Office Financial Evaluation and Management

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ABSTRACT

Surgeons are facing greater pressures as business entities with each passing year. With limited ability to compensate by increasing workload, surgeons must understand finances and practice management. Strategic planning for the survival of a clinical practice now requires a background in business long absent in the formal education of surgeons. This article provides an introduction to the basic principles of office finance, management, and the revenue cycle.

KEYWORDS: Finance, management, revenue cycle

Objectives: On completion of this article, the reader should be familiar with methods to evaluate the financial aspects of a colorectal surgery practice.

Surgeons are facing greater pressures as business entities with each passing year. Office expenses continue to increase 1 to 3% per year and payer contracts hardly keep pace to cover these costs. To compensate, once it was easy to increase clinical revenues for a practice by increasing the work delivered. Surgeons worked more hours per week to cover the rising costs of care. We limited our continuing medical education and worked more weeks per year. Eventually, we ran out of hours in the day and weeks in the year. Surgeons needed more creative finances and practice management. Strategic planning for the survival of a clinical practice now requires a background in business long absent in the formal education of surgeons.

In order for a surgical practice to continue as a “going concern” it is important to define the practice model and long-term goals and outline the management of office finance and business operations. The most efficient and successful means for achieving proper management and business operations requires the application of processes and structure to the entire business. For some surgeons it is difficult to restructure their office routines from a clinical model to a business model. Yet,

the business world is an evolving creature where market forces foster a world of change. The market forces we engage in as surgeons focus on the care of patients in several settings and with a variety of controls centered around payers. Healthcare management is one of the more complex and convoluted business frameworks one could encounter. If we were to set out to design a perfect system, the current infrastructure might not even exist as an option for consideration. Be that as it may, we must deal with our current situation and realize that the system is likely to change even more radically with each presidential election. We have escalating costs and numerous uninsured with decreasing reimbursements. This is a formula for change. To prepare for such change, we must have a workable business model that can adapt promptly and succeed.

PRACTICE MODELS

Surgical practice models vary from solo practitioners to large, complex university practices. Some surgeons find value in single-specialty groups while others seek reward in multispecialty groups. Our practice models are often

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tied to the location of our practice. Numerous variables such as geography, family values, or professional goals influence where we eventually decide to establish our practice. Some practices involve a mix of general practice, general surgery, and colon and rectal surgery. Other practices are focused on colon and rectal surgery alone. Some involve outpatient anorectal practices, while others involve complex, hospital-based organizations. Life-styles and age influence practice patterns. Regardless of the practice model, each has unique sets of management and financial challenges. Even in the perfect business world it is difficult to create systems or processes that completely capture the business aspects of our work. That is to say, the work is never done. It is important to realize that the management of a practice is an ongoing exercise requiring business acumen, creativity, and patience.

I will focus the discussion on two key areas for success in an office: organizing an office for efficiency and the basics of office finance and its revenue cycle. It is important to note other topics such as compliance, personnel, office policies and procedures, and so on.

Organizing an Office for Optimal Efficiency

Oftentimes our office is the “front door” to our entire clinical practice. It is the place where patients receive their first impression of the surgeon. It is also the home for the business arm of the practice where most of the coding, billing, and collections occur. If the office is well run and organized, if patients see the office as a place of help and support to them when they are sick, then the patients will think well of the surgical practice as a whole. If the office is disorganized, makes frequent mistakes, and doesn’t display “the customer always comes first” spirit—then patients will probably think less of their surgeon. Even though surgeons may not be in direct charge of the management of their office, they are viewed by the patient as the natural leader, and therefore, somehow at fault for lapses in the performance of the office.

Let us remember that we are a service industry where our product is the health and well-being of our patients, with all of the complexities and variables that come along with humans. Corporate inefficiency, if taken to the extreme, costs lives and increases complications as much as the actual operation or procedure. Therefore, surgeons are often caught in the middle of inefficiencies that result from business decisions associated with increasing costs (supplies, complex equipment, malpractice premiums, etc.) and decreasing revenue from insurers. This cost/income squeeze is increasing across the United States and hitting surgical specialties especially hard. This is why you, the surgeon, must be on the offensive to stomp out inefficiencies and improve your practice as quickly as possible.

