known additional information needed.		
4. Schedule a site visit that will include a visit to the client's office.		
5. Perform the site visit. The site visit should include at a minimum the following steps: a. Obtain a copy of the client prepared questionnaire/checklist and any other documents requested from the client.		
b. Interview personnel necessary to obtain an understanding of the nature of the client's practice.		
c. If the client has not already done so, perform an inventory of the office furniture and equipment if it is to be included in the appraisal.		
6. Perform the research necessary to adequately document comparisons of the client to industry standards.		
7. Perform the research necessary to adequately document the economic outlook section of the report.		
8. Perform the analysis of the practice data necessary to adequately calculate the estimates of value for the practice.		

[1] Any references to the term "client" mean the practice being valued, even though in many cases the actual client may be another entity or representative for the physician practice.

Work Program Step:	**Initials or N/A**	**Date**
9. Prepare the estimates of value for the practice. Has the appraiser considered the impact of all three approaches to value?		
10. Draft a copy of the report. Document the type of report requested on the firm's valuation engagement processing form.		
11. Clear any review notes generated during the independent technical review.		
12. If necessary, obtain a representation letter from the client regarding the information received from the client and used during the valuation engagement.		
13. Complete a copy of the firm's valuation engagement processing form.		
14. Deliver the report to the client.		

Tool 19-A
Model Compliance Plan for Physician Practices

(Practice Name)

Compliance Plan

(Date)

TABLE OF CONTENTS

(PRACTICE NAME)

INTRODUCTION

The Board of Directors of (Practice Name) has adopted a comprehensive Code of Conduct and Corporate Compliance Plan. These actions by the Board of Directors of (Practice Name) represent a commitment to the highest standards of ethical, professional, and personal conduct. The Code of Conduct and Corporate Compliance Plan is an important part of ensuring that (Practice Name) is committed to the highest standards of excellence to conduct business in an ethical and legal manner.

(Practice Name) upholds and supports compliance with the rules and regulations relating to the procedures established for billing state and federal government sponsored health programs, as well as commercial third party payers. The goal of this Corporate Compliance Program is to promote prevention, detection, and resolution of potential violations of the multitude of laws and regulations that affect the Practice's work.

Employees of (Practice Name) have a responsibility to ensure that their behavior and activity is consistent with the Code of Conduct and the Corporate Compliance Plan. As a part of this accountability, employees have a personal duty to report and disclose any known violations of any laws, regulations, or corporate policies and procedures. Each employee must report any inappropriate, unethical, or illegal behavior to the Corporate Compliance Officer or his or her immediate supervisor. Employees can be assured that good faith reports of noncompliance can be made without fear of retribution or retaliation.

It is the responsibility of every (Practice Name) employee to become familiar with and abide by these standards of conduct, as well as policies and procedures that apply to the individual job responsibility. If you have any questions or concerns regarding these policies, or wish to report any violations that you have observed, you should contact the Corporate Compliance Officer, (Name), to have a confidential conversation.

Your cooperation is greatly appreciated in this important effort of (Practice Name).

(Lead Physician)

PURPOSE OF THE COMPLIANCE PROGRAM

(Practice Name) is committed to employing the highest ethical standards and complies with the laws and regulations that govern them. Our Practice believes that its dedication to these principles inspire confidence in our patients, our business partners, and all government agencies.

The goals of the Corporate Compliance Program are:

- To establish compliance policies and procedures that are reasonably capable of reducing the prospect of transgression.

- To guarantee that all rules and regulations relating to billing state and federal government health plans and commercial third-party payers are followed.

- To communicate the standards and procedures to all employees through training programs or dissemination of information.

- To assure open lines of communication so employees can anonymously report problems, without fear of retaliation, to those responsible for ensuring compliance.

- To enforce standards through means of discipline applied to all employees, including individuals responsible for oversight and detection of offenses.

HOW THE COMPLIANCE PROGRAM WORKS

The (Practice Name) Corporate Compliance Program maintains a compliance manual that describes many of the policies regarding compliance with the law, the ethical standards of conduct, and standard operating procedures. Employees are required to review and comply with the Practice's policies and procedures in this manual.

The Board of Directors of (Practice Name) has appointed a Corporate Compliance Officer for the Practice. The Corporate Compliance Officer is responsible for implementing and monitoring the program for the Practice. The Corporate Compliance Officer is responsible for receiving and addressing all compliance related questions or situations that may arise.

Employees are encouraged to report any known compliance violation to the Corporate Compliance Officer at (Practice Name). The Practice has also provided an anonymous compliance box where employees can report any concerns in writing. Retaliation for reporting offenses is strictly prohibited by law and the Board of Directors of (Practice Name). If an employee of the Practice becomes aware of, or suspects, a violation of Practice policy, it is his/her responsibility to report the violation either directly to the Corporate Compliance Officer or anonymously through the compliance box. Failure to report the violation may also subject the employee to disciplinary action.

If the Corporate Compliance Officer discovers credible evidence of misconduct that is a direct violation of the law, he or she will report that evidence to the Practice's legal counsel authority and the Board of Directors of (Practice Name).

The Compliance Manual describes the Practice's policies covering various areas that include compliance with the law, ethics, and standards of conduct. The Board of Directors at (Practice Name) will receive a copy of this corporate compliance manual, as well as designated affiliated personnel.

Employees will be given the Code of Conduct and have an unabridged, full copy of this manual accessible at all times. The Code of Conduct is a set of specific policy statements that should guide the actions of the Practice and its personnel. The department supervisor can direct employees to the manual located in each area of the Practice.

Every employee will receive compliance training on an annual basis. The Corporate Compliance Officer's responsibility is to ensure that every employee involved with the billing process is educated about applicable laws and regulations governing provider billing and documentation.

The Corporate Compliance Officer will make an annual assessment of the success of the Compliance Plan. The assessment will be based on the examination of results of a coding and documentation audit, reports of any outside audits that may have been conducted, and a risk assessment of the Practice. Based on the assessment, the Compliance Officer and Board of Directors may propose and implement changes to the Compliance Plan in light of the conclusion of the report.

(PRACTICE NAME)

MISSION STATEMENT

Above all else, (Practice Name) is committed to the care and improvement of human life. In recognition of this commitment, we will strive to deliver high quality, cost-effective healthcare in the communities we serve. In pursuit of our mission, we believe the following value statements are essential and timeless:

- We recognize and affirm the unique and intrinsic worth of each individual.
- We treat all those we serve with compassion and kindness.
- We act with absolute honesty, integrity, and fairness in the way we conduct our business and the way we live our lives.

We trust our employees as valuable members of our healthcare team and pledge to treat one another with loyalty, respect, and dignity.

(PRACTICE NAME)

RESOLUTION OF THE BOARD OF DIRECTORS
CORPORATE COMPLIANCE PROGRAM

Whereas the policy of (Practice Name) has always been that it is of primary importance to comply with all state and federal laws and faithfulness to the Practice's ethical standards;

Whereas the Board of Directors has always strived to promote and enforce adherence to the Practice's established policies and procedures;

Whereas the Board of Directors believes the implementation of a Corporate Compliance Program is a means to cultivate adherence to the Practice's policies and procedures;

Therefore, it is hereby determined that the Board of Directors approves the development and implementation of a comprehensive Corporate Compliance Program that is consistent with the Practice's policies of federal and state law and ethical standard compliance.

Further determined that the Board of Directors has authorized the Compliance Committee consisting of the Compliance Officer, management, and physicians to oversee the development, implementation, and maintenance of the Corporate Compliance Program. The Compliance Committee is responsible for reviewing the program on an annual basis to determine its effectiveness and reporting to the Board of Directors on any significant issues related to the program.

Further determined that (Name) is named the Corporate Compliance Officer who is authorized to develop, implement, and maintain the Corporate Compliance Plan on a daily basis. The Corporate Compliance Officer will report to the Compliance Committee on a quarterly basis on issues related to the compliance program.

This resolution has been unanimously adopted the _____ day of _____, 20XX upon motion duly made and seconded.

_____ _____
President, Board of Directors Vice President, Board of Directors

_____ _____
Treasurer, Board of Directors Secretary, Board of Directors

(Practice Name)

Code of Conduct

(PRACTICE NAME)

CODE OF CONDUCT

(Practice Name)'s Code of Conduct provides guidance to all employees and assists in carrying out the daily activities within appropriate ethical and legal standards. These obligations apply to the Practice's relationships with patients, affiliated physicians, third-party payers, subcontractors, independent contractors, vendors, consultants, and one another.

The Code of Conduct is a critical component of the overall Ethics and Compliance Program. (Practice Name) has developed the Code of Conduct to ensure they meet their ethical standards and comply with applicable laws and regulations.

The Code of Conduct is intended to be comprehensive and easily understood. In some instances, the Code deals fully with the subject covered. In many cases, however, the subject discussed has so much complexity that additional guidance is necessary for those directly involved with the particular area to have sufficient direction. To provide additional guidance, the Practice has developed a comprehensive set of compliance policies and procedures, which may be accessed in the (Practice Name) Corporate Compliance Manual. Those policies expand upon or supplement many of the principles articulated in this Code of Conduct.

Though we promote the concept of management autonomy, the policies set forth in the Code of Conduct are mandatory and must be followed.

While all employees of (Practice Name) are obligated to follow the Code of Conduct, leaders are expected to set the example, to be in every respect a model for all employees. Leadership at (Practice Name) must ensure that those on their team have sufficient information to comply with laws, regulations, and policies, as well as the resources to resolve ethical dilemmas. They must help to create a culture within (Practice Name) that promotes the highest standards of ethics and compliance. This culture must encourage everyone in the organization to share concerns when they arise. (Practice Name) must never sacrifice ethical and compliant behavior in the pursuit of business objectives.

Fundamental Commitment to Stakeholders

We affirm the following commitments to (Practice Name) Stakeholders:

To our patients: We are committed to providing quality care that is sensitive, compassionate, promptly delivered, and cost-effective.

To our (Practice Name) employees: We are committed to a work setting which treats all employees with fairness, dignity, and respect, and affords them an opportunity to grow, to develop professionally, and to work in a team environment in which all ideas are considered.

To our third-party payers: We are committed to dealing with our third-party payers in a way that demonstrates our commitment to contractual obligations and reflects our shared concern for quality healthcare and bringing efficiency and cost effectiveness to healthcare. We encourage our private third-party payers to adopt their own set of comparable ethical principles to explicitly recognize their obligations to patients, as well as the need for fairness in dealing with providers.

To our regulators: We are committed to an environment in which compliance with rules, regulations, and sound business practices is woven into the corporate culture. We accept the responsibility to aggressively self-govern and monitor adherence to the requirements of law and to our Code of Conduct.

To the communities we serve: We are committed to understanding the particular needs of the communities we serve and providing these communities quality, cost-effective healthcare. We realize as an organization that we have a responsibility to help those in need. We proudly support charitable contributions and events in the communities we serve in an effort to promote good will and further good causes.

To our business partners: We are committed to fair competition among prospective business partners and the sense of responsibility required of a good customer. We encourage our business partners to adopt their own set of comparable ethical principles.

*The term "stakeholder" refers to those groups of individuals to whom an institution sees itself as having obligations.

Relationships With Our Healthcare Partners

Patients

Patient Care and Rights

Our mission is to provide high quality, cost-effective healthcare to all of our patients. We treat all patients with warmth, respect, and dignity and provide care that is both necessary and appropriate. We make no distinction in the care of patients based on age, gender, disability, race, color, religion, or national origin. Clinical care is based on identified patient healthcare needs, not on patient or organization economics.

We seek to involve patients in all aspects of their care and obtain informed consent for treatment. As applicable, each patient or patient representative is provided with a clear explanation of care including, but not limited to, diagnosis, treatment plan, right to refuse or accept care, care decision dilemmas, estimates of treatment costs, and an explanation of the risks and benefits associated with available treatment options.

In the promotion and protection of each patient's rights, each patient and his or her representatives will be accorded appropriate confidentiality, privacy, security, and protective services, and the opportunity for resolution of complaints.

Patients are treated in a manner that preserves their dignity, autonomy, self-esteem, civil rights, and involvement in their own care. (Practice Name) has established processes for prompt resolution of patient grievances, which include informing patients of whom to contact regarding grievances and informing patients regarding the grievance resolution.

Patient Information

We collect information about the patient's medical condition, history, medication, and family illnesses to provide quality care. We realize the sensitive nature of this information and are committed to maintaining its confidentiality. We do not release or discuss patient-specific information with others unless it is necessary to serve the patient or required by law.

(Practice Name) employees must never disclose confidential information that violates the privacy rights of our patients. No (Practice Name) employee, physician, or other healthcare partner has a right to any patient information other than that necessary to perform his or her job.

Subject only to emergency exceptions, patients can expect their privacy will be protected and patient-specific information will be released only to persons authorized by law or by the patient's written consent.

Third-Party Payers

Coding and Billing for Services

(Practice Name) will take great care to assure all billings to government payers, commercial insurance payers, and patients are true and accurate and conform to all pertinent federal and state laws and regulations. We prohibit any employee or agent of (Practice Name) from knowingly presenting or causing to be presented claims for payment or approval, which are false, fictitious, or fraudulent.

When claiming payment of professional services, (Practice Name) has an obligation to its patients, third-party payers, and the state and federal governments to exercise diligence, care, and integrity. The right to bill Medicare or Medicaid programs carries a responsibility that may not be abused. (Practice Name) is committed to maintaining the accuracy of every claim it processes and submits. Any false, inaccurate, or questionable claims should be reported immediately to a supervisor or to the Corporate Compliance Officer.

The Practice will operate oversight systems designed to verify claims are submitted only for services actually provided and services are billed as provided. These systems will emphasize the critical nature of complete and accurate documentation of services provided. As part of the Practice's documentation effort, they will maintain current and accurate medical records.

False billing is a serious offense. Medicare and Medicaid rules prohibit knowingly and willfully making or causing to be made false statement or representation of a material fact in an application for benefits or payment. It is also unlawful to conceal or fail to disclose the occurrence of an event affecting the right to payment with the intent to secure payment that is not due. Examples of false claims include:

- Upcoding to a more complex procedure than was actually performed. Upcoding reflects the practice of using a CPT code that provides a higher billing code than the service actually reflects.

- Requesting reimbursement for services that have not been rendered to the patient. Billing for services not actually rendered to a patient involves submitting a claim that represents that the physicians or healthcare provider performed a service, which was either not performed or not performed completely.

- Filing duplicate claims to the third-party payer. Duplicate billing occurs when the Practice submits more than one claim for the same service or the bill is submitted to more than one primary payer at the same time. Although duplicate billing can occur due to simple error, systematic, or repeated double billing may be viewed as a false claim, particularly if any overpayment is not refunded.

- Falsely reporting a particular healthcare professional performed a procedure.
- Reporting a procedure was rendered in a manner it was not.
- Billing for services that are not medically necessary. A claim requesting payment for medically unnecessary services intentionally seeks reimbursement for a service that is not warranted by the patient's current and documented medical condition. On every HCFA 1500 claim form, a physician or provider must certify that the services were medically necessary for the health of the patient.
- Billing excessive charges.
- Billing Medicare patients for services rendered when a procedure-specific Advance Beneficiary Notice has not been signed.
- Submitting unbundled services. Unbundling is a practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests or procedures that are required to be billed together; therefore, at a reduced payment.
- The failure to refund duplicate payment to the third-party payer.

(Practice Name) employees who prepare or submit claims should be alert for these and other errors.

Any subcontractors engaged to perform billing or coding services must have the necessary skills, quality control processes, systems, and appropriate procedures to ensure all billings for government and commercial insurance programs are accurate and complete. (Practice Name) will only contract with such entities that have adopted their own ethics and compliance programs. Third-party billing entities, contractors, and preferred vendors under contract consideration must be approved consistent with the corporate policy on this subject.

