Getting Billing Right

MEDICAL BILLING IS BAFFLING, TIME-CONSUMING, AND EXPENSIVE. Luckily, there are solutions. We assembled industry experts for a frank conversation on breaking through the billing maze. Here are their thoughts on the biggest problems in billing and how better processes, technologies, and partnerships can help.

PARTICIPANTS

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Pamela L. Moore, PhD, CPC, has spent the past 10 years learning, writing, and teaching on practice management issues. She is currently senior editor at Physicians Practice, America’s Leading Practice Management Journal, serving as lead researcher, consultant, and writer.

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Rosemarie Nelson, MS, has experience in information systems, as a medical office manager, and as a consultant to physicians. As a healthcare consultant with the Medical Group Management Association, she regularly conducts educational seminars on a variety of healthcare technology and operational topics.

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Bette A. Warn brings many years of experience as a hands-on medical practice administrator and practice management consultant. Today, she serves as executive director for ATD Resources, LLC, a physician-owned billing service that supports 60 providers across several specialties.

John R. Thomas
CEO, President, MedSynergies, Inc.
John R. Thomas (JR) has more than 15 years of experience in healthcare finance, having held numerous leadership positions in financial and medical operations focusing on revenue cycle management, emerging healthcare markets, and core finance for both physician practices and hospitals.

Pamela: Let’s start by getting a sense of billing process problems.

John: I think the problem starts in registration where the data is created; if the data creation process contains errors, there are problems collecting down the line. Everybody focuses on the error follow-up process, but the focus should be on the front end.

Bette: And often there’s somebody working the front desk who doesn’t have a ton of training.

John: Or there is high turnover. And there isn’t adequate technology in the office. We really need about seven pieces of information for eligibility alone: Is a subscriber covered? What is their deductible? The allowable? Are we in or out of network? What is their coinsurance? Is this a covered service?

TECHNOLOGY IS A START

Bette: The basis for success, though, is really technology. In our own group, we have put a lot into clearinghouse technology in the last two years, and it has returned its investment three-fold. We can verify eligibility and authorizations and confirm patient demographics before claims go out the door.

Rosemarie: Sometimes groups invest in it but only use a tenth of it. So you have to invest in the implementation of all the features and functionality that you’re looking for. Plus, all systems aren’t created equal. There are still practice management systems that provide for a reconciliation of today’s appointments and charges, but if you’ve got multiple resources scheduled, that reconciliation isn’t so sweet. Because now you’ve got an appointment for a lab, an x-ray, and for the physician, and it looks like you’re missing charges when in essence you aren’t.

Pamela: So technology can help breakdowns at the front desk. Where else throughout that billing cycle do you commonly see problems?

Bette: We have been able to improve reimbursements by educating physicians about documentation, coding, making sure they’re being paid appropriately for the services they’re providing. When you talk about revenue cycle management, it’s dynamic, and it spreads across the scope of the practice, from the time of registration to fighting with the insurance company to get that claim paid.

John: All along the billing cycle, technology helps, but you have to feed it. Just because you buy a system for half a million dollars, you won’t solve your problems. You need to make sure you have the right people running it. You need to set up reporting mechanisms.

Practices need to convert to more of a manufacturing mentality. How many CPT codes went in? How many were received by the payer, how many have been paid, how many have been denied, how many can you appeal a day per FTE? Convert yourself into a Krispy Kreme. How many doughnuts — CPT codes — are you producing a day? Instead of looking at collection ratio, look at payment per unit, payment for your RVU.

Pamela: Often, when I go into a practice and I ask them for just a simple report, they look at me like I’m insane.

Rosemarie: Most practice management systems provide decent reporting, but you often need to use an add-on tool from the vendor or write your own reports. Too few people invest in learning how to use those reporting tools effectively so they can get some of the greater detail.

John: How many practices look at collection effectiveness on an RVU basis?
We started out with one clearinghouse and our rejection rate because we can clean claims management; I don’t know if everybody finds all of the problems they face in terms of denial it gets them a lot of data. But it doesn’t solve getting electronic remittance, a big positive because that’s a positive. In most cases, practices can get their A/R out electronically.

Bette: Yes, but in our practice, because we have spent the money we have on technology, in two years we’ve reduced our staffing by three full-time equivalents. Our cost for collecting is now only 8.9%.

BILLING FIXES
The Clearinghouse

Pamela: So there are a lot of risks and costs and hassles involved in the billing process. One solution is to use a clearinghouse. Practices think they’ll get some type of claims adjudication. They will get some baseline claims scrubbing, and then the clearinghouse will just somehow facilitate and make things easier in general.