SOLUTIONS TO THE PROBLEM OF INCREASING COST AND DECREASING PAYMENT

1. Increased involvement by you, the surgeon, in the management of the practice
2. Improving the efficiency of your office (increased work with less cost)
3. Increasing your competitive advantage in the market place
4. Analysis of the practice patterns/insurance companies to select the best market and patient base for your practice (increased pay for less work).

Involvement by the Surgeon in the Practice Although this is perhaps the most critical of all of these solutions, surgeons are not “trained” or prepared for business management. The good news is that we can develop reasonable expertise in practice management in a short period of time, thanks to our intuitive nature as dogged problem-solvers. Also, once your staff sees that you are interested in what they are doing, and how well they do their job, they will try harder on their own. It has long been known that one of the most effective management techniques is to “manage by walking around.” By that, we mean that businesses and employees instinctively try harder when the boss is visible in their area and asks questions. You, the surgeon-boss, have been trained in the skills of observation of a patient. Employees are similarly easy to read—those who are not helping the organization are fairly easy to spot: disorderly, inattentive, and easily distracted. Good employees display just the opposite traits in most cases. At any rate, asking questions, reviewing reports, holding regular meetings with the staff, and listening to their thoughts are all good investments in your practice—and by the way, they are also great management tools.

Increasing the Efficiency of Your Practice This speaks to the concept of producing more output with less work or cost and involves harnessing the flow of information within the practice. Too often, practices repeat the same mistakes over and over—losing money in the process. By detecting when and where errors occur, the goal of information management in a surgical practice is to then feed back those errors and to institute changes to prevent future errors. The flow of patients and information along with the critical feedback loops are shown in Figure 1.

Using practice management reports to analyze each major component of collection and processing of information, the surgeon-manager can put in place new processes to correctly capture and process the correct information. There are several major areas of a surgical practice that are particularly important in this attempt to increase efficiency of your practice.

Figure 1 Patient and information flow in a surgical practice.

Patient Registration Of all of the processes in the office, the correct collection of the essential patient information is the most important. It is necessary to have this information collected as soon as possible, so that the practice can help the patient with items such as obtaining prior approval, determining the amount of unmet deductible, and noting the presence of pre-existing conditions. Timely billing is possible only if you have the correct patient and insurance information. It is desirable, for patients seen initially in the hospital, to confirm and verify patient information while the patient is still hospitalized. Relying upon hospital-supplied information to be accurate and complete is fraught with danger and leads to insurance denials long after the patient has been treated and gone. If your practice detects errors or omissions in this vital patient information collection, and then corrects how those errors occurred, then over time your practice will become very efficient at this task.

Surgery Scheduling One of the frequent mistakes made by surgeons is a rush to operate on elective cases before all of the insurance and financial information is available and analyzed. Having a hair-trigger on the scalpel frequently puts the surgeon in the position of arguing with an insurance company over things that should have been discussed (and decided) long before the patient goes to the operating room. I recommend that each practice develop a form to use for scheduling a patient for elective surgery as an aid to prevent such problems. Included on this form are places for prior approval information (whom your office talked to, when information was obtained, confirmation number, etc.), existing deductible amount, and if the patient has made payment arrangements prior to surgery. The form lets the surgeon know when all of these important details have been covered, and elective surgery can proceed.

Charge Collection and Entry Capturing all charges for procedures done by the surgeon is obviously essential if you are going to eventually be paid. This is done by a variety of methods, and as long as all charges are being

captured, then whatever system you use is fine. But if you don't have a system in place, you are likely missing valuable charges—and therefore missing even more valuable payments. I encourage every practice to examine how charges are captured and to implement a charge capture system that doesn't just rely upon a busy surgeon's memory, as this will surely fail from time to time (and as you age, this will surely fail time after time . . .). Coding of surgical procedures should be done either by the surgeon or by the office staff from the operative report. Remember that the operative report is used as the gold standard in any audit done by an insurance company, and if the surgeon has done the coding, he or she must make sure that the code and dictation match.

