

# MEDICAL PRACTICE REVIEW

PRACTICE: \_\_\_\_\_

DATE: \_\_\_\_\_

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## Financial Analysis

1. Payor mix % of patients in each insurance class:

Medicare:	% _____
Medicaid:	% _____
Champus	% _____
Workmen's Comp:	% _____
HMO/PPO	% _____
Blue Cross	% _____
Commercial	% _____
Self Pay	% _____

2. What percentage of total charges is adjusted off each month.

\$ \_\_\_\_\_ Total Charges                      \$ \_\_\_\_\_ Adjustments

\_\_\_\_\_ % of adjustments to charges.

3. What percentage is collected each month of *gross*:

\$ \_\_\_\_\_ Charges                      \$ \_\_\_\_\_ Collected \_\_\_\_\_ %

\$ \_\_\_\_\_ Net (Charges minus adjustments) \_\_\_\_\_ %

### Detect Shift in Payer Mix

	<i>Payer Last Yr.</i>	<i>This Yr.</i>
Medicare	_____ %	_____ %
Medicaid	_____ %	_____ %
Commercial Plans	_____ %	_____ %
PPO Plans	_____ %	_____ %
HMO Plans	_____ %	_____ %
Workers' Compensation	_____ %	_____ %
Self Pay	_____ %	_____ %
Other	_____ %	_____ %
 Total	 100%	 100%



## SERVICE ANALYSIS WORKSHEET

For the month beginning \_\_\_\_\_ and ending the month of \_\_\_\_\_, 19\_\_

Physician Name \_\_\_\_\_

Month	NP Visits	EP Visits	Hosp Admits	Hosp Visits	Procedures	X-Rays	Lab Tests
Month 1							
Month 2							
Month 3							
Month 4							
Month 5							
Month 6							
Month 7							
Month 8							
Month 9							
Month 10							
Month 11							
Month 12							
<b>Total</b>							
<b>Monthly Avg</b>							

## Analysis of Billing and Collection System

### PATIENT SCHEDULING

What are patients instructed when they call into the office for an appointment?:

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What is the office visit payment policy:

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### ANALYSIS OF SMALL RECEIVABLE BALANCES

**Practice Name:** \_\_\_\_\_

**Worksheet Preparation Date:** \_\_\_\_\_

Accounts receivable balance as of _____	\$
Total of balances that are \$200 or less (small balances)	\$
% of small balances to total accounts receivable	%

When is the patient's insurance information first obtained?:

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When is insurance verified:

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### PATIENT CHECK IN



PATIENT CHECK OUT

Does the doctor complete all information on the charge ticket? yes no

If the patient is on a managed care plan, how does the front desk know how much to collect as a copayment from each patient?

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When the patient checks out, is all the charge and payment information entered into the computer before the patient leaves the office? yes no. If no, explain why not:

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If the patient has an overdue balance, is there an attempt to collect this amount from the patient while the patient is in the office? yes no. If no, explain why not:

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If the patient is scheduled for surgery, does the office attempt to collect a surgical deposit? yes no

Do patients receive any type of financial counseling before the procedure is performed? yes no

When a patient checks out after the office visit is complete, does the front desk (or check out desk) attempt to collect full payment, deductibles, and/or copayments? yes no



## **BILLING**

Explain how the office communicates inpatient (generally hospital) charges to the office so that the office can bill these services to the patient's insurance carrier.

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How are surgical or procedural charges captured so they may be billed properly and timely?

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How often are insurance claim forms filed each week?

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Are operative notes attached to claim forms when they are filed with an insurance company?  
\_\_yes \_\_no; If yes, detail situations when operative notes are attached:

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Does the doctor dictate notes on a timely basis? \_\_yes \_\_no; If no, how long does it take and explain why.

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Does the practice utilize electronic billing? \_\_yes \_\_no; If no, explain why.

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Are insurance claim forms held for any reason? \_\_yes \_\_no; If yes, explain situations when this occurs.

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How accurate is the front desk or other personnel in obtaining the patient's insurance information?

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How are charge denials handled in the office?

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**COLLECTIONS**

When does the practice begin following up on unpaid insurance claim forms?

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What is the practice's follow up procedure for unpaid insurance accounts?

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How does the office follow up on unpaid patient receivables and how often?

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When are patient account statements mailed out?

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Are collection letters used by the practice? yes no; If yes, how often are they sent out and what types of collection letters are sent.

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Does the practice use a collection agency? yes no; If yes, how often are accounts sent to the collection agency?