It is illegal to make any false statement to the federal government, including statements on Medicare and Medicaid claim forms. It is illegal to use the U.S. mail to scheme to defraud the government. Any agreement between two or more people to submit false claims may be prosecuted as a conspiracy to defraud the government.

(Practice Name) promotes full compliance with each of the relevant laws by maintaining a strict policy of ethics, integrity, and accuracy in all billing to third-party payers. Each employee involved in submitting charges, preparing claims, billing, and documenting services is expected to abide by the highest standards of personal and professional responsibility.

Legal and Regulatory Compliance

(Practice Name)'s services may be provided only pursuant to appropriate federal, state, and local laws, regulations, and conditions of participation. Such laws, regulations, and conditions of participation may include subjects such as certificates of need, licenses, permits, accreditation, access to treatment, consent to treatment, medical record-keeping, access to medical records and confidentiality, patients' rights, clinical privileges, corporate practice of medicine restrictions,

and Medicare and Medicaid program requirements. The Practice is subject to numerous other laws in addition to these healthcare regulations and conditions of participation.

(Practice Name) will comply with all applicable laws and regulations. All employees, physicians, medical staff members, and contract service providers must be knowledgeable about and ensure compliance with all laws, regulations, and conditions of participation; and should immediately report violations or suspected violations to a supervisor or the Compliance Officer.

(Practice Name) will be forthright in dealing with any billing inquiries. Requests for information will be answered with complete, factual, and accurate information. The Practice will cooperate with and be courteous to all inspectors and surveyors and provide them with the information to which they are entitled during an inspection or survey.

During a survey or inspection, employees must never conceal, destroy, or alter any documents, lie, or make misleading statements to the agency representative. They should not attempt to cause another employee to fail to provide accurate information or obstruct, mislead, or delay the communication of information or records relating to a possible violation of law.

In order to ensure that the Practice fully meet all regulatory obligations, (Practice Name) must be informed about stated areas of potential compliance concerns. The Department of Health and Human Services, and particularly its Office of Inspector General, has routinely notified healthcare providers of areas in which these government representatives believe insufficient attention is being accorded to government regulations. The Practice should be diligent in the face of such guidance about reviewing these elements of our system to ensure their correctness.

(Practice Name) will provide its employees with the information and education they need to comply fully with all applicable laws, regulations, and conditions of participation.

Dealing With Accrediting Bodies

(Practice Name) will deal with all accrediting bodies in a direct, open, and honest manner. No action should ever be taken in relationships with accrediting bodies that would mislead the accreditor or its survey teams, either directly or indirectly.

The scope of matters related to accreditation of various bodies is extremely significant and broader than the scope of this Code of Conduct. The purpose of the Code of Conduct is to provide general guidance on subjects of wide interest within the organization. Accrediting bodies may be focused on issues both of wide and somewhat more focused interest. In any case, where (Practice Name) determines to seek any form of accreditation, obviously all standards of the accrediting group are important and must be followed.

Business Information and Information Systems

Accuracy, Retention, and Disposal of Documents and Records

Each employee of (Practice Name) is responsible for the integrity and accuracy of the organization's documents and records, not only to comply with regulatory and legal requirements, but also to ensure records are available to support our business practices and actions. No one may alter or falsify information on any record or document.

Medical and business documents and records are retained in accordance with the law and the record retention policy. Medical and business documents include paper documents such as letters and memos, computer-based information such as e-mail, or computer files on disk or tape, and any other medium that contains information about the organization or its business activities. It is important to retain and destroy records only according to Practice policy. Employees must not tamper with records, nor remove or destroy them prior to the specified date.

Information Security and Confidentiality

Confidential information about the organization's strategies and operations is a valuable asset. Although employees may use confidential information to perform their jobs, it must not be shared with others unless the individuals have a legitimate need to know this information and have agreed to maintain the confidentiality of the information. Confidential information includes personnel data maintained by the organization; patient lists and clinical information; patient financial information; passwords; pricing and cost data; information pertaining to acquisitions, divestitures, affiliations and mergers; financial data; details regarding federal, state and local tax examinations of the organization or its joint venture partners; research data; strategic plans; marketing strategies and techniques; supplier and proprietary computer software. If the employee's relationship with (Practice Name) ends for any reason, he or she is still bound to maintain the confidentiality of information viewed during employment. This provision does not restrict the right of employees to disclose, if they desire, information relating to their own compensation, benefits, or terms and conditions of employment to individuals or entities outside of the Practice. (Practice Name)'s clinical and business processes rely on timely access to accurate information from their computer systems. Employees' passwords act as individual keys to the Practice's network and to critical patient care and business applications, and they must be kept confidential. It is part of each employee's job to learn about and practice the many ways he or she can help protect the confidentiality, integrity, and availability of electronic information assets.

Electronic Media

All communications systems, including electronic mail, Internet access, and voice mail are the property of the organization and are to be used primarily for business purposes. Highly limited reasonable personal use of (Practice Name) communications systems is permitted; however, employees should assume these communications are not private. Patient or confidential information should not be sent through the Internet until such time that its confidentiality can be assured.

Employees may not use internal communication channels or access to the Internet at work to post, store, transmit, download, or distribute any threatening materials; knowingly, recklessly, or maliciously false materials; or obscene materials including anything constituting or encouraging a criminal offense, giving rise to civil liability, or otherwise violating any laws. Additionally, these channels of communication may not be used to send chain letters, personal broadcast messages, or copyrighted documents that are not authorized for reproduction; nor are they to be used to conduct an external job search.

Employees who abuse our communications systems or use them excessively for nonbusiness purposes may lose these privileges and be subject to disciplinary action.

Financial Reporting and Records

(Practice Name) has established and maintains a high standard of accuracy and completeness in the documentation and reporting of all financial records. These records serve as a basis for managing their business and are important in meeting their obligations to patients, employees, business partners, and others. These records are also necessary for compliance with tax and financial reporting requirements.

All financial information must reflect actual transactions and conform to generally accepted accounting principles. No undisclosed or unrecorded funds or assets may be established. (Practice Name) maintains a system of internal controls to provide reasonable assurances that all transactions are executed in accordance with management's authorization and are recorded in a proper manner so as to maintain accountability of the organization's assets.

Workplace Conduct and Employment Practices

Health and Safety

(Practice Name)'s facility must comply with all government regulations and rules. The Practice's policies have been developed to protect employees from potential workplace hazards. Employees should become familiar with and understand how these policies apply to their specific job responsibilities and seek advice from their supervisor whenever they have a question or concern. It is important for employees to advise their supervisor of any serious workplace injury, or any situation presenting a danger of injury, so timely corrective action may be taken to resolve the issue.

License and Certification Renewals

Employees and individuals retained as independent contractors in positions which require professional licenses, certifications, or other credentials are responsible for maintaining the current status of their credentials and shall comply at all times with federal and state requirements applicable to their respective disciplines. To assure compliance, (Practice Name) may require evidence of the individual having a current license or credential status.

(Practice Name) will not allow any colleague or independent contractor to work without valid, current licenses or credentials.

Relationships With Business Partners

(Practice Name) promotes management of business partners in a fair and reasonable manner, consistent with all applicable laws and good business practices. The Practice promotes competitive procurement to the maximum extent practicable. The selection of business partners will be made on the basis of objective criteria including quality, technical excellence, price, delivery, adherence to schedules, service, and maintenance of adequate sources of supply.

Sanctioned Individuals

(Practice Name) has policies and procedures in place to ensure they do not contract with, employ, or bill for services rendered by an individual or entity that is excluded, suspended, debarred, or ineligible to participate in federal healthcare programs; or has been convicted of a criminal offense related to the provision of healthcare items or services and has not been reinstated in a federal healthcare program after a period of exclusion, suspension, debarment, or ineligibility, provided that we are aware of such criminal offense. The Practice routinely

searches the Office of Inspector General and General Services Administration's lists of such excluded and ineligible persons.

Marketing Practices

Antitrust

Antitrust laws are designed to create a level playing field in the marketplace and to promote fair competition. Discussing (Practice Name) business with a competitor, such as how fee schedules are established, could violate these laws. Competitors are other group practices or health systems in (City, State) and surrounding areas. In general, avoid discussing sensitive topics with competitors or business partner, unless proceeding with the advice of management or the Board of Directors.

Marketing and Advertising

(Practice Name) may use marketing and advertising activities to educate the public, provide information to the community, increase awareness of our services, and to recruit colleagues. We will present only truthful, fully informative, and nondeceptive information in these materials and announcements. All marketing materials that utilize patient data will have the written consent of the patient prior to its use.

Environmental Compliance

It is the policy of (Practice Name) to comply with all environmental laws and regulations as they relate to the organization's operations. The Practice will comply with all environmental laws and operate with the necessary permits, approvals, and controls. The Practice will diligently employ the proper procedures with respect to handling and disposal of hazardous and biohazardous waste including, but not limited to, medical waste.

(Practice Name)

The Compliance Program

(PRACTICE NAME)

THE COMPLIANCE PROGRAM

Plan Overview

Recent changes in the laws and regulations affect how clinical providers may bill Medicare for their services. This Corporate Compliance Plan has its origin in the new federal and state laws, but is intended to set standards for billing of all services to all payers.

The goal of the Corporate Compliance Plan is to ensure that clinical services are properly documented and accurately billed. Bills are coded according to the complexity of a procedure or service, as measured by established components. The Centers for Medicare & Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services responsible for administering the Medicare program, has developed guidelines, which identify proper coding for bills submitted to Medicare for payment.

Program Structure

The Corporate Compliance Program is intended to demonstrate in the clearest possible terms the absolute commitment of the organization to the highest standards of ethics and compliance. The elements of the program include setting standards (the Code of Conduct and Policies and Procedures), communicating the standards, providing a mechanism for reporting potential exceptions, monitoring and auditing, and maintaining an organizational structure that supports the furtherance of the program.

This plan is an integral part of (Practice Name)'s ongoing effort to achieve compliance with federal and state laws relating to billing for clinical services. This plan provides for oversight by a Compliance Officer.

Education

The Compliance Officer's responsibility is to ensure that every employee involved with the billing process is educated about applicable laws and regulations governing provider billing and documentation. The Compliance Officer is responsible for the development and supervision of all in-service training on billing and documentation requirements. Such training and education may include presentations, videotapes, pocket cards, and newsletters. Employees will be required to verify in writing that they received training by whatever method outlined in this Plan. Every employee involved with the billing process must attend a compliance training session annually.

Attendance for training by employees involved in billing is mandatory. The Compliance Officer is responsible for tracking attendance and has the authority to discipline for non-attendance. Discipline may include required supervision, review of charts for some period of time, or sanctions.

Resources for Guidance and Reporting Violations

To obtain guidance on an ethics or compliance issue, or to report a suspected violation, the employee may choose from several options. (Practice Name) encourages the resolution of issues, including human resources-related issues (for example, payroll, fair treatment, and disciplinary issues), through the Practice's management levels whenever possible. It is an expected good practice, when you are comfortable with it and think it appropriate under the circumstances, to raise concerns first with your supervisor.

(Practice Name) will make every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports possible misconduct. There will be no retribution or discipline for anyone who reports a possible violation in good faith. Any employee who deliberately makes a false accusation with the purpose of harming or retaliating against another employee will be subject to discipline.

Personal Obligation to Report

(Practice Name) is committed to ethical and legal conduct that is compliant with all relevant laws and regulations and to correcting wrongdoing wherever it may occur in the organization. Each employee has an individual responsibility for reporting any activity by any employee, physician, subcontractor, or business partner that appears to violate applicable laws, rules, regulations, or the Code of Conduct.

Non-Retaliation

It is the policy of (Practice Name) that no person shall retaliate in any form against a person who reports in good faith an act or suspected act of noncompliance. Employees may be disciplined for making intentional false reports or noncompliance. Any employee who is found to have retaliated for such a report in violation of this policy shall be subject to discipline.

Internal Investigations of Reports

The Compliance Officer will investigate every report of noncompliance as soon as practicable. Investigations may include interviewing employees and reviewing documentation. Each employee must cooperate with such investigations and may be disciplined for failing to do so.

Once the Compliance Officer completes an investigation, he or she will make a report to the Board of Directors. This report will be the basis for the Compliance's Officer's plan or recommendation of corrective action or discipline. Reports will be retained for six years.

Corrective Action

The Compliance Officer will have authority to impose corrective action and/or discipline for single or repeated instances of noncompliance in order to make this Compliance Plan effective. All violators of the Code of Conduct will be subject to disciplinary action.

If a physician, healthcare provider, or employee is found to be noncompliant in a single instance or relatively insignificant percentage of cases over a short period of time, the Compliance Officer may require that the person undergo an education session.

If a physician, healthcare provider, or employee fails to comply with billing or documentation requirements repeatedly, sanctions may be more severe. The Compliance Officer will review the recommended corrective action or discipline with the Board of Directors.

Plans of correction and discipline may include, but are not limited to:

- Requirement to attend educational sessions;
- Expanded auditing, internal or external;
- A period of required supervision;
- Self-reporting of violations;
- In egregious cases, termination of employment.

Internal Auditing and Other Monitoring

Monitoring of compliance with billing rules is a central feature of this Corporate Compliance Plan. The Compliance Officer must be able to ensure compliance through an understanding of current regulations and overall levels of compliance throughout the Practice at any given time.

Under this Corporate Compliance Plan, there will be both internal and external auditing of proper coding and chart documentation. Internal auditing will be done by the Compliance Officer or designee who will conduct periodic chart reviews. Each clinical physician or healthcare provider who bills for services at (Practice Name) will be subject to annual chart reviews for proper documentation and coding of clinical services. The Compliance Officer will communicate the results of the review to the physician or healthcare provider and to the Board of Directors. If the level of compliance is found to be inadequate, a plan of correction or education will be implemented.

The Compliance Officer may engage an external audit by an independent consultant as deemed necessary to assess the overall compliance of the Practice. All employees must cooperate fully with this effort by making themselves available, and may be disciplined for not doing so.

The external auditor will report to the Compliance Officer concerning the results of its investigation. The Compliance Officer will present this report to the Board of Directors.

Ongoing Assessments

The Compliance Officer will make an annual assessment of the success of the Corporate Compliance Plan based on the results of internal and external audits. Based on this, the Compliance Officer may propose to the Board of Directors changes to the Corporate Compliance Plan in light of the conclusions of the report.

(PRACTICE NAME)

EMPLOYEE ACKNOWLEDGMENT

(Practice Name) requires all employees to sign an acknowledgment confirming they have received the Code of Conduct, understand it represents mandatory policies of (Practice Name), and agree to abide by it. New employees will be required to sign this acknowledgment as a condition of employment. Each Practice employee is also required to participate in annual Code of Conduct training, and records of such training must be retained by each facility.

Adherence to and support of (Practice Name)'s Code of Conduct and participation in related activities and training will be considered in decisions regarding hiring, promotion, and compensation for all candidates and employees. New employees must receive Code of Conduct training within 30 days of employment.

Acknowledgment Card

I certify that I have received the (Practice Name) Code of Conduct, understand it represents mandatory policies of the organization and agree to abide by it.