As part of the feedback loop for information flow, focus on the denial reports for your practice. You should routinely examine your denials due to "incorrect CPT code" or "incorrect modifier" by comparing the operative note, the charge/CPT code submitted, and the denial for that claim. If you see a trend or pattern of repetitive denials, then investigate why these are being denied. Your coding group or person may be incorrectly coding or attaching the wrong diagnosis code, for example.

Insurance Tracking Tracking of insurance claims is important to collect what is owed the practice, but also to detect if mistakes have been made that prevent the insurance company from paying the claim. Understanding how insurance companies process claims is essential to understanding how to get paid. When claims fail, examine them for erroneous information that was submitted. Making changes in your system to prevent similar errors from occurring will increase your efficiency (less work required to collect more money). The process of insurance tracking must be regularly scheduled and the results reviewed to keep the surgeon abreast of the practice. I suggest that you set up a regular pattern of insurance company or financial class review per month. For instance, you may want to have your staff review all Medicare claims the first week in the month, Medicaid and self-pay in the second week, commercial insurance the third week, and the remainder the final week of the

month. By the time the first of the month rolls around (it's Medicare time again . . .) claims and refilings have been in and returned from the prior month, allowing your staff to focus on the ones that were denied again. Examining slow-paying insurance claims and denials can provide an early tip-off to changes insurance companies have made in claims payment policy and allow the practice to make changes accordingly.

Collections Having a well-defined and thought-out collections policy makes for an organized and efficient practice. Payment for services rendered is expected for every other industry and business, but somehow for surgery, some expect to pay less than their entire bill. Proper education of patients as to what your practice expects from them in regards to your bill is important and has been shown to increase the collection rate. To properly educate your patients, your office must have a well thought-out policy of how, what, why, and where payment is expected to be made. This policy should include what is expected for payment before and after surgery and what steps your office will take if payment is not made. You should decide what steps your office will take (and when) before the account is turned over to a collection agency. There is a wealth of information that is available for feedback from collections activity, such as missed second insurance information and incorrect patient or insurance company information. This information should be collected and used to improve the front-end information-gathering and claim-processing portions of your practice, so that repetitive errors are not made—well—err—repetitively.

OTHER IMPORTANT FACTORS FOR AN EFFICIENT PRACTICE

Reduction of Costs in Practice Cost reduction usually means more money left over for expansion of the practice or for salary for the surgeon. There are many traditional ways to reduce costs, but some may be counterproductive, if cost reductions lead to poor patient care. For large organizations, many of the overhead costs are relatively fixed and are not amenable to change by the surgeon. Small practices, however, can effect change more easily. Small practices have clarity in the “shared mission” and everyone can focus on efficient lean practices. Large practices have complex missions and it is more difficult to focus on one clear mission.

Analysis of Practice Patterns and Selection of Best Market/Patient Base By studying your patient mix and insurance reimbursement, it may be possible to select those patients, operations, or particular insurance companies that you want to attract to your practice and those that are less desirable. Factors to consider in this equation are unnecessary denial rate for “clean claims,”

slow/low payment by certain companies, certain procedures that have a high denial rate, and so on. The impact of this difference in reimbursement can be quite dramatic. Frequently, there may be up to a 300% difference in reimbursement per service or visit between two insurance companies. This means that you would have to see three of company B's patients to make up for one of company A's patients that didn't see you because your appointment schedule was taken up by all of those “B” patients in your office. Each practice must evaluate and stratify its patients and attempt to optimize appointment scheduling, operating room scheduling, and so on to optimize its return on a given amount of work done.

BASICS OF OFFICE FINANCE AND THE REVENUE CYCLE

Financial management of a surgical practice covers a broad spectrum of activities associated with the business aspect of surgery. Financial reports generate a collated overview of a practice, the “numbers,” so to speak. Financial management is a step beyond financial reporting. Financial management looks beyond the numbers hoping to improve the business operations and the bottom line. Financial management asks the why's and how's in an attempt to enhance return on your investment. Thus, the goal is to deliver as many services as possible with price in excess of cost through proper reporting and management.