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Total balances turned over to collection: \_\_\_\_\_  
Total amount collected by the agency: \_\_\_\_\_  
Percent collected: \_\_\_\_\_%

Total individual accounts turned over to collection: \_\_\_\_\_  
Total individual accounts where collection occurred: \_\_\_\_\_  
Percent collected: \_\_\_\_\_%

Does the practice routinely review a detailed aging of the accounts receivable? \_\_yes \_\_no

## Frequency Report Review

Statistics for \_\_\_\_\_ months, from \_\_\_\_\_ to \_\_\_\_\_

OFFICE VISITS:      Fill in the total number of times performed.

<u>CPT CODE:</u>	<u>TIMES DONE</u>	<u>PERCENTAGE</u>
99201	_____	_____
99202	_____	_____
99203	_____	_____
99204	_____	_____
99205	_____	_____
Total		100%
99211	_____	_____
99212	_____	_____
99213	_____	_____
99214	_____	_____
99215	_____	_____
Total		100%
99221	_____	_____
99222	_____	_____
99223	_____	_____
Total		100%
99231	_____	_____
99232	_____	_____
99233	_____	_____
Total		100%
99241	_____	_____
99242	_____	_____
99243	_____	_____
99244	_____	_____
99245	_____	_____
Total		100%
99251	_____	_____
99252	_____	_____

99253	_____	_____
99254	_____	_____
99255	_____	_____
Total		100%
99291	_____	_____
99292	_____	_____
Total		100%

Codes not within the range for the specialty that require further investigation:

Findings: \_\_\_\_\_

Findings: \_\_\_\_\_

Findings: \_\_\_\_\_

Findings: \_\_\_\_\_

Per your review of the frequency report, please list the following:

CPT Codes Missing	CPT Codes Misused	Comments
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

## Analyze Practice Overhead

What is the percentage of total collections paid out in overhead before compensation and benefits to the physician?

Total Collections: \$ \_\_\_\_\_

Total Overhead: \$ \_\_\_\_\_

Percent \_\_\_\_\_%

General overhead percentage per specialty survey: \_\_\_\_\_%

Comments:

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If necessary, analyze major overhead expense categories as a % of collections:

Payroll: \$ \_\_\_\_\_%

Comment: \_\_\_\_\_

Rent: \$ \_\_\_\_\_%

Comment: \_\_\_\_\_

Medical Supply \$ \_\_\_\_\_%

Comment: \_\_\_\_\_

Office Supply \$ \_\_\_\_\_%

Comment: \_\_\_\_\_

Laboratory \$ \_\_\_\_\_%

Comment: \_\_\_\_\_

Prof. Fees \$ \_\_\_\_\_%

Comment: \_\_\_\_\_

X-Ray \$ \_\_\_\_\_%

Comment: \_\_\_\_\_

### Accounts Receivable Analysis

Month	Total A/R	Current	%	30+	%	60+	%	90+	%

Is % of accounts receivable over 90 days reasonable: \_\_\_yes \_\_\_no

Comment:

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Determine if accounts receivable over 90 days increased from month to month. If so, this could indicate a problem with, or lack of, collection activities in the office. Comment:

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Total amount of credit balances in current accounts receivable balance \$ \_\_\_\_\_

Is this amount reasonable? \_\_\_yes \_\_\_no. If yes, investigate.

Comment: \_\_\_\_\_

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Percent of total accounts receivable, all balances less than \$200: \_\_\_\_\_%. Refer to related worksheet in billing and collection section.

Comment:

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NEXT, tie down the ending accounts receivable balance using the following formula:

Beginning accounts receivable	_____	_____
Add: charges		_____
Add: debit adjustments		_____
Less: collections for the period		_____
Less: credit adjustments, including bad debt write-offs		_____
Ending accounts receivable	_____	

If the ending balance per the books does not agree with formula above, investigate immediately:

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If the accounts receivable aging detail reveals numerous small balances, refer to the worksheet included in the billing and collection section used to analyze front desk collections.

Comment: \_\_\_\_\_

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**Receivables Aging by Payer Class**

Month	Total A/R	Current	30 days	60 days	90 days	Over 90 days
Medicare						
Medicaid						
Indemnity						
PPO plans						
HMO plans						
Workers compensation						
Self pay						
Other						

**Receivables Aging by Specific Insurance Company**

Month	Total A/R	Current	30 days	60 days	90 days	Over 90 days
Aetna US Healthcare						
Cigna						
Pacificare						
Kaiser						
Healthsource						
Beechstreet						
Blue Cross/Blue Shield						
Prudential						

## **Review of EOBs**

Now that you have calculated and analyzed the financial performance of the practice, the next step in the assessment process is to review explanation of benefits. An EOB is the document that accompanies the reimbursement check from the insurance company, Medicare, or any other third party payer. This piece of paper shows the practice what it billed, what the payer will pay for the service, and whether or not there is any deductible and copayment due from the patient.

