

THE “ABC’S” OF PHYSICIAN COST ACCOUNTING

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The need for physician cost accounting data has been prompted by the emergence of capitation and risk-sharing among hospitals and physician group practices. It is no longer sufficient to know the costs of hospital services only: accurate cost data must be developed for the continuum of care. In initiating a costing effort, physician practices can benefit from some of the cost accounting lessons that have been learned by hospitals over the past decade. Although many principles of hospital cost accounting can be applied, there are unique considerations to bear in mind, however, when costing out physician practices. An *activity-based costing* approach addresses these issues, and is a feasible approach in the physician practice setting.

APPROACH

A traditional cost accounting approach would focus on the direct caregiver time, and treat other indirect activities as fixed costs, to be allocated to the patient and product level using an arbitrary statistic. However, patient-care activities in a practice encompass a broad range of activities for both physicians and staff members. In addition to the time spent by physicians and other caregivers in office visits and procedures, a multitude of other activities are necessary to coordinate the care for the patient, including, for example; responding to phone calls, reviewing results of diagnostic tests, and dictation. Each of these activities must be factored into a costing effort. To allocate these costs on an arbitrary basis would potentially understate or overstate the true costs of each episode of care. Thus, an *activity-based costing* approach is actually well-suited to a physician practice.

Activity-based costing, by definition, assigns costs to activities based on their use of resources, and assigns costs to products (i.e., encounters, units of service) based on their use of activities. ABC varies from traditional costing in two ways. First, ABC maintains that costs that were traditionally treated as fixed or overhead should receive more attention in a costing effort, and should be assigned on a true “cause-and-effect” basis. This entails the assignment of fixed and indirect costs at two levels; from support departments to the patient care areas (i.e. at the department level), and from patient care areas to the product (i.e. unit of service) level. The second differentiation between ABC and traditional cost accounting is that in ABC, costs are viewed by activity, rather than by financial category. This introduces a common language to be used by the cost accountant and the clinician, who already views costs by activity. A by-product of viewing costs by activity is that ABC allows managers to identify costs of “non-value added” activities, and thus supports total quality management efforts. Hence, ABC leads to “ABM,” activity-based management.

An activity-based costing approach can be considered more practical in a physician practice setting than in a hospital because the range of activities, and types of costs, is less diverse. Although each specialty and each practice is unique, it is possible to develop a list of activities that would work across all practices in the organization. A hospital, on the contrary, would typically require a unique activity list for each department (Radiology’s list of activities would

be entirely different from Surgery's).

STEPS

1. Analyze billing codes: Physician practices, as part of a costing effort, should determine the need for additional detail, beyond the CPT4 codes, to capture variations in costs among patients and procedures. Statistical codes, with a price of zero, can be set up to track the costs of unbilled activities such as prenatal visits. In addition, statistical codes could also track the volume of related ancillary services such as referrals to sub-specialists and lab tests ordered. Although insurers are moving toward further bundling of services (e.g., for minor surgical procedures), practices need to consider keeping or adding codes to better track costs. In assessing whether an activity or supply should be tracked separately, the factors to consider are the cost of the item or service, and the variability among patients.

2. Determine which services will be studied: All office visits should be studied, while the "80/20" rules can be applied to other procedures and lab services. Any codes that are not studied are assigned a default cost standard.

3. Develop the list of activities: As part of an "ABC" approach, a list of activities is developed by the practice managers, or caregivers themselves. This list could vary by type of staff. The list for physicians and other practitioners might include the following activities: office visits and procedures, dictation, reviewing test results, patient phone calls, time at hospital, and administrative time. An activity list for nursing staff and medical assistants might include: room setup, patient prep, visit or procedure time, post-procedure time, patient education, and clinical administration (phone calls, etc.). In addition, office staff would develop a unique list, which might include such activities as appointment scheduling, insurance verification, and patient registration.

It is important to keep the activity list from becoming overly detailed. An activity should be broken out only if the practice manager (or other person involved in the costing effort) will be able to estimate the proportion of time and cost expended on that activity (see step 5. below).

4. Determine the costs required to support the activities: The costs of the practice must be compiled by cost category. Physician costs will include benefits, continuing medical education, dues, licenses and malpractice, in addition to physician salaries. Non-physician salary costs will include other practitioners, RN's and medical assistants, and clerical and administrative staff. Nonsalary costs include medical supplies, minor equipment, and office supplies.

5. Develop cost breakouts by activity: The cost accounting team will develop percentage breakouts by activity, for each cost category. This step can be handled in one of several ways. The practice manager can develop these estimates by observation, or by informally interviewing some of the physicians and staff involved ("What percentage of your time is spent on office visits?"). Alternatively, each physician and staff member could be interviewed separately or asked to complete a form. The latter method would produce more accurate results, as each physician's unique set of responsibilities and work-style would be reflected. Lastly, another approach could involve conducting time studies. The cost/benefit tradeoff should first be

examined before initiating this approach, as it may unnecessarily prolong the cost accounting process.

6. Develop salary standards: For each activity, a time standard or weight is developed at the billing code level, to determine the assignment of costs at this level. Time standards are developed for any activities that represent discrete episodes (office visits and procedures), while cost weights or RVU's are developed for other activities such as coordination of care, administrative time, and malpractice costs. To use malpractice costs as an example, higher weights are assigned to surgical procedures, with lower weights assigned to routine office visits.

7. Develop supply and equipment standards: Detailed supply standards may not be required in the costing study, if supply costs are not significant on a "per unit" basis. If it is determined that supply costs will be studied, the supplies that are specific to the type of visit or procedure are built into the cost standard. The study should focus on higher-cost medical/surgical supplies, with the remaining lower-cost supplies being spread across all billing codes, either evenly or on the basis of the labor standards.

Equipment standards are developed for any specialized medical equipment (e.g., an ultrasound machine), and would involve assigning the depreciation costs of the item to the relevant billing codes. The depreciation for the remaining equipment, which is not specialized, is assigned to all remaining codes, either evenly or based on the labor standard.

8. Assign costs of activities to billing codes: Using the cost breakouts by activity from step 5, and the standards/weights established in steps 6 and 7, the costs of each activity are then assigned to the billing code level. For example, the costs of the activity "office visits" are assigned to each office visit CPT4 code (new patient level 1, new patient level 2, etc.). In this step, volumes by billing code are applied to the standards or weights for each activity, to determine each billing code's "share" of the activity costs. The result of this step is the calculation of actual costs by billing code and patient encounter.

CONDUCTING A READINESS ASSESSMENT

Before undertaking a physician costing effort, the readiness for cost accounting must first be assessed. Is cost data for the physician practices readily available? Is it sufficiently detailed by cost category? Is patient encounter data, by billing code, readily available? Is this information being interfaced into the Decision Support system (if DSS has been implemented)? If so, are the patient encounter records linked to the hospital records?

Once these and other questions are addressed and the costing study is initiated, it is important that the cost accounting team thoroughly plan out the costing process, and develop a clear picture of the outcome of the cost meetings.

CONCLUSION

Because activity-based costing does not have a long history in healthcare, it is easy to dismiss

this approach as being overly complex and excessive for a physician practice. However, adopting this approach for physician practices will address up-front issues that might otherwise compromise the accuracy and hence, the credibility, of the cost accounting study.