_____

Employee Signature

_____

Printed Name

_____

Position

_____

Date

(Practice Name)

Internal Compliance Procedures

(PRACTICE NAME)

COMPLIANCE OFFICER AND COMPLIANCE COMMITTEE

The Shareholders of (Practice Name) shall make every effort to assure the complete support and appropriate funding for the policies, procedures, and personnel described in this plan, and has assigned oversight responsibility of this Compliance Plan to the Compliance Committee. Outlined below are the duties of key personnel:

1. Compliance Officer:

    a. Coordination of the program, planning, activities of the Compliance Committee, and educational and training programs.

    b. Reporting on a regular basis to the Shareholders on compliance activities.

    c. Periodically revising the program due to changing needs of the organization, as promulgated by the Compliance Committee and approved by the Shareholders.

    d. Ensuring that Shareholders, management personnel, employees, and any other contracted agents are aware of the requirements of the Practice's compliance program.

2. Corporate Compliance Committee:

    a. Overseeing and monitoring the implementation of the compliance program.

    b. Assisting practice management members in establishing methods to improve the Practice's efficiency and quality of services, and to reduce the Practice's vulnerability to fraud, abuse, and waste.

    c. Continually analyzing the organization's industry environment, the legal requirements with which it must comply, and specific risk areas; and periodically assessing and revising existing policies and procedures due to changes in the needs of the organization and in the laws, policies, and procedures of government and private payer health plans.

    d. Assisting the appropriate personnel in coordinating internal compliance review and monitoring activities, including annual or periodic reviews of departments, and the development and/or revision of internal systems and controls to ensure consistent application of standards as part of daily operations.

e. Investigating and acting on matters related to compliance, including the flexibility to design and coordinate internal investigations and any resulting corrective action within the Practice, if appropriate, with agents and independent contractors.

f. Direction of an appropriate strategy to continually develop and revise policies and programs to promote compliance, encourage reporting of suspected fraud and other improprieties without fear of retaliation, and ensure proper response to reports of noncompliance.

(PRACTICE NAME)

TRAINING AND EDUCATION

The Compliance Training Program will ensure that all employees will be educated as to the purpose, contents, and requirements of the corporate compliance policy on a periodic basis. Attendance and participation in training is a condition of continued employment and failure to comply with training requirements could result in disciplinary action, including possible termination.

1. Newly hired employees will receive initial compliance training on the Compliance Plan and receive a complete copy of the code of conduct policy as part of new employee orientation.

2. All Shareholders, employed physicians, and employees will receive periodic corporate compliance training.

3. Targeted training, including coding, billing, and business development, will be provided to management and other employees whose actions affect the accuracy of the claims submitted to the Government.

4. Upon completion of this training, individuals will be required to sign a written acknowledgment confirming their:

    a. Pledge to adhere to the Compliance Plan; and

    b. Acknowledgment that the individual understands that failure to comply with the Compliance Plan may lead to disciplinary actions up to and including termination of employment or contractual relationship with the organization.

(PRACTICE NAME)

COMPLIANCE COMMUNICATION PROCEDURES

It shall be the policy of (Practice Name) to take reasonable steps to achieve compliance with established ethics standards by having in place and publicizing a reporting system whereby employees can report possible wrongdoing by others within the organization without fear of retribution.

1. Clarification of Policy:

   Practice employees may seek clarification from the Corporate Compliance Officer in the event of any confusion or question with regard to a Practice policy or procedure. Questions and responses will be documented and dated and, if appropriate, shared with other staff so that standards, policies and procedures can be updated and improved to reflect necessary changes or clarifications.

2. Reporting System:

   Reports of concern may be made orally or in writing, and can be directed to a member of the Compliance Committee, or may be anonymously reported. The Practice has established a compliance concern box for such reporting or questions. All reports will be taken seriously, and the following steps will be taken:

   a. A written record of the report shall be made.

   b. No promises will be made to the party making the disclosure regarding his/her liability or what steps (Practice Name) may take in response to the report.

   c. The appropriate supervisor or manager and the Compliance Committee shall review the reported wrongdoing to determine the need for consultation with outside legal counsel. If outside legal counsel is required, the Practice Administrator or one of the Shareholders shall contact outside counsel to determine what steps will be taken.

   d. A member of the Compliance Committee shall present periodic reports to the Shareholders, including a report on all reports of wrongdoing, the results of investigations, and any subsequent remedial action taken.

3. Protection of Employees:

   (Practice Name) will strive to maintain the confidentiality of an employee's identity; however, there may be a point where the individual's identity may become known or may have to be revealed in certain instances when Government authorities become involved.
   It is the policy of (Practice Name) that no employee shall be punished solely on the basis that he or she reported what he or she reasonably believed to be an act of wrongdoing or a violation of this plan. However, an employee will be subject to disciplinary action if

(Practice Name) reasonably concludes that the report of wrongdoing was knowingly fabricated by the employee or was knowingly distorted, exaggerated, or minimized to either injure someone else or to protect himself or herself.

In determining what, if any, disciplinary action may be taken against an employee, (Practice Name) will take into account an employee's own admissions of wrongdoing, provided, however, that the employee's admission was not previously known to (Practice Name) or its discovery was not imminent, and that the admission was complete and truthful. An employee whose report of misconduct contains admissions of personal wrongdoing will not, however, be guaranteed protection from disciplinary action. The weight to be given the self-confession will depend on all the facts known to (Practice Name) at the time it makes its disciplinary decisions.

(PRACTICE NAME)

AUDITING AND MONITORING

1. Internal

   In order to assure that (Practice Name) has taken reasonable steps to achieve compliance with its ethic standards, it shall be the responsibility of the Compliance Committee to meet annually to review the effectiveness of the plan and to propose any required changes to the plan.

   This review will analyze if the compliance elements have been satisfied, for example, whether there has been appropriate dissemination of the program's standards, training, ongoing educational programs, and disciplinary actions, among others. This process will verify actual conformance by all personnel with the compliance program.

2. External

   (Practice Name) shall engage an external firm to conduct, on a sample basis, an audit of the accuracy of medical record coding.

(PRACTICE NAME)

RESPONDING TO DETECTED OFFENSES AND DEVELOPING CORRECTIVE ACTION INITIATIVES

Violations of the Practice's compliance program, failures to comply with applicable federal or state law, and other types of misconduct threaten our status as a reliable, honest, and trustworthy provider capable of participating in federal healthcare programs. Detected, but uncorrected misconduct can seriously endanger the mission, reputation, and legal status of the Practice.

Consequently, upon reports or reasonable indications of suspected noncompliance, the Compliance Committee will initiate prompt steps to investigate the conduct in question to determine whether a material violation of applicable law or the requirements of the compliance program has occurred and, if so, will take steps to correct the problem.

Reporting to Authorities

It shall be the policy of (Practice Name) to carefully evaluate all allegations of wrongdoing to determine (a) if the allegation appears to be well founded and (b) whether the allegation warrants reporting to enforcement authorities.

1. An internal investigation may include, but is not limited to, any of the following:

    a. Interviews

    b. Review of relevant documents

    c. Engaging counsel, auditors, or other experts for assistance in the investigation

    If an investigation of an alleged violation is undertaken and the Compliance Committee believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those subjects should be removed from their current work activity until the investigation is completed. In addition, the Compliance Committee should take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

2. Records of the investigation should contain:

    a. Documentation of the alleged violation

    b. Description of the investigative process

    c. Copies of interview notes and key documents

    d. Log of witnesses interviewed and the documents reviewed

e. Results of the investigation, for example, disciplinary action taken, corrective action implemented

If, after a thorough internal investigation, there is credible evidence of misconduct from any source that may violate criminal, civil, or administrative law, the Practice will promptly report the existence of misconduct to the appropriate authorities.

(PRACTICE NAME)

DISCIPLINARY GUIDELINES

(Practice Name) is committed to complying with all applicable laws. The observations of all laws governing business activity are of the utmost importance to the continued success of (Practice Name). Toward this end, the Practice intends to avoid even the appearance of wrongdoing because such appearances, however innocent, may lead to expensive and time-consuming litigation and adverse publicity. While it is not practical to attempt to list all laws to which (Practice Name) is subject, it is obvious that neither (Practice Name) nor its employees should encourage or participate, directly or indirectly, in such activities as theft, fraud, embezzlement, bribery, misappropriation or conversion of property, false statements to the government, discriminatory employment practices, and violations of environmental or workplace safety laws. Employees should not engage in fraudulent, deceptive, or corrupt conduct toward the Practice, its customers, suppliers, contractors, employee representatives, or anyone else with whom it has business relations. Examples of prohibited activities include kickbacks, inflated billings, and the offering, accepting or soliciting, directly or indirectly, of money, goods, or services where the purpose of the action is to influence a person to act contrary to the interest of his own employer or principal or fiduciaries.

If an employee violates any law or regulation in the course of his or her employment, the employee will be subject to sanctions by the Practice.

In addition to direct participation in an illegal act, employees will be subject to disciplinary actions taken by the Practice for failure to comply with the principles and policies set forth in this Compliance Program. Examples of actions or omissions that will subject an employee to discipline on this basis include, but are not limited to, the following:

1. A breach of the Practice's policy;

2. Failure to report a suspected or actual violation of law or a breach of the policy;

3. Failure to make, or falsification of, any certification required under the Compliance Program;

4. Lack of attention or diligence on the part of supervisory personnel that directly or indirectly leads to a violation or law; and/or

5. Direct or indirect retaliation against an employee who reports a violation of the Compliance Policy or a breach of the policy.

The possible sanctions include, but are not limited to, termination, suspension, demotion, reduction in pay, reprimand, and/or re-training. Employees who engage in intentional or reckless violation of law, regulation, or this Compliance Program will be subject to more severe sanctions than accidental transgressors.

(PRACTICE NAME)

ARREST AND CONVICTIONS

An employee must report in writing to his or her superior any charge, arrest, indictment, or conviction within three (3) days of its occurrence. An employee need not report offenses such as traffic violations that are punishable only by fine.

Supervisors who receive written notice from an employee of that employee's charge, arrest, indictment, or conviction shall report that notice to the Administrator within one day of receipt of notification. The Administrator must report such notification immediately to the Compliance Committee.

Charges, arrests, indictments, and convictions reported by an employee shall be reviewed in accordance with (Practice Name)'s policy to determine whether the employee's unlawful conduct requires employee reassignment or otherwise affects or violates the requirements of the policy.

(PRACTICE NAME)

EMPLOYEE RECRUITMENT, HIRING, AND TERMINATION

1. The application for employment requires the applicant to disclose any criminal conviction or exclusion action. Practice policy prohibits the employment of individuals who have been recently convicted of a criminal offense related to healthcare or who are listed as debarred, exclude, or otherwise ineligible for participation in federal healthcare programs.

2. The Administrator must conduct and document reasonable reference checks for all employees, and conduct and document reasonable and prudent background investigations for potential employees as directed by the Shareholder.

   Reference checks are completed prior to any offer of employment being rendered, and in circumstances where a background investigation is required, the employment offer is contingent upon the outcome of this investigation.

3. In order to assure that (Practice Name)'s terms of employment are consistent with the corporate compliance policy, all employees shall satisfy the following requirements:

   a. Upon completion of new employee orientation, all employees shall sign a written statement that includes the following:

      - Acknowledgment that the employee shall read (or has read) the employee handbook and agrees to be bound by it.

      - Acknowledgment that the employee has been provided a copy of and received an overview of the corporate compliance policy and shall be bound by such, including employee training, duties, and discipline.

      - A representation by the prospective employee that he or she has reported in writing any and all charges, arrests, indictments, and convictions of any criminal offense.

      - A representation by the prospective employee that he or she has never been discharged from previous employment for cause, except as reported in writing in the employment application.

4. An exit interview will be conducted with all employees upon termination. This documentation will be retained in the permanent employee personal record.

(PRACTICE NAME)

GOVERNMENT AUDITS, INVESTIGATIONS, AND LITIGATION

It shall be the policy of (Practice Name) to cooperate fully in connection with all government audits and investigations and to respond in a timely manner to all requirements imposed by involvement in litigation.

1. Search Warrants Served Upon the Practice

   If the investigator presents a search warrant, the following actions are suggested:

   a. Do not obstruct or interfere with the execution of the search warrant.

   b. Request a copy of the search warrant and the affidavit in support of the search warrant.

   c. Request the identity of the agents or officers servicing the warrant and conducting the search.

   d. Immediately notify the attorney for the Practice and fax him or her a copy of the search warrant together with the name of the agent serving the warrant.

   e. Request that the search not commence for a reasonable time sufficient for the Practice's attorney to be notified and have time to arrive at the Practice. This may not normally be granted, but should be requested nevertheless.

   f. Notify the agent or officer servicing the warrant that all inquiries concerning the warrant or the search should be directed to the Compliance Officer.

   g. The Compliance Officer should accompany the officers or agents at all times during the search. The conduct, statements, and questions of the agents should be carefully recorded.

   h. Carefully note or record the items searched for and seized, and the location from which the items or documents were taken.

   i. If employees consent to an interview, note the identity of each employee interviewed and make notes of any statements made during the interview.

   j. If the agents or officers seize files which contain privileged documents, such as correspondence to and from counsel, audits prepared by or at the direction of counsel, and so on, request that such documents be sealed without further examination, and delivered to the Magistrate for an on-camera review before being turned over to the law enforcement agency.

k. Obtain a copy of the inventory of the search from the agent or officer.

l. Request that the Practice be allowed to make copies of each document seized.

m. Never destroy or hide a document or tell anyone else to do so.

n. Never alter a document or tell anyone else to do so.

2. Notice to Employees

Because there are healthcare and medical care providers that have defrauded the government through the improper billing for medical services covered by federally funded programs, the government has increased investigations of healthcare facilities across the country in recent years. These types of investigations may be conducted by the Department of Justice through the United States Attorney's Office; the Federal Bureau of Investigation; and the Department of Health and Human Services through the Centers for Medicare & Medicaid Services (CMS) or the Office of Inspector General.

The Shareholders of (Practice Name) have previously adopted a policy of zero tolerance for fraud and abuse through the enactment of the Compliance Plan.

Since the government may randomly select the Practices or other healthcare providers for audits and/or investigations, it is possible that within the next few years some agency of the government may conduct such an audit or investigation of (Practice Name). (Practice Name) is providing you this notice to advise you that investigators seeking to interview you regarding any knowledge you may have about any matter that is being audited or investigated may contact you. You should be aware of the following:

a. Investigators have the right to contact you and to request an interview.

b. You have the right to speak with investigators. You also have the right to request a time and place for this interview which is convenient to you.

c. You have the right to consult with legal counsel prior to deciding whether to submit to an interview. Legal counsel for (Practice Name) is available to meet with you prior to any such interview and to be with you during the interview if you should so choose. You also have the right to retain your own attorney if you feel that is necessary.

d. You have the right to decline to be interviewed.

If you do consent to an interview:

a. You have the right to have an attorney present during the interview, to confer with an attorney in advance, and to terminate the interview at any

time. You may request that legal counsel for (Practice Name) be present during your interview.

b. Statements made to investigators may constitute legal admissions, which may later be used as evidence against you or (Practice Name) in legal proceedings.

c. Remember that you should **TELL THE TRUTH** and should only state matters you know to be a fact. A false statement to an investigator may constitute a criminal offense.

CONTACT WITH NON-(PRACTICE NAME) EMPLOYEES

1. All contacts with anyone claiming to represent any local, state, or federal agency shall be immediately reported to your supervisor, manager, or member of the Compliance Committee.

2. Unless it is part of an employee's written job description to have contact with the following categories of individuals, all employees are governed by the following rules:

   a. Contact with Media

      All contacts with anyone from the media must be referred to the Administrator.

   b. Contact with Attorneys

      All contacts with anyone claiming to be an attorney should be immediately referred to the Administrator.

   c. Contact with Competitors

      All contacts with anyone representing a competitor of (Practice Name) or employed by a competitor should be reported to your immediate supervisor. A supervisor to whom such contacts are reported shall immediately report the incident to the Administrator.

   d. Patient Relationships

      Employees and agents shall comply with (Practice Name) policies regarding patient relationships, including, without limitation, patient admissions, referrals, and treatment.