The financial assessment, along with your analysis of the billing and collection process, should show you where potential problems might lie within the practice. It will indicate to you either standard or substandard financial performance, and as such, has a direct bearing on the physician(s), practice personnel, and practice operations. A review of EOBs is the next step in the assessment process because this review will confirm some of your suspicions resulting from your review of the practice's financial data and related practice management statistics. A review of the EOBs, along with the financial analysis, will allow you to specifically pinpoint potential problem areas within the operations of the practice and its office(s). From here you will be able to concentrate this part of your assessment on these likely problem areas.

EOBs are arguably the most important documents within a medical practice. This is because it provides a wealth of information about the practice. By inspecting closely EOBs, you will be able to tell if:

1. The practice is coding properly;
2. The practice is filing its charges correctly;
3. The practice is having problems in the billing process;
4. The practice's personnel are competent;
5. The practice's fee schedule is adequate; and
6. The receivables management process is working or not.

You should inspect enough EOBs necessary for you to formulate an opinion about the six issues just mentioned. Once you do so, the assessment process can proceed to a detailed analysis of the practice's billing and collection process and other specific practice areas.

Gaining access to EOBs is sometimes difficult however. Some smaller offices will place them in the patients' medical records. Larger practices store them off the premises or even throw them away once the reimbursement check is posted to the patient's account. This is such an important part of the assessment process, you must get your hands on these documents. Once you have gained access to the EOBs, complete the worksheets on the following pages:





















**Interviews with Personnel**

Office Manager (Administrator): \_\_\_\_\_(Name)

How long in Position: \_\_\_\_\_

What are the job duties of the Office Manager (Administrator)?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_
- 9. \_\_\_\_\_
- 10. \_\_\_\_\_

What problems does the Office Manager (Administrator) think exist in the office?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What solutions does the Office Manager (Administrator) think would solve the problems?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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How is the office morale and attitude toward the physician?

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**Insurance Claims Preparer**

Name \_\_\_\_\_ Position \_\_\_\_\_

What are your responsibilities?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

What do you think works well in the office

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What do you think needs improvement

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What are ways to improve?

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**Office Nurse**

Name \_\_\_\_\_ Position \_\_\_\_\_

What are your responsibilities?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_

Do you do any CPT coding of office services? \_\_\_yes \_\_\_no

Do you select the ICD-9 Diagnostic Code for why patient was there? \_\_\_yes \_\_\_no

What history, medications taken, complaints or other information do you record in the patients charts prior to them seeing the doctor?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you involved with documenting or coding any hospital services? \_\_\_yes \_\_\_no

Do you perform any services for the patients (i.e., shots, blood pressure checks or other services when the doctor does *not* see the patient on that day)? \_\_\_yes \_\_\_no

Are you often required to work through lunch and after regular business hours? \_\_\_yes \_\_\_no

Do you okay refills on prescriptions? \_\_\_yes \_\_\_no

Do you answer questions over the telephone? \_\_\_yes \_\_\_no

Where is it documented? \_\_\_\_\_

What do you see that works well in the office?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Front Office Receptionist**

Name \_\_\_\_\_

Position \_\_\_\_\_

What are your responsibilities?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_
- 7. \_\_\_\_\_
- 8. \_\_\_\_\_

What do you see that works well in the office?

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What do you see that could use improvement?

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What are ways to improve?

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### Medicine Fee Evaluation

From the Frequency Report list the 5 most commonly performed office visits (CPT code range 999201-99215).

Description	CPT Code	Relative Weight	Fee	Conversion Factor

From the Frequency Report list the most common Hospital Admission 99221- 99223, and the 2 most common levels of daily hospital visits, 99231 - 99233 and most common level of office consultations 99241-99245

Description	CPT Code	Relative Weight	Fee	Conversion Factor

What is the range from lowest to highest of the Conversion Factors: \_\_\_\_\_

What codes are unusually high: \_\_\_\_\_

What codes are unusually low: \_\_\_\_\_

What is the Average Conversion Factor for all services evaluated in the this section: \_\_\_\_\_





## Charge Ticket Evaluation

One part of the assessment process is to perform a review of the charge tickets the office uses. This includes the office charge ticket (which almost all practices have) and if applicable, the hospital charge ticket and the surgical charge ticket. As stated in the chapter on analyzing the practice's billing and collection processes, these tickets are used to record what services are rendered to patients and are then used as a tool to bill the physician's services. Therefore, it is important to review these charge tickets since any mistakes on them could result in a billing error or missed billing opportunities.