Let us take one look at financial and operational techniques that employ management of cost structure and volume. Surgery and healthcare are commonly compared with other service industries. Much like hotels and airlines, we provide a service to our patients. Unlike hotels and airlines, we lack sophisticated financial systems and procedures that outline our business. Hotels and airlines set their prices to compete against others. They have mature cost management systems that help define the precise cost for each aspect of their service. They precisely define the costs of a service—the hotel room, the linens per room, or the toiletries. Airlines know the actual costs for a seat on a plane including the costs of food and beverages, fuel consumption per seat, etc. When did you last update your charges? Does it matter?

Our costs are not so well defined. Actually, our patient costs hardly seem critical to us when we are busy delivering care. Other surgeons are often quick to remind me that patients arrive on our doorstep and we make every effort to provide for their needs—whether their particular needs are profitable or not. We cannot pick and choose. Each visit does not translate into revenues that cover the expenses. In some sense, that is very true, and thankfully so for ill patients. In another sense, a surgeon *can manage* a practice by creating

different opportunities for the practice through adjusting his or her availability or service lines.

Only recently have physicians begun to understand the specific costs and benefits from managing lines of service. If the cost is too prohibitive, it may make sense to limit available time for losing propositions. For example, as a colorectal surgeon, restorative proctocolectomies with an ileoanal reservoir are professionally rewarding operations. The operations are long and involved. Preoperative downtime and postoperative management are consuming for the surgeon. A surgical practice that solely performs such procedures will struggle financially. Other colorectal surgical practices schedule one day per week or more performing colonoscopies. While not as glamorous, the return on the investment for endoscopies affords opportunities for restorative proctocolectomies. Have you listed your E/M (evaluation and management codes) services? Have you properly balanced the schedule in your office to meet financial demands? Medicare reimbursement is based on a relative value unit (RVU) system (Fig. 2).

Without financial systems in place to provide analysis for a fiscally balanced clinical practice, a new surgeon fresh from training will struggle through a few rough years to understand this fiscal principle. In large multispecialty groups or academic medical centers, financial management must identify the various niche surgical areas and provide support from other areas

within the group to allow the niche expertise to find its proper place within a department. Loss leaders and profit centers are readily identified.

Third-party intermediaries complicate our fiscal management process within the price-setting environment through complex payment agreements and convoluted payment policies. It is important that we develop sound fiscal reports to analyze our practice.

The financial reports serve multiple needs. Corporate financial reports are records of the financial status of the business. These reports are used to determine opportunities for cost savings, revenue enhancement, improved contracting, and general business operations. The basic reports include the *balance sheet*, the *income statements*, and *statements of cash flow*. The foundation for these reports is a common set of standards, called generally accepted accounting principles (GAAP accounting). GAAP developed from the Securities and Exchange Commission (SEC) in response to the stock market crash and the Great Depression of the 1930s. From the basic reports, each business entity develops reports that are specific to that industry. Many of the specific reports are developed around a few simple ratios derived from line items in these three reporting tools.

Before we start on the basic reports, let us appreciate the fundamentals of the accounting equation:

$$\text{Assets} = \text{Liabilities} + \text{Owner's Equity}$$

Figure 2 Relative value units (RVU).

Table 1 The Accounting Equation

Assets	Claims on Assets	
Assets =	Liabilities	Owner's Equity
Cash	Accounts payable	Preferred stock
Inventories	Wages payable	Common stock
Buildings	Taxes payable	Capital stock
Land	Notes payable	Retained earnings
Equipment	Bonds payable	
Accounts receivable	Intermediate term debt	
Marketable securities		

Assets are exemplified in cash, inventories, building, land, equipment, accounts receivable, and marketable securities. Liabilities may consist of accounts payable, wages, taxes, bank loans, bonds, and other debts. The owner's equity flexes according to what remains from assets less liabilities. These may be represented in preferred stock, common stock, capital stock, or retained earnings (Table 1).