      If you have questions about any legal rights concerning any such investigations and/or interviews, please feel free to contact the attorney for (Practice Name).

(Practice Name)

Policies and Procedures

(PRACTICE NAME)

Category: Billing Office **Policy # _____**

Title: Waiver of Co-payments and Deductibles

Origination Date:_____ **Review Date:_____**

_____ _____

Authorized Signature **Authorized Signature**

Policy

(Practice Name) will not routinely waive contractual co-payments and deductibles.

Purpose

(Practice Name) renders services to patients that are reimbursed primarily through third-party payers and patients. Patients with health insurance coverage are under obligation with their carrier to pay contractual co-payments or deductibles to healthcare providers.

Federal and state healthcare programs such as Medicare and Medicaid as well as third-party carriers prohibit the waiver of co-payments and deductibles for services rendered. Under federal law this practice violates the anti-kickback legislation. Specifically, a physician is (1) treating one class of patients differently than another, or (2) may be obtaining referrals in exchange for the waiver.

Exceptions

1. An exception to this policy may be made if it has been established under the state poverty regulations that the patient is indigent or undergoing financial hardship.

Procedure

1. The co-payment or deductible will not be waived when services are rendered.
2. Patients must receive three billing statements.
3. All attempts should be made to secure payment for the claim.
4. The financial status of indigent patients or patients under financial hardship must be documented in the billing records as the reason for the adjustment.
5. The Practice Administrator will approve the adjustment prior to its posting into the billing system.
6. Adjustments will be made using an adjustment code with the descriptor Indigent or Hardship.

(PRACTICE NAME)

Category: Billing Office **Policy #** _____

Title: Credit Balances

Origination Date:_____ **Review Date:**_____

_____ _____

Authorized Signature **Authorized Signature**

Policy

Overpayments on patient accounts will be routinely investigated and refunds issued expeditiously when warranted.

Purpose

Occasionally Medicare, Medicaid, third-party payers, or patients make a duplicate payment on accounts resulting in an overpayment. Additionally, requests for refunds may be made by the carriers or patients regarding the overpayment to the account.

Procedures

1. All credit balance accounts will be investigated no less than every 45 to 60 days.

2. If it is determined that an overpayment has been made to the account, a refund request form will be completed and submitted to the Administrator for approval. The refund request will have attached an itemized account statement and related Explanation of Benefits.

3. Requests for refunds will require the Administrator's or Assistant Administrator's approval prior to debiting the patient's account.

4. The refund will be posted to the patient's account after the refund check is issued.

(PRACTICE NAME)

Category: Billing Office **Policy #** _____

Title: Medicare Advance Beneficiary Notice

Origination Date:_____ **Review Date:**_____

_____ _____

Authorized Signature **Authorized Signature**

Policy

Medicare patients will sign and date an Advance Beneficiary Notice (ABN) each time a service is rendered that the carrier may deny because CMS has determined that it is contractually a non-covered service. The ABN must specifically identify each procedure in writing.

Purpose

There are services that a physician may need to perform on a Medicare patient that either are not covered or are deemed medically unnecessary by the carrier. When this occurs, patients must be informed by the physician in advance of the specific services that will not be covered under Medicare. The patient must sign an Advance Beneficiary Notice (ABN) for each occurrence. The service is billed to Medicare with a "GA" modifier. The physician can then bill the patient for these services once a denial has been received from Medicare.

Procedure

1. The patient must sign and date in advance an ABN for each service that Medicare may deny as not covered or medically unnecessary.

2. The procedure code for the service should be submitted to Medicare with a "GA" modifier.

3. Once the provider has received the Medicare denial, the provider can bill the patient.

(Practice Name)

Compliance Forms

(PRACTICE NAME)

BILLING EMPLOYMENT APPLICANT QUESTIONNAIRE

Applicant Name:_____ Social Security Number_____

Have you ever been convicted of a felony or misdemeanor?

- ❑ No
- ❑ Yes. If Yes, please explain below.

_____

_____

_____

Have you ever been excluded, debarred from, suspended, or sanctioned by the Medicaid or Medicare program or any other federally funded healthcare program?

- ❑ No
- ❑ Yes. If yes, please explain below.

_____

_____

_____

List any ownership in a healthcare or health-related business that you or a family member has. Include any Medicare or Medicaid provider numbers for each.

_____

_____

_____

Have any entities that you have ownership in been excluded, suspended, or debarred from or otherwise sanctioned by Medicare, Medicaid, or any other federally funded healthcare program?

- ❑ No
- ❑ Yes

(PRACTICE NAME)

PROVIDER EMPLOYMENT APPLICANT QUESTIONNAIRE

Applicant Name:_____ Social Security Number_____

Certification/Specialty_____

UPIN Number_____

(Attach Curriculum Vitae)

Have you ever had your license suspended or revoked?

- ❑ No
- ❑ Yes. Please attach a summary of the reasons underlying this action.

Have you ever been convicted of a healthcare related felony or misdemeanor?

- ❑ No
- ❑ Yes. If so, please attach an explanation.

Have you ever been excluded, suspended, or debarred from the Medicare or Medicaid program, or any other federally funded healthcare program?

- ❑ No
- ❑ Yes. If so, please attach an explanation.

List any ownership in a healthcare or related business in which you or a family member has direct or indirect ownership. Include the Medicare or Medicaid provider numbers for each.

_____

_____

_____

Have any healthcare entities that you have ownership in been excluded, suspended or debarred from Medicare, Medicaid, or any other federally funded healthcare program?

- ❑ No
- ❑ Yes

Have you ever defaulted on a Health Education Assistance Loan?

- ❑ No
- ❑ Yes. If so, please attach an explanation.

(PRACTICE NAME)

SUSPECTED VIOLATION REPORT

It is optional to provide the following information:

Name:_____ Position _____

Please describe the suspected violation: _____

_____

_____

_____

Name of person(s) involved:_____

Time period that this suspected violation occurred:_____

What evidence do you have to prove the above allegations:_____

_____

_____

Have you discussed the suspected violations with anyone else?

- ❑ Yes. If so, who_____
- ❑ No

Would you be willing to confidentially discuss the suspected violation with:

- ❑ The Compliance Officer
- ❑ The Compliance Committee
- ❑ Corporate Attorney
- ❑ Other _____

(PRACTICE NAME)

INCIDENT REPORT

This report is to be completed by the Compliance Officer.

Suspected violation report date:_____ Reported by_____

Description of suspected violation:_____

_____

_____

_____

_____

_____

_____

_____

Action Taken:_____

_____

_____

_____

_____

_____

Date of Discussion with Reporting Employee:_____

Date Incident Report Closed:_____ Date Discussed by Compliance Committee _____

_____ _____

Compliance Officer Chairman of Compliance Committee

(PRACTICE NAME)

EMPLOYEE EXIT INTERVIEW

Employee Name _____ Position_____

Date of Hire _____ Date of Termination _____

Reason for Leaving _____

_____

An exit interview is an opportunity for you to express your thoughts and opinions about the Practice. This feedback may be used for future improvements. It is very important that you provide your honest feedback.

Please check the response that closely matches your feeling on the following:

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
Your Job				
Job orientation and training				
Recognition for your work				
Workload				
Opportunity to do interesting/challenging work				
Opportunity to learn new skill or job duties				
Personnel				
Your Administrator's effectiveness				
Your Administrators willingness to discuss problems				
Friendliness of co-workers				
Cooperation of co-workers				
Physicians' treatment of staff				
Communication, Policies & Procedures				
Information received on Practice policies				
Communication between departments				
Communication from management				
Opportunity to share your ideas				
Proper tools to do the job				
Working Conditions and Benefits				
Physical work environment				
Salary				
Benefits				

What would you change about your job if you could? _____

_____

_____

What did you enjoy the most about your job? _____

_____

_____

What would you change about the Practice if you could? _____

_____

_____

_____

The following questions relate to the Corporate Compliance Program of (Practice Name). Please respond to the following:

	Yes	**No**
Did you ever witness any conduct in the Practice that would be characterized as unethical or illegal?		
Were you ever asked to engage in conduct that you believed either unethical or illegal?		
Have you ever heard rumors or reports about the Practice of unethical or illegal conduct that you considered credible?		
Were any company documents, including those that may have been created by you, removed from the Practice and not returned by you?		
Have you given any company documents to persons not employed by the Practice?		
Have you witnessed or do you have knowledge of any employee giving company documents to persons not employed by the Practice?		
Have you been interviewed by a government investigator, agent, or attorney or asked to interview about possible unethical or illegal conduct relating to the Practice?		
While employed at the Practice, did you or any family member own, operate, invest in, assist, or otherwise have interest in any company or enterprise, which competes with or does business in the healthcare industry?		

_____ _____

Employee Signature Date

_____ _____

Interviewer or Practice Administrator Signature Date

Tool 19-B: Sample Periodic Audits

Example 1

(Practice Name)
August 20XX Quarterly Review

Name of Provider:
Name of Auditor:
Date of Audit: August 19, 20XX

The quarterly review of ten medical records on August 19, 20XX, revealed nine CPT errors and six ICD-9 errors, compared to the May 20, 20XX review with three CPT errors and one ICD-9 error. In May the CPT error rate was 13.6% and in this review the CPT error rate was 40.9%.

The recommendations for _____ are:

- Consultations must have a letter to the requesting physician giving the provider's opinion, advice, and/or plan for this patient. The progress note does not contain all the criteria of documented request, documented opinion and advice, and a written report within a short period of time back to the requesting physician. The letter needs to contain a brief summary of the visit and the findings.

- New patient and consultations at a level four require a comprehensive history of present illness, a comprehensive physical examination, and moderate medical decision making. Both the 1997 and 1995 guidelines were used in evaluating the physical examination. Physical exam documentation is a requirement for new and established patient visits unless counseling is the bulk of the visit and time is used.

- Diagnoses should be consistently recorded. It is not necessary to have all of the diagnoses from the medical record on the CMS 1500. The diagnoses should be listed if they were treated or affected the treatment of care for that day. It is not appropriate to enter a diagnosis on the CMS 1500 that is not documented in the corresponding progress note.

- Missing documentation accounted for several of the errors. Urinalysis documentation was not found in three of the cases reviewed and one progress note was missing.

Summary of medical record review

MR 1.

(Patient Name) visit was coded as 99243. For consultation visits, there must be a letter back to the requesting physician. The documentation met level 99203. The urinalysis code and the cystoscopy were coded correctly.

MR 2.

(Patient Name) visit was coded as a level four consultation (99244). This was coded correctly but the urinalysis documentation was missing. The 1995 guidelines were used to meet the level billed.

MR 3.

(Patient Name) visit was coded as a 99245 (level five consultation). This code requires high medical decision making. The correct code is 99244. The urinalysis documentation was missing. PVR documentation was found but not billed.

MR 4.

(Patient Name) visit was coded as 99213, level three established patient visit. The documentation met this level.

MR 5.

(Patient Name) visit was billed correctly.

MR 6.

(Patient Name) visit was coded as a level two new patient. No exam documentation was found which is one of the three key components for new patient visits. The correct code is 99499, unlisted E/M code. The urinalysis was correctly coded. LLQ pain and hematuria were documented in the progress note; however, ureteral calculus was billed. The documentation did state "probable uric acid stone" but this signs and symptoms should be coded until the diagnosis has been confirmed.

MR 7.

(Patient Name) visit was coded correctly.

MR 8.

(Patient Name) progress note and urinalysis documentation were not found for the date of service reviewed.

MR 9.

(Patient Name) visit was coded as a 99204. The 1995 guidelines were used to meet this level. Incomplete emptying was documented in the progress note but was not billed.

MR 10.

(Patient Name) visit was coded as a 99243 (level three consultation). No consultation letter to the requesting physician was found. A level three consultation visit requires a detailed history. The correct code is 99202.

Example 2

(Practice Name)
August 20XX Quarterly Review

Name of Provider:
Name of Auditor:
Date of Audit: **August 19, 20XX**

The quarterly review of ten medical records on August 19, 20XX, revealed six CPT errors and eight ICD-9 errors, compared to the May 20, 20XX review with six CPT errors and two ICD-9 errors. In May the CPT error rate was 40% and in this review the CPT error rate was 22.2%.

The recommendations for Dr. _____ are:

- Make sure that a clear chief complaint is documented.

- Documentation of history and exam did not meet the level billed in three of the cases reviewed. We recommend that the documentation guidelines be reviewed. We did use the 1995 guidelines to meet the levels in some of the cases.

- Make sure that your consult letters reflect your opinion, which is a requirement for consultations. Try to avoid words such as "refer." Medicare may interpret this as a referral (transfer of care) instead of a consult.

- Diagnoses should be consistently recorded. It is not necessary to have all of the diagnoses from the medical record on the CMS 1500. The diagnoses should be listed if they were treated or affected the treatment of care for that day. It is not appropriate to enter a diagnosis on the CMS 1500 that is not documented in the corresponding progress note.

- When documenting family history and social history, using the phrase "non-contributory" would be better than "none."

Summary of medical record review

MR 1.

(Patient Name) visit was coded correctly as a 99203, level three new patient visit. Urinary retention was documented but not billed.

MR 2.

(Patient Name) visit was coded as 99212; however, the documentation supported a 99213. Urge incontinence was documented in the progress note and listed on the fee ticket but was not on the CMS 1500 claim form.

MR 3.

(Patient Name) visit was correctly coded as a 99203, level three new patient visit using the 1995 documentation guidelines.

MR 4.

(Patient Name) visit (6/4/03) was coded as a 99244. Level four consultations require a comprehensive history and exam. There was not any documentation of the kidney cyst, hematuria or BPH, creating a medical necessity problem. What was the reason for the bladder scan?

MR 5.

(Patient Name) visit (7/2/03) was coded as a 99213(level three established patient visit) but the documentation only supported a 99212.

MR 6.

(Patient Name) visit was coded as a level two new patient visit, 99202; however, the documentation supported a 99201. G0002 is a deleted coded and should not be used. BPH was not documented.

MR 7.

(Patient Name) visit was correctly coded as a 99214 using the 1995 documentation guidelines. There needs to be a clear separate report for each test that is billed.

MR 8.

(Patient Name) visit was correctly coded as a level two consult.

MR 9.

(Patient Name) visit was coded as a 99243; however, the physical exam only supported a 99242. Mixed incontinence was documented.

MR10.

(Patient Name) visit was coded correctly as a 99201. The correct diagnosis code should have been V25.09 (Contraceptive management – family planning advice). The patient was not actually being admitted for the sterilization that day.

Example 3

(Practice Name)
August 20XX Quarterly Review

Name of Provider:
Name of Auditor:
Date of Audit: **August 19, 20XX**

The quarterly review of ten medical records on August 19, 20XX, revealed six CPT errors and three ICD-9 errors for a CPT error rate of 34.8%. The error rate in the May 20, 20XX review was 45.5%. The errors were related to not enough physical examination for the level coded.

The recommendations for Dr. _____ are:

- Documentation of history and exam did not meet the level billed in three of the cases reviewed. We recommend that the documentation guidelines be reviewed.
- Missing documentation accounted for three of the errors.
- Diagnoses should be consistently recorded in the assessment.

Summary of medical record review

MR 1.

(Patient Name) visit was coded as a 99202, level two new patient visit; however the history and physical exam documentation only supported a 99201. The transcriptionist left blank spaces and the physician had not filled them in.

MR 2.

(Patient Name) visit was coded as 99203, level three new patient visit. This patient was seen by Dr. _____ on 12-26-XV and should have been coded as an established patient visit. The correct code is 99213.

MR 3.