When errors occur, the staff will have to spend time determining why the error was made and then either refile or appeal the denial for payment if the opportunity presents itself to do so. Some errors are in fact true errors and a payer will not reimburse the billing. In this situation however, at least there will be documentation of the error. When an inadequate charge ticket results in missed billing opportunities, most of the time the practice is totally unaware of when this happens; there is nobody saying to the practice "Hey, you just missed some revenue!" This is why charge tickets must capture all services that can be rendered and related billing opportunities identified on it.

### The Office Charge Ticket

A sample of an office charge ticket was shown in chapter \_\_ on the discussion of a practice's billing and collection processes. As also mentioned in that chapter, an office charge ticket is commonly referred to in the physician community as a "superbill." You should obtain a copy of the office charge ticket and do or look for the following:

1. First, ask how long it has been since the superbill was updated. It should be updated at least once a year since CPT and ICD-9 codes change each year. If the answer is something other than "annually," you can most likely assume there might be errors to be found on the charge ticket.
2. Take current office charge ticket and trace all CPT (service) and ICD-9 (diagnosis) Codes listed to the CPT and ICD-9 Books.

These codes are listed directly on the charge ticket. A doctor usually circles or checkmarks them after he or she has performed the service. This tells the office staff what the doctor did to the patient and this information is used to check the patient out of the office and bill their insurance company (Refer to chapter \_\_ for more explanation on how the charge ticket impacts a practice's billing and collection process). Therefore, the codes listed on the superbill must be correct.





The top half of the charge ticket could be used for CPT codes and the bottom half used for the diagnosis codes. However, you want to make it as easy as possible for the physician to record his or her office services; therefore, you will want as many codes as possible on the ticket. This is why some offices prefer to have the CPT codes on the front of the office charge ticket and the ICD-9 codes on the back.

2. Make sure all levels of service are included on the office charge ticket.

All levels of service must be included on the charge ticket, including those for new patient visits, established patient visits, and office consultations. The following are the codes that should be included; keep in mind some medical specialties might not need these codes (ex. Pathology) and that some practices might not perform consultative visits (ex. Family practice):

New patient office visit codes: 99201, 99202, 99203, 99204, 99205

Established patient office visit codes: 99211, 99212, 99213, 99214, 99215

Office consultation codes: 99241, 99242, 99243, 99244, 99245

There are two reasons why all of the levels of service should be included on the office charge tickets. The first is to make sure the doctor is not accidentally miscoding his or her services simply because all of the levels of service are not on the charge ticket. Specifically, you want to make sure the doctor is not accidentally “upcoding” his or her services. Upcoding means the doctor is recording a higher level of service than what was actually performed. Upcoding can result in the following:

- Denial of the billed charge by an insurance company;
- Downcoding of the service to a lower CPT code by an insurance company; or
- An audit by an insurance company (or any other third party payer, such as Medicare).

The denial or downcoding of an “upcoded” charge are usually tied together in that usually the CPT code that was billed does not agree with the ICD-9 code that was billed with it. In these situations, the diagnosis code explains a condition or symptom that is much less than the CPT code that was billed. A real simple example is the patient who has the flu and the doctor bills code 99214 for the minor treatment (keep in mind as the levels go up, the patients are suppose to be sicker and sicker; i.e. have more complicated problems).

When upcoding occurs, the doctor could be risking an insurance audit as well, especially one from a governmental agency such as Medicare and Medicaid. This often occurs when a doctor utilizes one or two codes time after time again, and is usually the result of having few number of codes on the charge ticket (the ones actually on the charge ticket are the higher levels of service).

The level of service must always be supported by appropriate chart documentation. For evaluation and management services, for example, medical records must include documentation of the following:

- The patient's chief complaint;
- The patient's history;
- The physical examination and review of systems;
- Medical decision making
- The treatment or management plan
- The consultation/coordination of care

If the CPT code billed does not agree with the documentation in the patient's medical record, the practice will usually owe monies back to the payer because he or she has been overpaid (i.e. a lower level of service should have been billed that supported the chart documentation). Civil penalties may also be assessed; a criminal investigation could occur if there was a deliberate attempt by the doctor to upcode the services.

