



Pulse Check

Business & Practice Management Issues for Health Care Professionals

WINTER 2010

Internal billing and coding audits can help Plug Up Those Revenue Drains

If your practice is like that of many others, you may be losing money because of holes in your billing and coding process. Conducting an internal billing and coding audit will help you plug up these potential revenue drains before your cash flow dries up. Working with your CPA or health care consultant will help you plug up any revenue drains in your practice.

An internal billing and coding audit can help identify whether physicians are submitting accurate claims for reimbursement — that is, coded according to CPT codes, guidelines and conventions and as required by payor payment policies.

How the audit works

Internal billing and coding audits begin with an analysis of the services offered by your physicians and how often they've been performed in the last six months. This data will vary among physicians in different specialties depending on the conditions treated and populations served.

Coding knowledge is critical

When the practice is ready to conduct regular audits, you'll need to bring together a team of individuals to oversee the process. The primary responsibility should go to a single staff member who has a good knowledge of CPT codes, the RBRVS, and payor reimbursement policies and practices. The rest of the team will consist of your health care consultant and other relevant staff and physicians. On the other hand, you may wish to retain an outside, independent billing company to perform the audits.

The Office of Inspector General (OIG) and the AMA both offer tools that can help you get started: the OIG's "Compliance Program Guidance for Individual and Small Group Physician Practices" and the AMA's "Physician Compliance Planning."

Audit parameters

Next, your audit team must decide whether the audit should be *prospective* or *retrospective*, and how often the audits will be performed. (The OIG recommends a minimum of annual audits.) A prospective audit looks at a sample of claims before they're submitted, while a retrospective audit reviews claims after they've been processed. In the latter case, any billing errors or overpayments discovered must be resolved through the payor's repayment procedure.

Other parameters that the team must determine include how large a sample of medical records will be taken and how they will be selected. (The OIG recommends at least five records for each federal payor, or five to 10 medical records randomly chosen for each

physician.) Make sure a true, representative sample is taken, and that enough accounts are reviewed — pulling a small sample of records can yield misleading results. Then the team must select audit tools and criteria for determining the appropriateness of claims made for each medical record.

Finding the holes

The purpose of a billing and coding audit, as mentioned before, is to identify areas of heightened risk for error or negligence that warrant closer monitoring. To that end, the audit team must develop or obtain a checklist for analyzing the appropriateness of all aspects of each claim. It's also important to be able to confirm that the services provided were "medically reasonable and necessary." The determination should be made using the definition of that term from each payor's medical service agreement with the practice.

Next, the audit team must investigate whether language in patients' medical records matches and supports the services that were billed. To do this accurately you must know whether the payor is using the 1995 or 1997 version of the CMS E/M coding guidelines. The medical record must satisfy every required element of each service. Claims that weren't properly processed by the payor should be identified, and the practice staff instructed how to correct the failure to pay and what they should do to prevent future problems. Be sure to document all the work that went into preparing for and conducting the audit, and the remedial measures taken as a result. If an audit uncovers a long-running pattern of errors, you may need to take more substantial remediation steps with payors. In such cases, consult your health law attorney.

Reap the rewards

Conducting an internal billing and coding audit can result in monetary rewards that are well worth the time and effort. Contact our office if you are interested in our assistance.



(formerly known as "G.A.B. Sessions")

Healthcare Practice Managers Education Series

Mark your calendar for the first session of 2010 (held at the HMWC offices at 17501 East 17th Street, Tustin, CA 92780-7924):

Thursday, February 25, 2010, 12:00-2:00 p.m.

**Employee Benefits Survey Data:
What are practices doing this year?**

Questions?

Contact Lori Stodd, (714) 505-9000 ext. 127 or MES@hmwccpa.com

Fundamentals of a Successful Practice Merger

Physician practice mergers continue to be a trend in the health care profession. And with good reason: Each practice in the merger immediately gains access to a larger patient base and greater clout in negotiating with payors. In addition, the overhead per physician usually drops, and the two practices are often able to pool capital resources. But a merger shouldn't be entered into lightly. Let's take a look at some issues that will need to be addressed.

Can you work together?

Physician incompatibility issues (e.g., hours worked, staffing needs required per physician, compensation and benefits expectations) can easily spoil the potential benefits of a merger. All of these problems can be mitigated through diligent premerger exploration and negotiation.

Are there other concerns?

There are other areas of concern when practices merge:

Legal structure. You can structure the newly merged practice as a general partnership, limited liability corporation, limited liability partnership, or professional corporation, which can be either an S or C corporation. Although general partnership was the preferred structure 20 years ago, it no longer makes sense because of the shared responsibility among all physician-owners for the deeds and liabilities of each. Most practices choose one of the other three forms because they offer liability protection for the individual physicians for any negligence of the other partners. The disadvantage of these structures is that the new practice must obtain new Employer Identification Numbers (a merged practice will operate under one ID number) and Medicare assignment accounts, which could result in delays in claims processing and receipts of payment.

Organization and practice operations. Some of the greatest benefits of a merger come from integrating operational routines, such as medical record keeping, scheduling, billing and claims filing. There must be a sharing of all personnel, including clinical staff, to encourage a sense of unity and team spirit. Under the merged practice structure, a single manager should supervise all administrative staff to prevent them falling back on old reporting relationships and allegiances.

The combined practices should also implement standard policies and procedures for charting, billing, scheduling, and prescription refills.

Calculating physician compensation. Many physician groups compensate their owners based on some type of productivity

model. The typical measures of productivity are net revenue, patient encounters and relative value units (RVUs). Or you could calculate each physician's contribution to overall net earnings by subtracting their monthly practice expenses from their monthly net revenue. A productivity metric also is sometimes used to determine the share of ancillary service profits to which each physician is entitled.

Compensation calculations are usually based on recent figures, such as a rolling average of the physicians' net revenues for the past several months. If each doctor intends to maintain similar work hours, you can project his or her take-home pay for the first couple of years of the new practice's operations.

Allocating practice expenses. Another challenge will be determining how to spread operating expenses among the physician-owners. Resist the temptation to divide these costs evenly among them, because some physicians will incur more costs than others. Your CPA can suggest a number of methods for allocating expenses. One might be taking fixed costs — such as equipment, supplies, utilities and staff payroll — and allocating them according to each physician's net revenue as a percentage of total practice net revenue.

Another approach might be taking variable costs — such as lab, surgical and X-ray supplies — and allocating them to physicians on the basis of the number of patients seen or procedures performed. Or allocate personal costs — such as CME, liability insurance, dues and subscriptions — to each physician incurring these expenses.



Healthcare Practice Leader

Steve Williams, CPA, is HMWC's Managing Partner and Healthcare Practice leader. He has worked extensively with physicians and other high income taxpayers for over twenty years. He specializes in consulting services to medical practices, as well as tax and financial planning. He is a member of the American Institute of CPAs, the California Society of CPAs, the Medical Group Management Association, and Affiliated Healthcare Advisors. Steve is a frequent speaker on medical consulting and tax issues.



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