(Patient Name) visit was correctly coded as 99213 (level three established patient visit). There was no urinalysis or cystoscopy documentation found.

MR 4.

(Patient Name) visit was correctly coded as a level three consultation. BPH was not documented. The balanitis diagnoses should have been coded. All diagnoses that are treated or affect the treatment for that date of service should be coded.

MR 5.

(Patient Name) visit was coded as a 99242 (level two consultation visit) but the correct code is 99213. The fee ticket was marked correctly as an established patient visit but it was billed as a consult. Ureteral calculus documentation not found.

MR 6.

(Patient Name) documentation was not found for this date of service.

MR 7.

(Patient Name) visit was correctly coded as a 99213.

MR 8.

(Patient Name) visit was coded correctly as a 99213. Elevated PSA was documented and should have been billed as an additional diagnosis.

MR 9.

(Patient Name) visit was coded as a 99203, level three new patient visit, but the documentation supported a 99202. A detailed history and exam are required for a 99203.

MR 10.

(Patient Name) visit was coded as a 99202 but the documentation supported a 99201. An expanded problem focused exam was not documented.

Example 4

(Practice Name)
August 20XX Quarterly Review

Name of Provider:
Name of Auditor:
Date of Audit: **August 19, 20XX**

The quarterly review of ten medical records on August 19, 20XX, revealed six CPT errors and two ICD-9 errors for a CPT error rate of 31.8%. The error rate in the May 20, 20XX review was 22.2%.

The recommendations for Dr. _____ are:

- Diagnoses should be consistently recorded in the assessment with the progress note and with procedure documentation.

- Consultations must have a letter to the requesting physician giving the provider's opinion, advice, and/or plan for this patient. The progress note does not contain all the criteria of documented request, documented opinion and advice, and a written report within a short period of time back to the requesting physician. The letter needs to contain a brief summary of the visit and the findings.

- The physician should sign the nurses' sheet so that the information may be included in the review.

Summary of medical record review

MR 1.

(Patient Name) visit was coded as 99202 (level two established patient visit). An expanded problem focused exam is required but no exam documentation was found. The correct code is 99499, an unlisted evaluation and management code. The diagnoses need to be listed in an assessment or impression at the end of the note. Physicians should sign the nurses' sheet because when signed, any information that is included on that sheet can be counted in the audit.

MR 2.

(Patient Name) visit was correctly coded 99204 (level four new patient visit). The 1995 documentation guidelines were used to meet this level.

MR 3.

(Patient Name) visit was correctly coded as a 99203. Coronary atherosclerosis of native coronary artery, 414.01, was not addressed or treated.

MR 4.

(Patient Name) visit was coded correctly as a 99242.

MR 5.

(Patient Name) visit was coded as 99214, level four established patient visit. The documentation supported a 99213. Comprehensive history and exam are required for a level four new patient or consult visit.

MR 6.

(Patient Name) visit was coded as 99243 (consultation) but the documentation met a 99203 (new patient visit) because there was not a letter back to the requesting physician. The documentation stated that the patient was not aware of having any stress incontinence but it was billed.

MR 7.

(Patient Name) visit was coded as 99244 (consultation) but the documentation met a 99204 (new patient visit) because there was not a letter back to the requesting physician.

MR 8.

(Patient Name) visit was correctly coded.

MR 9.

(Patient Name) visit was coded correctly.

MR 10.

(Patient Name) visit was coded correctly as a 99214 but the urinalysis documentation was missing. The 1995 guidelines were used to meet the level billed.

Tool 22-A: Sample Strategic Planning Physician Questionnaire

I. GENERAL

What is the philosophy or mission that guides this collection of physicians?

What is your individual philosophy or mission?

Do you favor continued growth in the number of physicians in the group? Explain.

As a group, are we too:	Always	Sometimes	Seldom	Never
1. Rigid				
2. Inconsistent				
3. Flexible				
4. Democratic				
5. Autocratic				
6. Procrastinating				
7. Slow to Decide				
8. Generous				

Please circle your level of group commitment.	Extremely Committed	Very Committed	Committed	Indifferent	Not Committed
Please circle the group's overall commitment to each other.	Extremely Committed	Very Committed	Committed	Indifferent	Not Committed

II. PRACTICE-ORIENTED

How do you obtain your patients?

Who are your major referral sources?

Why do patients come to your practice?

What are the strengths of the practice?

What are the weaknesses of the practice?

What is the group's status within the [City, State] medical community?

III. THE MEDICAL MARKET

Who is your competition for patients?

What makes your group unique and different from other area physicians?

What opportunities are available in the market place for [Practice name]?

What is your target market for patients?

How do you feel about managed care?

To date, how has managed care affected your group?

In the future, how will managed care affect your group?

Do you feel threatened? Explain.

How do you think [Practice name] should align itself in the market place?

Should [Practice name] align with a partner to win managed care contracts? Explain.

Do you have a preference for a partner? If yes, who and why?

Do you need statewide coverage for your services?

How would you rank the following options?*

Remain Free Standing	Sell to a Hospital	Join a Multi-Specialty Group	Form a Large Single Specialty Group	Form a Statewide Network	Sell to a Practice Management Company	Contract with a Management Services Organization

*Note: Designate a number (from 1 to 7) in order of preference, 1 being the preferred and 7 being the least preferred.

IV. BUSINESS OPERATIONS

What are the business goals of the practice?

How often are the business goals discussed?

How are business decisions made in the practice?

Do you feel that emotions play a large role in decision-making? If yes, explain.

What are some of the group's business strategies?

Are you adequately staffed for the new challenges of managed care? Explain.

Does the group invest sufficient capital, time, etc., to succeed with managed care?

What role do you play in administration?

Tool 23-A

REQUEST FOR PROPOSAL

This form may be used to gather information for determining a healthcare practice's hardware and software needs. Following is another form that may be used for physician start up projects to obtain bids from computer companies that also reflects criteria in the first form.

COMPANY INFORMATION

I. Please provide the following information:
- A list of references.
- A copy of the company's hardware and software support agreement
- A copy of the company's software license agreement
- The location of software and hardware support
- The guaranteed response time and alternatives to downtime
- Information regarding the users group:
  -Chairperson name and telephone number
  -Operations/Meetings

I. Please answer the following questions:
- Who initiates program modifications and enhancements?
- Do you make custom program modifications? If yes, what is the procedure for handling program modifications?
- Is there a software maintenance agreement?
- Is there a software enhancement agreement?
- How is installation conducted?
  -Is the running of cables included in installation?
- How is training conducted?
  -Number of hours
  -Location of training
  -Structure of training
- Do you have an implementation plan for each installation?
- How long has your company been in business?
- Who is your oldest customer using this system?
- How many customers do you have:
  -In _____?
  -Nationally?
- Is the source code available? Ownership or escrow?
- Describe the expansion capabilities of your system?
  -Does the software provide for upward migration into larger hardware?
- Please provide samples of the standard daily and monthly reports provided by your system. Please reference reports to specific questions in this document.

GENERAL INFORMATION

- Are user manuals provided? How often are they updated?
- Please list all application programs and how they integrate.
- How do you provide support for user problems and questions for software? For hardware?

HARDWARE AND SYSTEM ARCHITECTURE

I. Please provide a description of the hardware proposed for this installation, covering all items listed below.

- CPU
  Speed
  RAM - Initial
  Upgradeable to _____
  Manufacturer
  Architecture
  Users supported – Initial
  Upgradeable to_____
- Disk Capacity - Initial
  Upgradeable to_____
- Monitors or Terminals
  Color or Monochrome
  Graphics
  RAM
  Multiple Sessions
  Keyboard
- Printers
  Line or Dot Matrix
  Laser
  Bar Codes
  Graphics
  Speed
  RAM
- Backup Device (daily & archival)

- Communications
  Modems
  Software
  MAN (Metropolitan Area network)
  WAN (Wide Area Network)
- Other Optional Peripherals (Barcode Readers, Optical Scanners)

II. Hardware Operating System

III. Programming Languages Supported

SOFTWARE APPLICATIONS REVIEW

I. Patient Registration

- Does the system have the ability to integrate with hospital demographics and edit data prior to posting or updating practice records?
- Can patient demographics be transferred between multiple practices or locations on the system while maintaining security of financial data?
- Can the system search for patient by:
  -Name
  -Social Security Number
  -Date of Birth
  -Insurance Certificate Number
  -Responsible party
  -Others
  Does the search screen provide for further identification by date of birth, address, or other identifiers?
- Can the system assign alpha-numeric account numbers automatically? Maximum length? Can the user override?
- Can patient accounts be assigned to a class or type that the user defines? How many types are available?
- What information is captured at the patient registration screen?

I. Patient Scheduling

- Does the system have a scheduling module?
- Does the system handle a "temporary" patient information records for new patients until the patient comes for the appointment?
- Does the system schedule by:
  -Provider?

-Room or equipment?
-Location

- How far in advance can the user schedule?
- Can the system accommodate scheduling a provider and another resource (i.e. procedure room, treadmill room, etc.) Concurrently? Consecutively?
- Does the system allow for "work-ins" or overbooking? How?
- Does the user define the schedule for each provider? How?
- Can the scheduler accommodate changes in provider schedules from week to week? (e.g. provider schedules patients on Monday, Tuesday and Friday this week but Monday, Wednesday and Thursday for the next week)
- Can the scheduler be used to allow time for meetings or other planned activities (e.g. meetings at the hospital)?
- What type of on-screen viewing of schedules is available?
  -Week-at-a-glance?
  -Month-at-a-glance?
  -Day by day?
- Does the system print the following based on scheduled patients:
  Encounter forms:
  -What information is printed on the form?
  -Can user print encounter forms if not using appointment scheduling module?
  Alpha or numeric chart pull list:
  -Credit manager's report
  -Schedules by provider, room or equipment?
  -Cancellation list?
- What type of on-screen patient type and financial information is provided at the appointment scheduling screen?
- Does the system track encounter forms?
  Prints a missing encounter form report?
  -Is this a perpetual report or daily with file reset each day?
- Does the scheduler have recall capabilities?
  -Automatic recall?
  -Recall notices?
  -Recall reports?
- What is the recall criteria? Last visit date? Date of last procedure specified by user (i.e., pap smear, immunization)? Date of birth?
- Does the scheduler locate available appointments by:
  -Date?
  -Range of date?
  -Weeks prospective?
  -Time slot and/or day of the week?
  -Type of appointment?
  -First available?

I. Patient Billing and Statement Preparation

- Does the system allow for "family billing"? If yes, explain how this feature functions.
- Can guarantor on patient account differ from subscriber on insurance for patient?
- What type of patient statement formats are available?
- In addition to dunning messages can user enter a standard comment such as "Holiday Greetings" that will appear on all statements?
- Are statements printed for all balances or patient due only? Does statement separate amounts due from patient from amounts due from insurance? Does the statement group the payments and adjustments for each visit/charge with the open item?
- Is the billing cycle defined by the user? Explain.
  - -Can the user produce statements daily or weekly? How?
  - -Can the user produce "demand" statements?
  - -Is a "walk-out" receipt or statement available?
- Can the user determine which patients receive statements based on:
  - -Account balance age?
  - -Activity within a date range?
  - -Financial class or patient type?
  - -Amount of account balance?
  - -List others
- What sort options are available for statement printing?
- What controls are in the system to ensure that all patients receive a statement?
- Is account age based on bill date, service date or posting date?
- Does the system provide an automated in-house collection capability? Custom collection letters? Custom delinquent notices? Can system track results by collector? Please describe.
- Can the user opt accounts out of the automatic system?
- Can system track results by collector?
- Can promises to pay be tracked or budget payments established?
- Can the user define dunning messages for statements for various age categories?
- What types of reports are available to assist with in-house collection efforts? Please provide samples.
  - -What parameters can the user select in generating the report(s)?
  - -Does it have the ability to sort for printing by age of outstanding balance? By amount of outstanding balance?
  - -Does it maintain prior collection notes from previous attempts to collect?
  - -How are accounts submitted to outside collector's handled?

I. Insurance Billing and Processing

- Does the system handle electronic claims transmission?
  -Direct to carrier? For which carriers? Asynch or Bisynch? Is national standard format used?
  -To clearinghouse? Which one? What fees?
- Explain how the system performs the electronic claims transmission.
  -Downloaded to a PC?
  -Direct transmit from system CPU?
  -What communications protocol?
  -National standard format?
- What edit reports print prior to transmission?
- What reports print to identify claims billed electronically?
- When are insurance claims generated after posting charges?
  -Can the user define when forms are printed or transmitted and to which carriers?
  -Does the system automatically generate the claim or does the operator tell the system to file the claim?
- Can specifications or claims for a specific carrier be put "on-hold" or "pended" to delay printing or transmission?
- Can the user print "demand" or "instant" forms?
- Can claims be put "on hold" or "pended" to delay transmission or printing?
- Will the system print mailing labels for carriers?
- Can the user define the qualifiers for submission or printing?
  -Bill date?
  -Service date?
  -Carrier?
  -Activity within a date range?
  -Range of accounts or patients?
  -Others?
- Can the system accommodate different types of insurance form formats such as UB-92?
- Does the system have the ability to bill worker's compensation claims?
- How is accident information captured?
- Are claims automatically (without operator intervention) transferred to secondary and tertiary carriers after payments are posted? Can operator intervene?
- Can accept assignment change from one procedure to another on the same patient, same date of service?
- Can the system automatically default to bill the primary carrier on the patient record at the time of charge entry?
  -Can the user override at charge entry and assign another carrier or patient responsibility on a procedure by procedure basis?
- Will the system print forms for both assigned and non-assigned

claims?
- Does the system provide for an edit check for incorrect or missing data prior to claims transmission or printing forms?
- Does the system automatically rebill outstanding claims after a user specified number of days? Can user manual request a refile for a claim?
- Does the system provide a report of outstanding claims by carrier by age? Please provide a copy.
  -Can the user define the qualifiers for the report by carrier, age or other qualifiers?
- Is claim age based on date billed, service date or posting date?
- What sort options are available for insurance form printing?
- Can responsibility for assigned claims automatically convert to private pay by payer based on user defined number of days?

I. Payment Processing
- Can payments be entered by:
  -Batch?
  -At charge entry - time of service?
  -By patient?
- Is payment entry "on-line" (e.g. reflected immediately in patient account balance and on any inquiry screens)
- Can payments be applied by:
  -Procedure?
  -Claim?
  -Encounter?
  -Oldest balance first?
  -Equity posting split between providers?
  -Charges for the current day first?
  -Responsible party?
- Can payments be reversed or edited by the operator? What is the audit trail?
- Will the system allow an "overpayment" on transactions? Can payments be posted as "unapplied"?
- How are refunds processed? What reports identify credit balances? Can system generate refund check?
- Will system automatically calculate payment amount and/or contractual adjustments? How?
  -Can the user override adjustment or payment amount?
  -Does the user define which carriers need automatic contractual adjustments?
- Is responsibility for balance automatically transferred to secondary carrier or patient at payment entry?
  -Can the user override and specify transfer?
- Does the system have a method for comparing allowable amounts for

based on contract schedules against allowable amounts entered at payment entry to flag user for incorrect carrier payments? Explain.
- Are daily balancing reports available for each batch? Operator? Explain.
- What information is provided on day end balancing reports? Please provide sample.
- Can the system accommodate electronic remittance? For which carriers?
  -Explain how payments and adjustments are credited to accounts through electronic remittances?