The point should be clear: a good superbill helps avoid an insurance audit!

The second reason why all of the levels of service should be included on the office charge ticket is basically the opposite of the insurance audit discussion above: the practice wants to make sure it is not losing revenue because the higher levels of services are not included on the superbill. For example, many practices do not include code 99211 on their charge ticket because they feel they do not render this type of service; however, up further investigation, they do perform services at this level (ex. Blood pressure checks). At the opposite end, some practices in certain medical specialties will treat sicker patients more often than others. No matter, every practice wants the higher levels of service on the charge ticket in the event this type of treatment is ever rendered. One of the worst things that could happen in the situation where a doctor treats a very sick patient but checks only code 99213 because that is as high as the codes go on the charge ticket; codes 99214 and 99215 were left off.

A great indicator of these types of problems with the charge ticket is tied to your review of the practice's service frequency. By paying close attention to how often these office codes are billed, you can get an idea if there might be a problem with how the office charge ticket is designed. The following is a good example:

<u>CPT Code</u>	<u>Frequency</u>	<u>Percent Used</u>
99211	55	5
99212	92	9
99213	761	73
99214	111	11
99215	<u>22</u>	<u>2</u>
Total	1,041	100%

In this example, the doctor uses the established patient visit code 99213 73% of the time. Normally you will want to see a “bell shape curve” when first analyzing coding patterns for office visits. When you see this type of example, you want to make sure that the medical record documentation is supporting the code billed. On the other hand, if you see that certain of the codes were not billed at all, it is likely that not all of the codes are included on the charge ticket. Remember that the doctor is in the exam room and recording only those services that are on the ticket. This type of situation might be causing the practice to lose revenues and/or cause an audit.

A real life example was a urology practice. The doctors billed CPT code 99214 100% of the time when the CPT frequency report was looked at. When a doctor bills all his established patient visits at one CPT code, this was obviously incorrect. When the office charge ticket was looked at, guess what was listed as the only service for an established patient office visit: 99214!

1. Search for missing services.

To reiterate, the doctor will only record services that are included on the charge ticket. As such, you want to make sure all office services that can be billed are on the charge ticket. If you are not experienced at CPT coding, we suggest you have the physician or an office nurse go through the entire CPT book and identify the procedures and services that can be performed in the office. This may identify additional procedures that will need to be added to the charge ticket. Examples include supply and injection codes.

2. For specialty practices, make sure the office consultation codes are properly aligned on the charge ticket.

Medical specialists are often asked by other doctors to “consult” on a patient. This often occurs when there is a suspected or unknown problem that needs the help of a medical specialist. In these situations, the doctor will send the patient to the specialist to find out what is really wrong with the patient. Under most of these circumstances, the specialist should bill a consultation code for the visit. However, many times a consultation code is not billed simply because the charge ticket is not designed properly.

First, make sure the consultation codes are listed first on the charge ticket. This will prompt the specialist to think whether or not the encounter should be billed as a consultation. When these codes are “buried” in the middle of the charge ticket, the doctor may not have a tendency to bill the appropriate code. Even more important however is to make sure the consultation codes are even on the charge ticket to begin with. If the doctor is a medical specialist, take a very close look at the usage of consultation services on the CPT frequency report. If the frequency report shows a lower amount of consultative services than the office visit codes, it might be because the codes are not aligned correctly on the charge ticket (or even included on the charge ticket in some cases). However, keep in mind it is usually the result of a lack of education about when a consultation code can be billed.

3. Make sure the office charge tickets are prenumbered and missing tickets (i.e. numbers) accounted for.

Numbering charge tickets is a basic form of internal control. To prevent theft, all tickets should be numbered and accounted for. Evidence of missing tickets could be the result of employee embezzlement. Numbering and related accountability helps prevent the situation where an employee takes money from a patient, takes a superbill and gives it to the patient as a receipt, and then pockets the money. The charge and payment are never entered into the practice's computer system.

### Hospital and Surgical Charge Tickets

You will perform all of the same review functions mentioned above for these tickets as you will for the office charge ticket. You need to make sure all of these tickets are accurate and contain the services that the doctor will need to bill, along with related diagnosis codes. Keep in mind however that most doctors do not want to be burdened with a lot of paper when they perform their hospital rounds. This is why the hospital charge ticket is usually much smaller in size, often the size of an index card. The challenge here is to make the card as efficient as possible; usually CPT codes are used and the doctor will write in the diagnosis code.