The basic accounting reports we must consider are the balance sheet, the income statement, and the statement of cash flows. The healthcare industry is an industry built on low margins. Therefore we have to be extremely mindful of our cash flows. If the slightest changes occur, in our assets or liabilities, we will feel it promptly in our cash flows.

The *balance sheet* states the financial position of your practice at a fixed point in time. It could be at the end of a month, a quarter, or a year. Using GAAP and guidance from the Financial Accounting Standards Board (FASB), fair financial statements list the assets versus the liabilities and owner's equity. The components of a balance sheet must offset each other to "balance" the accounting equation. Assets list the current assets, restricted assets, or limited assets, property, plant and equipment, and so on. These assets are offset by liabilities and equity accounts.

The liabilities consist of short-term (current liabilities) and long-term (payment more than 1 year) debts. Equity accounts are composed of initial capital investments and earnings retained in the corporation (Table 2).

The *income statement* differs from the balance sheet. The income statement highlights the assets versus liabilities over a given period of time; a month, a week, or a quarter. The income statement generates the famous "bottom line." The income statement, also called the statement of revenue and expenses, reports the results of the operating activities for a given period of time. The bottom line reports whether there was a net profit or net loss over the time period measured (Table 3).

The *statement of cash flows* outlines the sources and uses of cash for a given period of time. It explains the flow of cash. The statement will outline what cash was present initially and cash that proves available at the period's end. It reports the net cash flow from three separate areas: *operations*, *investments*, and *finance activities*. Cash flow statements define first if a practice is profitable or if it spends money. Second, the cash flows represent where the money is made, or where the money is spent. For example, a practice may lose money on operations but prove profitable from investments in an ambulatory facility or from ancillary services. This information will assist a practice in defining the next steps—to stop the hemorrhage or to promote the successes.

The key language of finance focuses on a series of *ratios and reports* that are used for comparative analysis. We refer to these key items as the medical practice statistical reports. The five reports that are a "must" for a successful financial analysis of your practice are:

1. Gross charges and gross collection percentage
2. Gross allowables: gross charge less the contractual adjustment

Table 2 Balance Sheet

Assets		Liabilities	
Current Assets		Current Liabilities	
Cash	\$123,000	Accounts payable	\$100,000
Marketable securities	\$200,000	Notes payable	\$150,000
Accounts receivable	\$345,000	Total Current liabilities	\$250,000
Inventories	\$100,000		
Total current assets	\$768,000		
Long-Term Assets			
Buildings (gross)	\$350,000	Long-term notes	\$300,000
Accumulated depreciations	\$50,000	Total liabilities	\$350,000
Net buildings	\$300,000	Owner's equity	\$843,000
Land	\$325,000		
Total long-term assets	\$625,000		
Total assets	\$1,393,000	Total claims	\$1,393,000

Table 3 Income Sheet from January 1, 2001 to December 31, 2001

Revenue	
Gross production	\$3,000,000
Less contractual adjustments	\$1,400,000
Net production	\$1,600,000
Expenses	
Amortization	\$50,000
Bad debts	\$80,000
Insurance	\$75,000
Operating supplies	\$96,000
Professional fees	\$20,000
Rent	\$240,000
Utilities	\$9,000
Wages	\$100,000
Total expenses	\$670,000
Other Income	
Gain/Loss on sale of assets	\$0
Insurance settlements	\$250,000
Total other income	\$250,000
Net income (loss)	\$1,180,000

3. Accounts receivable (aging report)
4. Net production
5. Net collection rate.

These five reports create management opportunities. Understanding these financial points will guide your office efforts to enhance collections.

Gross charges represent your office fee schedule. Most fees are set as a percent of the Medicare fee schedule. Realize that some payers agree to provide you a percent of charges. Therefore, it serves your practice to maintain charges well above the Medicare levels. The *gross collection percentage (GCP)* represents net collections as a percent of the gross charges. Oftentimes providers share their disgust with a low GCP. It is important to realize that gross charges vary between practices and, therefore, these are not reasonable resources for practice comparisons. I can imagine practices with two different sets of gross charges, yet they receive the same net collections. In this instance, the GCP will vary despite the same actual payments.