VI. Charge Processing
- Can charges be entered:
  -By batch?
  -By patient?
- Are charges entered "on-line" (e.g. reflected immediately in patient account balance and on any inquiry screens)
- What data is captured at the time of charge entry?
  -Procedure code and fee?
  -Provider?
  -Referral source? By procedure?
  -Encounter form number?
  -Service location?
  -Dates of service?
  -Assignment?
  -Accident information?
  -Worker's comp information?
  -Insurance carrier?
  -Diagnosis - maximum number?
- Which of the above items default and which default items can be edited by the user at charge entry?
- Can the user add modifiers to CPT codes at charge entry? How many modifiers can be added? Can modifiers by alpha and numeric?
- Can operator enter "from-thru" dates for certain procedures? Does system calculate number of units based on "from-thru" dates?
- Can inpatient charges be entered without discharge date?
- Which of the above items default and which default items can be edited by the user at charge entry?
  -Can the user add modifiers to CPT codes at charge entry?
- Do daily balancing reports provide charge information by:
  -Provider?
  -Batch #?
  -Location of service?
  -Financial class or account type?
  -Payer type? Operator?

-Other

VII. Reports

- Does the system have accounts receivable aging reports?
  - -User defined aging categories?
  - -Aging by: provider, payer, financial class, location, practice?
  - -Can be run on demand at any time during the month?
  - -With patient detail?
  - -Summary version by payer type?
- Does the system monthly transaction reports for month-to-date and year-to-date information on charges, payments and adjustments by:
  - -Provider?
  - -Payer type?
  - -Other?
- Does the system provide charge and payment reporting by department or revenue center (i.e., lab, x-ray, etc.)? Can the user define these?
- Can system print custom reports for all data elements on the system? What data is available through custom report generator? Can user define selection criteria or screens?
- Does the system have a report for production in dollars and volume by procedure code by provider for month-to-date and year-to-date?
- Does the system have a report for month-to-date and year-to-date charges by diagnosis code?
- Does the system have a referral source report?
  - -By procedure?
  - -By dollars?
- Are month-end reports run under a job control or is each report individually requested?
- Does the system provide an analysis of cost per service?
- Can the system generate mailing labels? Can user define criteria for selection and data to print or format?
- Please provide sample copies of reports.

VII. Transaction Processing

- Does the system allow inquiry by transaction on patient account with detail on payment and adjustment activity on each transaction?
- How long does the system maintain transaction detail?
- Does the system allow open item accounting?
- Will the system allow an "overpayment" on transactions? How are these reported on month end reports?
- Does the user have the ability to enter free form notes on patient accounts? How many lines or pages of notes are available?
- Does the system allow multiple users to enter charges, payments, and adjustments on the same account concurrently?

- Do all transactions contain an operator ID and/or a batch ID?
- Provide detailed information on how batches are controlled (e.g., hash totals, etc.).
- Can the user enter multiple transactions (payments, charges or adjustments) on a patient without re-entering the patient screen?
- Can data entry errors be corrected by the user without reflecting on the patient statement? What is the audit trail?
- What type of audit or edit report provides control for deleted transactions?
- Can transactions for the next month be posted prior to closing the previous month? (e.g. Can the system run two months concurrently?)

VII. Master Files

- Does the system allow for multiple fee schedules?
  - -Maximum number of schedules allowed?
  - -By insurance carrier?
  - -By provider?
  - -By patient class?
  - -Other?
- Does the system allow for:
  - -Internal codes for procedures?
  - -Exploding or bundled codes?
  - -Alternative codes by payer type?
- Can user define:
  - -Service locations?
  - -Departments or revenue centers?
- Are diagnosis codes defined by the user?
- Are payment and adjustment codes defined by the user?
  - -Maximum number?
- Can payer classes be defined which will automatically convert to self pay upon payment of insurance company or a specified period of time?
- Can all data on the system be accessed through a custom report writer?

VII. System Structure

- Please describe available security on the system.
- Can an account be held between functions:
  - -To look-up or search for a code?
    - -For any type of other transaction?
    - -To handle another patient?
- Can reports print to a spooler or a print queue? Can the user determine the output device for printing reports?
- Is on-line help available? Please describe.
- Can code tables (utility files) be modified "on-the-fly" during

transaction entry? Can operator search for codes at data entry screens for patient registration, payment or charge entry?

- Does the system integrate with:
  - -Accounting programs?
  - -Word Processing?
  - -Desktop publishing?
  - -Voice recognition software for transcription?
- Does the software have e-mail capabilities?
- Can system files be accessed via modem from laptop or Palm Pilot?
- Does user define accounts for purging based on what parameters?
  - -Purge to disk or paper?
  - -Are purged files accessible on screen?
- What type of help screens are available? Can user "window" help at a task or field and return to task without interruption?
- Does system back-up require operator attendance? Can "end-of" processes be run without operator attendance?

XII. Managed Care

- Can the system track information by plan (e.g., co-pay amounts or payment ceilings)?
- How does the system monitor patient eligibility in the plan? Are effective dates and termination dates tracked? Are patient stop loss amounts tracked? Is the primary care "gatekeeper" physician information tracked?
- How does the system track referrals? How are authorizations for referral handled? Referrals in and referrals out?
- What management reports are available to track profitability of plans and analysis of referral patterns? Do reports compare capitated revenue to fee for service production?
- How does the system handle capitation? Please describe the transaction detail.

XII. Medical Records

- Does system use "templates"? User defined?
- What is method of data entry? (keyboard, voice, optical scan, pen based)
- Is it integrated with the A/R system?
- Will it produce recalls for follow-up visits?
- Can it interface with laboratory systems? Interface to download reports/results from outside diagnostic test suppliers?
- Can it print and track prescriptions? Is a drug interaction database available?
- What reports are available for tracking treatment plans or outcomes analysis? Can the system track CPT codes by diagnosis (i.e., course of treatment by diagnosis)?

- Are outcomes tracked by patient? What information is provided?

XII. Electronic Remittance

- Available for which carriers?
- Can EDI system convert various carriers to standard format for system integration or are there specific programs for each carrier?
- Is remittance advice (RA) transmittal at user request or during insurance claim transmission?
- What operator data entry is necessary to post payments for electronic RA's?
- Are electronic RA payments identified separately on account inquiry screens?
- How are duplicate payments handled?
- How are denials/rejects handled?
- What reports print for electronic RA's and payments applied?

IDENTIFICATION OF NEEDS

I. Background

- _____ Practice
- Doctors in practice: Current - 1, Max - unknown
- Number of locations: ___

II. Practice Size Information

- Practice(s) currently performs: ____ procedures per day
- Average number of transactions per patient: ____
- Anticipated growth: Expect physicians within __ months
- Months of patient history to retain: __ months (options: offsite purge, index, others?)
- Number of Insurance carriers: will exceed ____
- Number of procedures annually: >__
- Number of Diagnoses: Maximum
- Number of referring physicians: > ___
- Number of insurance claims: ___ per month
- Average number of outstanding accounts: ___

Sample Request for Proposal—Software Vendor

		Yes	No
1.	Does the software meet the specific billing needs of my specialty? *Note:* Obtain specialty specific references from the vendor.		
2.	Will the new system allow for data transfer from the existing system (demographic information and patient balances)? *Note:* When considering a vendor, not only do the patient demographics and account balances need to be pulled over, but in most physician practices, the schedule may extend as far out as a year. Extreme problems can arise when there are two schedules existing on two different systems. In addition, more than likely the practice will not keep their support, so it is best to transfer this information as well.		
3.	Does the system provide the necessary management reports? *Note:* Obtain samples of all practice management reports available with the system and compare to the practice specific list of reports desired.		

4.	Does the system provide for batch entry?		
5.	Do the menus and screens provide for efficient input and inquiry?		
6.	Are the commands too complex?		
7.	How, when, and where is training provided?		
8.	How is support handled and billed?		
9.	Does the system accommodate electronic filing of claims and electronic remittance posting?		
10.	Does the system have a managed care module that would allow for the loading of managed care fee schedules in order to determine appropriate reimbursement?		
11.	Does the system allow for multiple adjustment codes so that adjustments can be appropriately categorized and summarized?		
12.	Are collection modules adequate to assist the practice in efficient collection and follow-up activities? *Note:* Problems often arise when using automated collection modules. The practice needs to be informed on how an account is reflected in the accounts receivable when an item is resubmitted. It if is reflected as current (parameter set by billing date and not DOS), this can understate old accounts receivable and limit the collection module's efficiency. Also, be sure to get a response time for support calls. This is something you will also need to confirm with references. Response time can be as little as the same day and as long as two to three weeks. This can have a huge impact on collections.		
13.	Does the registration module provide information regarding referral requirements for managed care and co-payments?		
14.	Is the system HIPAA compliant? *Note:* The system must be HIPPA compliant. There are several companies out there right now that are racing to become HIPAA compliant, but still have not achieved this status. It is recommended that in the process of having an onsite presentation, the vendor submit from that site an example claim to a HIPAA compliant payer for acceptance. Many times vendors will allow a 60 day free trial period for the staff to better evaluate the software. This is essential and time should be set aside for the staff to work with the software to pinpoint any items he or she may see improvement on.		
15.	Does the system allow for privacy and security compliance? *Note: The* system needs to provide appropriate safeguards to patient information. Meaning, each module of the system should be password protected. In addition, the practice should have the ability to determine		

	which modules each employee has access to. For instance, not all employees should have the ability to place credit adjustments on patient accounts. This should be a management level individual. This password should also have the ability to pinpoint in the system what individual posted what to which account. Passwords should be kept confidential, not on a sticky at the corner of the computer and the system should prompt for a change in password at least every 60 days.		

Tool 24-A: Sample Internal Control Questionnaire

GENERAL INFORMATION - BOARD OF DIRECTORS/PHYSICIAN OVERSIGHT

1. How often does the Board of Directors (the Board) meet and are minutes prepared to document these meetings?

2. Does the Board function in accordance with its articles of incorporation and bylaws where financial matters are concerned and is this documented by the minutes?

3. Has the Board appointed a committee or individual(s) to act on the Board's behalf to address routine financial matters and if so, is the committee or person's responsibilities and authority clearly defined by the Board?

4. Does the practice have an accounting procedures manual and if so, has it been reviewed and approved by the Board?

GENERAL INFORMATION - BOARD OF DIRECTORS/PHYSICIAN OVERSIGHT (CONTINUED)

5. Does the Board approve any of the following and if so is there an established dollar threshold and/or policy for approval if applicable (an example could be that the Board's policy is to review and approve all patient account write-offs or transfers to collection over $50)?

    a. New bank accounts or investment accounts?
    b. Signers on bank or investment accounts?
    c. Capital purchases?
    d. Other purchases?
    e. New vendors?
    f. Insurance policy renewals to include fidelity bonding for all employees?
    g. New customers (if significant, like a new HMO relationship or new MIM clients) **[OL: Ask AU to spell out MIM?]**
    h. Patient accounts receivable write-offs, adjustments, courtesy and charity discounts?
    i. Patient account transfers to inactive files/collection agencies?
    j. New fee schedules and any adjustments or updates to those fee schedules?
    k. New hires or terminations?
    l. New financial and administrative policy (or changes to old)?
    m. Corporate compliance policy?
    n. Other?

6. What financial information does the Board review at its meetings?

    a. Income statement?
    b. Balance sheet?
    c. Year-to-date budget to actual comparisons?
    d. Physician production reports?
    e. Account receivable aging reports?
    f. Collections percentage reports?
    g. Collection period reports?
    h. Profitability of managed care contracts?
    i. Other?

GENERAL INFORMATION - STAFFING

Who Performs The Following Functions?	**Person Responsible & Job Title**
1. Collects cash at the front desk	
2. Opens the mail	
3. Lists mail receipts	
4. Prepares the deposit	
5. Reconciles the deposit to the mail receipt listing	
6. Reconciles the deposit to receipts per the accounts receivable system	
7. Makes the deposit	
8. Enters charges into the accounts receivable system	
9. Enters payments into the accounts receivable system	
10. Enters account receivable adjustments and write-offs	
11. Produces and mails patient statements	
12. Processes patient refunds	
13. Prepares patient refund checks	
14. Signs patient refund checks	
15. Performs overall review of accounts receivable/revenue reports	
16. Approves purchases (supplies, equipment, vendor payments)	
17. Enters accounts payable into the accounts payable system	
18. Prepares accounts payable checks	
19. Signs accounts payable checks	
20. Approves new hires	
21. Approves employee time cards	
22. Approves pay rate changes	
23. Enters payroll payable into the payroll system	
24. Prepares payroll checks	
25. Signs payroll checks	
26. Maintains personnel payroll files	
27. Has access to the petty cash fund	
28. Reconciles the petty cash fund	
29. Reconciles the regular bank account	
30. Reconciles the payroll bank account	
31. Reviews financial statements and manages the general ledger	

COMPUTER CONTROLS - GENERAL:

Information Technology Department Staffing:

Personnel	Position Title	Job Description (Summary Only)

Computer Hardware:

1. Describe the make and model of the practice's main processing computer(s):

2. What type of input and output devices does the practice have and what controls/measures are built into the system to prevent unauthorized access to the company's data using these devices?

COMPUTER CONTROLS – GENERAL (CONTINUED):

Computer Hardware (Continued):

3. What type of data storage means and capabilities do you have and where are they located?

4. Describe your local area network(s) (LAN(s)):

5. How many microcomputers do you have? Which are standalone and which are part of the LAN?

COMPUTER CONTROLS – GENERAL (CONTINUED):

Organization Controls:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there an information technology procedures manual?					
2	Is the information technology department (or staff responsible) independent of all other departments and functions?					
3	Are information technology personnel prohibited from initiating or authorizing transactions or changing data files?					
4	Is there separation of duties between software programmers and users if applicable?					
5	Are the duties of information technology personnel rotated periodically?					
6	Are information technology personnel required to take annual vacations?					

Systems and Program Development Controls:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are there established procedures and is approval obtained for development of new systems and programs, as well as modifications of existing systems and programs?					
2	Have formal testing procedures been established to check the functioning of new programs and modifications of existing programs (including testing of modifications made by vendors to purchased software)?					
3	Are procedures in place to prevent unauthorized changes to programs?					

COMPUTER CONTROLS – GENERAL (CONTINUED):

Access Controls (Please Complete This For Each LAN That You Have):

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is one employee assigned the responsibility for information technology security?					
2	Are there adequate physical controls to ensure that access to computer facilities are restricted to authorized personnel?					
3	Is terminal access control software used to insure that access to terminals is limited to specified persons?					
4	Is terminal access control software used so that individuals have access only to those programs or files that are necessary to perform their duties?					
5	If passwords are used to control terminal access are procedures established to determine that those passwords are confidential and unique?					
6	If passwords are used to control terminal access are passwords changed at regular intervals?					
7	If passwords are used are passwords promptly canceled for terminated employees?					
8	Are there procedures to prevent unauthorized public access through dial-up (e.g., dial-back, user ID, and/or passwords)?					
9	If confidential or sensitive information is transmitted through public carrier networks (e.g., by leased line), are protection methods used to prevent or detect unauthorized access, either through carrier security methods or independent methods (e.g. encryption)?					
10	Are there appropriate controls over access to operator instruction manuals?					

COMPUTER CONTROLS – GENERAL (CONTINUED):

Operational Controls (Please Complete This For Each LAN That You Have):

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are schedules prepared and followed for the processing of all computer applications?					
2	Are operators required to report system failures, restart and recovery, or other unusual incidents, and are those reports reviewed by an appropriate official?					
3	Are operator instruction manuals available to each computer operator (electronic or paper)?					
4	Do the operator instruction manuals include the organization policies that relate to the use of the computer system?					
5	Are there procedures in place that monitor computer operator compliance with the computer operator's instruction manual?					
6	Are there appropriate procedures in place for back-up of programs and data files?					
7	Are there appropriate procedures for storage of programs and data files?					
8	Are periodic data and hardware security briefings provided?					
9	In circumstances when operators must initiate input of data, do procedures exist to allow the operators to determine whether the input is properly authorized?					
10	Are there appropriate security controls when outside third parties are permitted to sign on your network to transmit data to your network?					
11	Are there appropriate security controls when outside third parties are permitted to sign on to the network to receive or access data from your network?					
12	Is virus protection software installed on the network and is it the most current version available?					