Gross allowables are far less commonly analyzed and far more important to know. A gross allowable represents your anticipated payer-specific expectations. That is, your gross charges are reduced according to your contractual adjustments, thus defining the amount you should expect to collect.

Once a charge has been sent to a payer, you have identified your *accounts receivable*, or monies you should expect to collect. Accounts receivable are rarely paid within 15 days. Most payers provide returns in 30 to 60 days. Thus, the typical benchmark for days in

accounts receivable is roughly 45 days (days in A/R). When the accounts are not paid, this may reflect a denied service or an issue with payment. As accounts age, it becomes more difficult to collect payments. Thus, optimizing payments means properly collecting data and properly submitting charges.

Net collections reflect the actual dollars collected for a service provided. Net collection percentage reflects the net collection as a percent of the gross allowables. That is to say, if a gross charge equals \$100 and the adjustments are \$20, the allowable is \$80. A net payment of \$40 creates a net collection of 50% (\$40 as a percent of \$80).

The next step highlights the components of the *revenue cycle*. The revenue cycle divides the various elements of revenue generation into similar groups. To create a complete revenue reward requires perfection in each step of the cycle. The revenue cycle begins with the contracts you sign; it runs through coding and billing for the services delivered; it outlines the postings for collections, payment postings, and adjustments. From this point the cycle should demonstrate denials, reworks, and write-offs. Finally, you step back from all these reports and outline contract conflicts, resolution plans, and strategies for new contracting for the next year (Fig. 3).

So far, we have generated balance sheets, income statements, statement of cash flows, the five medical practice statistical reports, and several mini-reports from within the revenue cycle. The revenue cycle mini-reports include a charge capture assessment, number of charge lag days, denial percentage, and a payer mix analysis.

But there is more. To understand these reports fully, you must also understand an important distinction between *cash basis accounting* and *accrual basis accounting*. Accrual-based accounting refers to “booking” the production on the date of service. Cash basis refers to “booking” the production when the cash is received. Cash basis simply refers to accounting for revenue as you actually receive it and accounting for expenses as you

Figure 3 Revenue cycle.

actually pay them out. Office managers typically use cash basis accounting. Cash basis generates your balance sheet, income statements, statement of cash flows, and tax information.

Accrual is important to track production performance, week to week and month to month. Surgeons tend to think of their business in terms of accrual basis. Accrual basis accounts for revenue as it is generated. Expenses are “booked” as you accrue them—rather than pay them out. For example, suppose you performed 100 office visits this week at \$50 each. On your accrual books, your office would note you have accrued \$5000 in revenue. From a cash basis, you will not see this revenue reported for 60 to 90 days. Instead, that month, your accountant will record the revenue you generated from 2 to 3 months prior.

This also serves notice on your cash flows. If you do not keep after the various payers, and your collections drift downward for that period of time, then your cash flows may fall below your monthly liabilities. To keep liabilities paid up and current, you would have to (1) reduce your income (thereby reducing your liability) or (2) borrow money to cover the cash needed.

These standard reports are available from most off-the-shelf billing software systems. So, just blow the dust off that large software manual on the back shelf in the billing office. Review the reports available and voila! You are generating data. Strength and success in your management will come from these data sources. This

chapter provided a few key concepts, but it is difficult to master these skills in a short period of time. It requires lifelong learning and seeking assistance from short courses frequently offered at various locations across the country. I strongly suggest starting slow, working with your office manager, and seeking continuing education.

CONCLUSIONS

Each passing year, surgeons face greater pressures as business entities. With limited ability to compensate by increasing workload, surgeons must understand finances and practice management. Strategic planning for the survival of a clinical practice now requires a background in business long absent in the formal education of surgeons. Surgeons must understand their practice model, office finance, and the revenue cycle and adopt methods to optimize efficiency. The principles discussed in this article will provide a starting point for surgeons interested in enhancing their abilities and improving their practice management.

AUTHOR NOTE

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