COMPUTER CONTROLS – GENERAL (CONTINUED):

Disaster Recovery / Contingency Planning:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there a written disaster recovery plan for the practice?					
2	Is off-premises storage maintained for all master files and transaction files and are they sufficient to recreate these files?					
3	If off-premise storage maintained for all systems, programs, and related documentation?					
4	Have contingency plans been developed for alternative processing in the event of loss or interruption of the information technology function?					
5	If contingency plans have been developed, have they been tested for adequacy in the event of a disaster?					
6	Are copies of the back-up files for programs, master files, and transaction files periodically read or tested to determine that they are usable for back-up and to validate that the back-up procedures being used are adequate?					

COMPUTER CONTROLS - APPLICATIONS

Computer Applications (Software):

Application (Software)	N/A	Name & Version	Vendor	Unmodified Commercial?	In-House?	Password Protected?	Staff Who Have Access to Software/Data
Operating System							
Access Control							
Accounting Software:							
General Ledger							
Accounts Receivable							
Accounts Payable							
Payroll							
Fixed Assets							
Network							
Database Management							
Communications							
Utilities							
Virus Protection							
Other							

COMPUTER CONTROLS – APPLICATIONS (CONTINUED):

Software Application: _____ (Please Complete For Each Software Application Where Applicable)

Input Controls:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are there procedures such as the following for authorizing input data, including master file changes:					
	Stamping or initialing source documents to show proper approval?					
	Programmed edit checks of existing customer account numbers for input transactions?					
	Requirement of supervisory override for certain transactions (for example, writing off patient receivable balances of any kind)?					
	Restrictions to assure that only specified personnel can make master file changes such as adding or changing accounts?					
2	Are there procedures such as the following to assure the completeness and accuracy of input data at initial recording:					
	Use of standard input forms?					
	Use of check digits and existence checks of account numbers?					
	Use of standard menu screens?					
3	Are there procedures such as the following to assure the completeness and accuracy of the conversion of input data into machine-readable form:					
	Use of batch totals, record counts, or other user control totals?					
	Use of key verification of input transactions?					
4	Are the following procedures used to assure that errors or rejected data are properly reentered into the system:					
	Assignment of responsibility for the control over errors detected to an appropriate person or group?					
	Maintenance of a manual or automated report of those errors?					
	Periodic review of the error report by an appropriate individual and follow-up of old items?					

COMPUTER CONTROLS – APPLICATIONS (CONTINUED):

Software Application: _____ (Please Complete For Each Software Application Where Applicable)

Processing Controls:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are there procedures such as the following to assure the completeness and accuracy of processed data:					
	Programmed edit checks such as validity or sequence tests?					
	Incomplete data tests?					
	Limit or reasonableness tests (comparison of codes or account numbers against a master file or table)?					
	Alphabetic versus numeric tests?					
2	Are there procedures such as the following to assure that data files are kept current and data is not changed other than through normal processing routines:					
	Reconciliation by the computer of item counts with independent control totals?					
	Production of exception reports for review by appropriate officials?					
3	Are there procedures such as the following to prevent processing incorrect files, detect errors in file maintenance, and highlight operator errors:					
	Program verification of file identification, dates, and version numbers?					
	Review of operator log for error messages caused by operator action?					

COMPUTER CONTROLS – APPLICATIONS (CONTINUED):

Software Application:_____ (Please Complete For Each Software Application Where Applicable)

Output Controls:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are there adequate procedures to assure that output is distributed only to authorized personnel?					
2	Is output scanned and compared to original source documents (such as the following):					
	Detailed comparison of master file revisions of nonnumeric data to source documents?					
	Detailed comparison to transaction lists?					
3	Does the output contain sufficient information to permit the detection of errors and the proper handling of subsequent corrections?					
4	Are error and discrepancy reports produced, kept, and reviewed by appropriate personnel to assure that the required corrections have been made (for example, "was-is" reports)?					
5	Are output control totals reconciled with input and processing control totals?					
6	Are there appropriate procedures for handling rejected transactions, reported errors or discrepancies, and unexplained reconciling differences?					
7	Is machine-readable output properly identified (for example, header and trailer labels on magnetic output media and external labels?					

REVENUE CYCLE (REVENUE, ACCOUNTS RECEIVABLE, CASH RECEIPTS, REFUNDS)

Revenue/Accounts Receivable Department Staffing:

Personnel	Position Title	Job Description (Summary Only)

General:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are there written policies and procedures for your accounts receivable, billing, and collections process?					
2	Are patient ledger cards (or computer files) stored in a secure location?					
3	Are patient accounts totaled and reconciled to the accounts receivable control account daily?					
4	Are patient accounts confirmed periodically?					

REVENUE CYCLE (REVENUE, ACCOUNTS RECEIVABLE, CASH RECEIPTS, REFUNDS) (CONTINUED)

Cash and Cash Receipts:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is the person who opens the mail independent of all accounts receivable and payable bookkeeping functions?					
2	Is the person who opens the mail independent of depositing cash receipts in the bank?					
3	Does the person opening the mail immediately stamp checks with a restrictive endorsement (for example “For Deposit Only”)?					
4	Does the person opening the mail list cash receipts before turning them over to the person who enters the cash receipts into the accounts receivable system?					
5	Is the listing of cash receipts prepared by the person opening the mail reconciled daily to the cash receipts posted to the accounts receivable system by a party independent of both functions?					
6	Are over-the-counter cash receipts controlled by pre-numbered receipts?					
7	Is the person who receipts over-the-counter cash payments independent of all accounts receivable and payable functions and the preparation of the, and making the, bank deposit?					
8	Are over-the-counter cash receipts reconciled daily to the receipts posted to the accounts receivable system?					
9	Is the bank deposit reconciled daily to cash the receipts posted to the accounts receivable system?					
10	Are bank deposits prepared and made by someone who does not receive cash?					
11	Is the person handling cash segregated from entering non-cash credits (write-offs and contractual adjustments) into the accounts receivable system?					

REVENUE CYCLE (REVENUE, ACCOUNTS RECEIVABLE, CASH RECEIPTS, REFUNDS) (CONTINUED)

Cash and Cash Receipts (Cont.):

12	Does someone other than the person who prepares cash receipts produce and mail patient invoices?					
13	Are monthly statements sent to all patients?					
14	Are complaints from patients about their monthly statements investigated by a person who is independent of the mail opening, cashier, and the accounts receivable bookkeeping functions?					
15	Are cash receipts deposited daily and intact?					
16	Are cash receipts stored in a secure location until deposited?					
17	Is a petty cash fund maintained and if so:					
	Is petty cash kept separate from mail receipts?					
	Is petty cash kept in a secure location in a lockbox?					
	Is one staff responsible for maintaining the petty cash fund?					
	Is the petty cash fund used to make change?					
	Has a limit been set for the maximum expenditure to be paid from the petty cash fund?					
	Is the petty cash reconciliation and accompanying receipts reviewed by the administrator or his or her designated representative before the petty cash fund is replenished?					
18	Are bank and investment accounts reconciled monthly?					
19	Are all voided checks properly maintained on file and secured and are gaps in check sequence explored by a person independent of the cash function?					
20	Does a member of the Board periodically review bank reconciliation(s) completed by office personnel?					
21	Are personal funds of all doctors completely segregated from the practice?					
22	Does the practice cash checks for employees?					
23	Does the practice have a policy that all employees are required to take annual vacation?					
24	Are all employees who handle cash bonded?					

REVENUE CYCLE (REVENUE, ACCOUNTS RECEIVABLE, CASH RECEIPTS, REFUNDS) (CONTINUED)

Recording:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are patient visit slips prenumbered and controlled?					
2	Are super-bills prenumbered and controlled?					
3	Does the superbill list the services commonly performed by the physicians of the organization?					
4	Does the superbill contain valid service codes?					
5	Are patient names per the superbills/charge tickets verified against the appointment schedule or sign-in sheet daily?					
6	Are superbills/charge tickets totaled and balanced at the end of each day and reconciled to the bank deposit?					
7	Are approved fee schedules utilized for patient charges?					
8	Are fee schedules periodically reviewed, updated, and approved by the Board of Directors and/or all physicians?					
9	Are worksheets or folders maintained that provide details for recording managed care receivables?					
10	Are charges and payments totaled and posted to patient accounts daily?					
11	Is access to computerized patient and accounts receivable data files and software limited to only those with authorization for such access?					

Collections:

1	Are statements mailed to patients at least monthly?					
2	Are self-addressed return envelopes included with the statements when they are mailed (to avoid lost payments)?					
3	Are patient billing complaints followed up on a timely basis?					
4	Is the payment of cash at the time of service encouraged?					
5	Are credit cards accepted?					

REVENUE CYCLE (REVENUE, ACCOUNTS RECEIVABLE, CASH RECEIPTS, REFUNDS) (CONTINUED)

Collections (Continued):

6	Is the office staff knowledgeable about the insurance claim filing requirements of:					
	Medicare?					
	Medicaid?					
	Workers Compensation?					
	TRICARE? **[OL: Regional? I don't recognize it. Delete?]**					
	Veterans Administration?					
7	Is the most recent edition of the CPT coding book available to all office staff, especially coders?					
8	Are insurance claims filed within five business days?					
9	Is there an established policy for notifying patients of amounts not paid by insurance?					
10	Is there an established policy for writing-off insurance adjustments?					
11	Are explanation of benefits (EOBs) forms retained and reviewed for improper adjustment of billed amounts?					
12	Is there an established policy for rebilling accounts that are coded incorrectly?					
13	Is there an established policy for following up on past due accounts (e.g., including a "past due" notice in statements mailed to patients, telephoning patients, etc.)?					
14	Are records of telephone calls and other patient contacts on past due accounts maintained?					
15	Is there an established policy for refusal or termination of treatment of nonpaying patients?					
16	Are past due accounts assigned to a collection agency after a specified period of time?					
17	Are accounts assigned to a collection agency transferred to an inactive file?					

REVENUE CYCLE (REVENUE, ACCOUNTS RECEIVABLE, CASH RECEIPTS, REFUNDS) (CONTINUED)

Collections (Continued):

18	Is the inactive file checked before accepting a new patient?					
19	Are accounts receivable aging reports prepared monthly?					
20	Are collection percentages calculated monthly?					
21	Are collection percentages based on at least six month of activity?					
22	Is the collection period calculated monthly?					
23	Are 90% or more of charges collected?					

Physician Oversight:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are all reduced fees or courtesy discounts approved by the physician(s)?					
2	Are all write-offs or transfers to the inactive file or collections approved by the physician(s)?					
3	Are all non-cash credits and adjustments approved by the physician(s)?					
4	When a physician(s) approves a patient account adjustment, is it documented?					
5	Is there a patient account adjustment log printed out daily or monthly (circle one) for review and approval by the physicians and/or administrator (circle one or both)?					
6	Are all fee schedules approved by the physician(s)?					
7	Are accounts receivable agings reviewed monthly by the physician(s)?					
8	Are collections percentages reviewed monthly by the physician(s)?					
9	Is the collection period calculation reviewed monthly by the physician(s)?					

PURCHASING CYCLE (PURCHASING, ACCOUNTS PAYABLE, AND CASH DISBURSEMENTS)

Purchasing/Accounts Payable Department Staffing:

Personnel	Position Title	Job Description (Summary Only)

Initiating Purchases:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there a purchasing and accounts payable procedures manual?					
2	Are all purchases over a predetermined amount of $_____ approved by the Board?					
3	Are all purchases under a predetermined amount approved by the administrator $_____ office manager $ _____?					
4	Are all nonroutine purchases (for example service contracts, fixed assets, investments) approved by the Board?					
5	If a purchase order system is used:					
	Are purchase orders prenumbered?					
	Are purchase orders accounted for?					
	Is physical access to purchase orders controlled?					
	Are open purchase orders periodically reviewed?					
6	Is the purchasing function performed by someone who is independent of payables and disbursements?					

PURCHASING CYCLE (PURCHASING, ACCOUNTS PAYABLE, AND CASH DISBURSEMENTS)(CONTINUED)

Receipt of Goods:

1	Are all purchased goods inspected and counted when received?					
2	Is a prenumbered receiving report prepared, or the goods recorded in a log when received to record the receipt?					
3	Does the receiving report indicate the date the items were received?					

Processing Purchases:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are invoices from vendors matched with the applicable receiving reports or log?					
2	Are invoices reviewed for proper quantity, price, mathematical accuracy, discounts, and freight terms?					
3	Is the invoice reviewed for proper account coding per the practice's chart of accounts?					
4	Are these reviews evidenced by a stamp and initialed by the reviewer?					
5	Are invoices from vendors posted to the accounts payable subsidiary ledger on a timely basis?					
6	Is the account's payable subsidiary ledger detail reviewed and reconciled to the amounts recorded in the general ledger and financial statements?					
7	Are statements from vendors reconciled to the accounts payable subsidiary ledger and/or other vendor reports?					
8	Are vendor debit balances reviewed periodically and collected?					
9	Is the invoice processing function independent of the purchasing and disbursements functions?					
10	Is access to computerized vendor and accounts payable data files and software limited to only those authorized for such access?					

PURCHASING CYCLE (PURCHASING, ACCOUNTS PAYABLE, AND CASH DISBURSEMENTS)(CONTINUED)

Initiating Cash Disbursements:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there a system in place to ensure that all disbursements are done in a timely manner to take advantage of vendor discounts?					
2	Is there a system in place to ensure that disbursements are not prematurely paid to maximize positive cash balances and interest?					
3	Are all disbursements made by pre-numbered checks?					
4	Is all supporting documentation such as purchase orders, invoices and receiving reports reviewed before the check is signed?					
	Is this support maintained on file to facilitate an audit trail?					
	Is this review evidenced by the reviewer with a stamp and initials?					
	Are each of the supporting documents reviewed canceled (clearly stamped or marked “paid”) to avoid duplicate payment?					
5	Do checks over a certain dollar amount require two signatures and is this control evidenced on the face of the check?					

Processing Cash Disbursements:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are cash disbursements posted to the cash disbursement ledger on a timely basis?					
2	Is the cash disbursement ledger reconciled to the amounts posted to the accounts payable subsidiary ledger?					
3	Is the accounts payable subsidiary ledger detail reviewed and totals reconciled to the totals reflected in the general ledger and financial statements?					
4	Are timely monthly bank reconciliations prepared or reviewed by one of the physicians, the administrator, or someone independent of the cash receipts function?					

PROPERTY, PLANT, AND EQUIPMENT (SAFEGUARDING AND ACCOUNTING FOR FIXED ASSETS)

Department Staffing:

Personnel	Position Title	Job Description (Summary Only)

Authorization and Initiation:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are fixed asset acquisitions and retirements authorized by the Board of Directors?					

Processing and Documentation:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are detailed records of fixed assets and the related accumulated depreciation maintained?					
2	Are detailed fixed asset records updated monthly for fixed assets additions, retirements and depreciation on a timely basis and reconciled to their respective general ledger accounts?					
3	Does a process exist for the timely calculation of depreciation expense for both book and tax purposes?					

PROPERTY, PLANT, AND EQUIPMENT (SAFEGUARDING AND ACCOUNTING FOR FIXED ASSETS)

Processing and Documentation (Continued):

4	Is there a written accounting policy that assists the accounting department personnel to:					
	Distinguish between capital items and repairs and maintenance expenses?					
	Established cut-off amount below which items are expensed?					
	Determine what the depreciable life should be for an asset?					
5	Are reconciliations between the detailed fixed asset ledgers, including depreciation expense, and the general ledger control accounts reviewed by a responsible person?					
6	Is a physical inventory of fixed assets conducted at least annually by a person(s) who does not maintain the property and equipment subsidiary ledger?					
	Is the inventory compared to the fixed asset subsidiary ledger?					
	Are discrepancies explored by a responsible party?					
	Are adjustments made to both the fixed asset subsidiary ledger and the general ledger control account?					

Safeguarding Fixed Assets:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are items adequately safeguarded from loss due to fire, theft, or misplacement?					
2	Are periodic reviews and appraisals made relative to insurance considerations?					
3	Are periodic reviews of the carrying value of fixed assets conducted?					
4	Is access to computerized fixed asset records and software limited to only those who are authorized for such access?					

PAYROLL CYCLE (PAYROLL PROCESSING)

Payroll Department Staffing:

Personnel	Position Title	Job Description (Summary Only)

Initiating Payroll Transactions:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there a procedures manual for processing payroll?					
2	Is there a personnel policy manual?					
3	Is the personnel policy manual distributed to all new personnel when they are hired?					
4	Are employment applications used and are background checks completed for new hires?					
5	Are new hires, wages, and salaries approved by the Board and is it in writing?					
6	Are bonuses authorized by the Board?					
7	Are employee benefits and perks authorized by the Board?					
8	Is proper authorization obtained for all payroll deductions?					
9	Do physical controls exist over personnel records that prevent their loss or use by unauthorized personnel?					
10	Is access to personnel files limited to those who are authorized and independent of the payroll or cash functions?					
11	Is access to computerized payroll records and software limited to only those who are authorized this access?					

PAYROLL CYCLE (PAYROLL PROCESSING) (CONTINUED)

Initiating Payroll Transactions (Continued):

12	Are notices of changes in personnel data reported promptly to the payroll accounting function?					
13	Are adequate time records maintained for employees who are paid by the hour?					
14	Is timekeeping independent of the payroll processing function?					
15	Are time cards required to be signed by employees?					
16	Are time clocks used to prepare and check payroll?					
17	Are time records for hourly employees approved by a supervisor?					

Processing Payroll:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Are persons preparing payroll independent of other payroll duties (such as timekeeping and distribution of payroll checks)?					
2	Is payroll calculated only using authorized pay rates, payroll deductions, and time records?					
3	Does payroll perform the following functions in preparing the payroll:					
	Check time cards for computations of payroll period hours?					
	Review time cards for specific overtime approval by supervisors?					
	Check overtime hours, rates, and computations?					
	Verify pay rates?					
4	Are payroll cost distributions reconciled to gross pay per the payroll records?					
5	Is payroll information such as hours worked periodically compared to production records?					
6	Is the payroll subject to final review and approval before payment by a responsible person outside the payroll department (such as the administrator or office manager)?					

PAYROLL CYCLE (PAYROLL PROCESSING) (CONTINUED)

Processing Payroll (Continued):

7	Are payroll checks (or net pay) distributed by persons who are independent of personnel, payroll preparation, time-keeping, and check preparation functions?					
8	Are persons distributing the paychecks rotated form time to time?					
9	Is the responsibility for custody and follow-up of unclaimed wages assigned to someone who is independent of personnel, payroll processing, and cash disbursement functions?					
10	If payroll checks are machined signed, is there adequate control over the signature plate?					
11	Is the person(s) who manually signs the payroll checks or controls the signature plate independent of the persons:					
	Approving hours worked?					
	Preparing payroll?					
	Operating the signature machine?					
12	Are payroll checks prenumbered, blank stock controlled, checks used in numerical sequence, and numerical sequence accounted for and reconciled to the payroll check register?					
13	Are voided/spoiled checks properly mutilated (removal of signature portion) and retained?					
14	Is “pre-signing” check strictly prohibited?					
15	Are gaps in check sequence in the payroll register investigated immediately and reconciled to the voided check stock?					
16	Do checks contain detail of gross pay and deductions so employees can review for accuracy?					
17	Are procedures in place to ensure that payroll taxes are paid timely and that payroll tax returns are filed when due?					
18	Are procedures in place to ensure that other withholdings, such as 401(k) and cafeteria plan withholdings, are remitted in a timely manner?					

PAYROLL CYCLE (PAYROLL PROCESSING) (CONTINUED)

Processing Payroll (Continued):

19	Are reconciliations prepared of gross and net pay amounts as shown on tax returns to total payroll on the payroll register and general ledger?					
20	Year-end preparation of W-2 forms:					
	Is the total of W-2 wages for the year reconciled to the general ledger and payroll register wages paid?					
	Are W-2 forms that have been returned or unclaimed, received and investigated by a person other than payroll and timekeeping personnel?					
21	Is there a monthly comparison of actual to budgeted payroll by a responsible person and are significant variances investigated and documented?					
22	Are detailed records maintained of the liability for compensated absences and are they regularly reconciled to the control account?					
23	Are postemployment and postretirement benefit accruals reviewed by a knowledgeable individual to ensure they are accurate and properly recorded?					
24	Is a separate payroll account maintained on an imprest basis?					
25	Is there a limitation on the amount for which payroll checks can be drawn or is a check protector use?					
26	Are employees with payroll responsibilities required to take vacations and are other employees required to perform those functions when an employee is absent?					

COST CONTAINMENT

Postage/Postage Meter:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there a written policy which addresses the personal use of the practice's postage/postage meter?					
2	Is the postage meter key controlled by a responsible party?					
3	Is the postage meter located in a place that can be observed by a responsible party to control the personal use of the postage meter?					
4	If the practice allows personnel to use the postage meter for personal use:					
	Is a log maintained for personnel to record their personal and business use of the practice postage meter?					
	If a log is maintained, is the log reconciled monthly by a responsible party to the monthly postage meter use reports and differences investigated?					
5	If the practice has pre-stamped business envelopes, are these envelopes secured under lock and key?					
6	Is the key controlled by a responsible person?					

Company Supplies:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there a written policy which addresses the maintenance and personal use of practice supplies, including the copy machine?					
2	Are practice supplies maintained in a centralized location that can be secured after business hours?					
3	Does the practice maintain a supply log whereby all personnel log out supplies they use from the supply room?					
4	Does a responsible party maintain an inventory of all supplies purchased, on hand and consumed and is it updated monthly?					

COST CONTAINMENT (CONTINUED)

Company Supplies (Continued):

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
5	Does a responsible party perform a monthly reconciliation of the supplies inventory to the supply log and the accounting records, and are discrepancies investigated?					
6	Do copy machine(s) require an access code to make copies?					
7	Are these codes changed periodically?					
8	If the practice allows personal use of the copy machine, is a logged maintained for personal and business use copies?					
9	If the practice maintains a copy log, is someone assigned to perform a monthly reconciliation of business and personal use copies to total copies and follow-up on discrepancies?					
10	Does the practice review its significant supply vendors and go out for bids on significant supplies on an annual basis?					

Telephone Use:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there a written policy which addresses the personal use of the practice's long-distance carrier for personal calls?					
2	Is there a system in place to detect whether employees are making personal long-distance phone calls?					
3	If the practice allows personnel to use the practice's long-distance:					
	Is a log (or other tracking system) maintained for personnel to record their personal use of the practice's long-distance service?					
	If a log (or other tracking system) is maintained, is a responsible party assigned to reconcile the log (or reports) to monthly telephone bills and investigate differences?					
	Is a responsible party assigned the duty of collecting fees for the cost of personal phone use?					

COST CONTAINMENT (CONTINUED)

Telephone Services:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is the practice paying for telephone lines and/or options that are not being used?					
2	Are answering and paging services being sent out for bid annually to determine if the same quality of service is available at a lower cost?					
3	Has the long-distance carrier been reviewed and sent out for bid annually to determine if long-distance fees could be reduced?					

Internet Use:

#	Control / Procedure	Responsible Personnel	N/A	No	Yes	Comments
1	Is there a written policy which addresses the personal use of the practice's Internet access?					
2	Is there a system in place to detect whether employees are accessing the Internet, what sites are being accessed, and for how long?					
3	Are only personnel who need the Internet to perform their duties allowed access to the Internet?					
4	Does the practice have the appropriate virus detection software to protect it from Internet viruses?					
5	Is someone assigned the responsibility to monitor Internet viruses and insure the practice's virus protection is up-to-date?					

Tool 24-B: Sample Accounting Review Report

Date

Administrator
Medical Associates, P.C.
Anywhere, USA

Dear Administrator:

The following areas of your practice have been evaluated as part of our review of your accounting processes and procedures. Our observations and recommendations are outlined in each section below.

Financial Reporting

Observation:
Financial statements are prepared on the cash basis, reporting income when collected and expenses when paid. Expenses are allocated to providers and ancillary departments based on the income distribution formula; however, no allocation is made to indicate the profit/loss of various offices/departments. Additionally, a comparison is prepared from actual to budget; however, it appears that the budgeted amounts are changed for prior months to reflect the actual amounts.

Recommendations:
1. Financial statements prepared on the accrual basis of accounting will more accurately reflect the financial results of operations. As indicated below, invoices should be posted to accounts payable when authorized for payment and should be reflected on the financial statements. Additionally, including charges, discounted for contractual adjustments and bad debts, as income will provide a better indicator of income for the month. Collections for the month typically reflect the results of the prior month's activities.

2. Consideration should be given to the preparation of financial statements by site of service. Additionally, special clinics, such as after-hours clinics, could be reported separately. This should assist in the management of costs and allow management to make informed decisions on allocations.

3. Adjusting the budget amounts to actual for prior periods does not fairly reflect the current operations against budgeted amounts. The budget should remain constant for the year and should only be adjusted for projected changes in future months when appropriate.

Accounts Payable

Observations:
A purchase order system is not currently used for ordering. Invoices are sent to the various employees responsible for ordering to be approved. A review of invoices pending in accounts payable indicated that invoices are occasionally not approved for payment until their due date.

Invoices pending payment totaled $77,725. Of that amount, approximately $30,000 was past due.

Since invoices are currently only entered prior to a check run, an aging of accounts payable was not available. Checks are prepared on the 10th month, however, attempts are made to prepare checks semi-monthly. Additionally, the lack of an aging combined with the monthly/semi-monthly payment of invoices provides for the early payment of some invoices and the late payment of others.

Recommendations:
1. A purchase order system should be used to streamline the process for invoice approval. The system would provide for the preparation of a duplicate purchase order when an order is placed. One copy of the order would be retained by the purchaser and one copy would be forwarded to the accounts payable clerk. When the order is received, the purchaser would compare the packing slip to the purchase order and approve or correct the slip. The packing slip would likewise be forwarded to the accounts payable clerk to be attached to the purchase order. Upon receipt of the invoice, the accounts payable clerk would compare the invoice to the packing slip and the purchase order. Any discrepancies should be resolved before entering the invoice into the accounts payable system. Once approved the invoice should be entered for payment with the appropriate due date.

Use of a purchase order system should likewise provide a tool to manage the purchasing process, allowing for appropriate order timing.

2. An aging of accounts payable should be prepared weekly and included with the weekly cash report.

3. Invoices should be paid semi-monthly on the 10th and the 25th to provide for the timely payment of accounts and to allow for the appropriate review of checks before they are signed.

4. Recurring payments (rent, equipment leases) should be set up for automatic payment.

Cash Management

Observations:
Currently, no reporting is provided to indicate available cash balances and cash requirements. Additionally, a manual ledger is used to maintain the bank balance during the month.

The bank account has not been reconciled, and a comparison of the manual ledger and the financial statements indicated a minor variation.

Since a lockbox is used for personal payments only, employees must still copy insurance EOBs and make deposits for third-party payer checks.

Recommendations:
1. A cash report should be prepared weekly (Friday) indicating the case balance and requirements for the upcoming week. The report will assist management in making informed decisions regarding the use of funds. A daily report should be prepared to indicate daily collections in light of cash needs for the week.

2. The general ledger system should be used to maintain the cash balance. This should eliminate any variances and provide for a more efficient use of time.

3. The bank reconciliations should be brought current as soon as possible, and subsequently reconciled each month.

4. Establish a lockbox for third-party payer checks.

Payroll

Observations:
Payroll for employees is currently bi-weekly and is performed in-house using manual time records. The process of checking the math on manual time reports and data input requires one week per month of employee time (estimated labor costs $600 per month).

Recommendations:
1. In order to minimize the fluctuations in cash flow requirements caused during the three payroll month, we recommend that payroll be changed to semi-monthly. This will increase the monthly requirement, but will equalize the payments during the year. Since the current income distribution formula does not provide for a hold-back of profits to fund for the months with three payrolls, a semi-monthly system should allow you to more effectively insure adequate cash flow to fund payroll costs.

2. An automated time system should be used to record and input employee time. A system can be installed that will interface with your payroll system, allowing for the accurate allocation of employee time and reducing the labor cost and time required to perform the payroll function.

Patient Refunds

Observations:
Refund checks are prepared on a weekly basis by the patient representatives. These checks are prepared manually and are drawn on the main operating account. A schedule of credit balances is not routinely prepared.

Recommendations:
1. A separate imprest bank account should be established for patient refunds. This will limit access to funds and should facilitate cash balancing and the reconciling of the bank account.

2. A credit balance report should be prepared monthly. Care should be given to the prompt investigation and refunding of all overpayments.

Income Distribution

Observations:
The current income distribution formula provides for the distribution of monthly profits to individual physician owners based on a formula tied to their direct productivity (collections), with certain modifications for ancillaries. With the current formula, bonuses could be incurred to physicians without adequate cash flow to pay the bonuses due to other physicians drawing compensation in excess of their allocated profits.

An allocation of total general and administrative expenses, rather that specific expenses, is made to ancillary revenue before allocation.

Losses incurred by contract physicians are allocated based on the productivity (collections) of the individual physician owners.

Recommendations:
1. Effective cash management is essential to provide for the pay-out of earned bonuses based on the current system. In order to provide for modifications prior to the pay-out of bonuses, a quarterly or semi-annual bonus pay-out should be considered. This would allow for the adjustment in compensation of physicians with negative balances prior to the pay-out of bonuses and would also assist management in securing and providing for adequate cash flow to pay bonuses.

2. The allocation of total general and administrative expenses to ancillary revenues should be reviewed and consideration should be given to a more direct allocation of these expenses.

3. Consideration should be given to including contract physicians in the compensation formula and allocating any losses/profits generated by the contract physicians equally among the owners. Currently, the net profit of the contract physicians cannot be determined since their collections are used to offset general and administrative expenses. By including the contract physicians in the formula, their performance can be objectively reviewed and addressed, allowing for more informed decision making in areas such as buy-in and compensation.

Budgeting and Debt Management

Observations:
The current annual budget has not been updated to reflect projected changes in operations. Additionally, the budget does not provide for the payment of pension contributions due for the prior year ($200,000). Amounts due for funding the current year pension obligation total $100,000.

The practice has secured both bank financing and equipment leases to provide capital for expansion. The cost of the debt ranges from 8% to in excess of 9%. Approximately 1/3 of the debt is maintained in a line of credit with a floating interest rate. Additional borrowing in the amount of $250,000 is anticipated to fund capital expenditures. Funds from the new borrowing will be used to fund pension accrual.

Recommendations:

1. The budget should be updated to provide for projected changes in new physician owner compensation, physician retirement, and funding of all accruals (such as pension) and anticipated capital expenditures.

2. Consideration should be given to a restructure of the existing debt and new borrowing needs.

Sincerely,