Rosemarie: To some degree that’s true. Clearinghouses help get claims out electronically. That’s a positive. In most cases, practices can get electronic remittance, a big positive because it gets them a lot of data. But it doesn’t solve all of the problems they face in terms of denial management; I don’t know if everybody finds that happens when they use a clearinghouse.

Bette: It does for us; it has dramatically reduced our rejection rate because we can clean claims up before they go out the door.

We started out with one clearinghouse and a year later changed to another one. When we started with the first clearinghouse, one of the physicians was not credentialed, and the claims all went into a black hole. We didn’t know it until that provider’s A/R was way up there.

Our new solution lets us know immediately if there is a problem. We get a rejection list on a daily basis, and it identifies everything from data entry problems to lack of credentialing. Our billing staff reviews the report daily and fixes those claims; it has dramatically reduced rejected claims.

Pamela: They give you insight into the process, but that’s not a guaranteed part of using a clearinghouse.

Bette: No. It’s choosing the right product.

Rosemarie: And how well you use the product.

"Because we’ve spent on technology, our cost for collecting is now only 8.9%."

Outsourcing

Pamela: Let’s talk about outsourcing, another solution to the billing snafus that trip up so many practices.

John: I don’t do my own laundry. I don’t mow my own grass. I outsource that, but it doesn’t mean I’m a lesser entrepreneur or business owner. But in billing outsourcing there have been a lot of fly-by-night companies, and a lot of physicians got burned. Physicians also believe they have better control over billing by keeping it in-house.

Jeff: Strictly speaking, it’s a great thing to outsource. It’s not really what you do as a physician; it’s not your skill set. This is exactly what practices should be outsourcing if it could be done well, and it sounds like the vendors just aren’t doing such a hot job.

Rosemarie: Few practices invest in staff to make their in-house operations better, another reason to outsource. Physician-owners might recognize that we need to get more continuing ed for nurse practitioners and midlevels, but continuing ed for the billing staff or receptionist is a foreign thought.

Bette: The key to a good outsourcing experience is having a good partner. Billing companies aren’t the mom-and-pop shops that were out there before, because those companies couldn’t provide the services and information practices needed. The challenge is keeping that personal relationship with the providers so that they have confidence and feel that you are working for them.

Rosemarie: Good billing companies have an account manager. There’s somebody who can accelerate an issue. There’s that monthly sit-down or whatever it is that helps to continually educate the practice about the process and what’s happening.

Pamela: If you’re being strategic about making an outsourcing decision or selecting a billing company, what do you really need to be looking for?

Rosemarie: I think performance. Like anything else, you want to talk to other satisfied and dissatisfied clients. That’s still important, because to some degree the payer relationship is still local. References are a great place to start.

Bette: Don’t underplay the relationship. You have to meet and know the people you’re going to work with, and how they’re going to support you.

John: Those relationships are often lost during the implementation phase. What we call the “dead zone,” which is the first 45 days past go-live when there’s no cash or data. That first 45 days is tough; it’s all emotion.

Rosemarie: Buyer’s remorse.

Bette: And that’s why it’s important to have that relationship — so you have realistic expectations.

John: I would also spend $5,000 to $10,000 and have the company come in and do an assessment before. Get a baseline. Show us how you’re going to measure our performance.

Pamela: There’s clearly another way that people make decisions about these things: how much it costs. So what can you expect?

Bette: There are a couple of different ways billing companies charge: by claims or by a percentage of net collections. Most frequently it’s by percentage of net collections, and I’ve seen it range from 5 to 15%.

Pamela: Is it one of those “you get what you pay for” deals?

Bette: Not necessarily. From a billing company’s perspective, they need to make a profit as well, and the revenue that’s generated on a percentage basis for a cardiovascular surgeon is going to be a whole lot different than it is for a primary care physician.

Pamela: How would you say the cost of outsourcing billing compares to the cost of staffing up for billing in-house?

Rosemarie: It’s pretty similar when you look at it over a three- to five-year period. Again, it is very specialty-specific. I’ve seen rates as low as 2% for somebody who’s doing all high-dollar, self-pay procedures — versus somebody who’s providing a billing service for an ER and maybe charging 13%.

How do we make an intelligent decision? We have to know what it’s costing us internally to do it, and what’s our success? What’s our denial rate? Plenty of groups know their days in A/R, but they have no idea that 5% of all their claims fail on first pass. And is that the right rate? Is that what we could expect, or could we be as low as 3%? What would be the investment to get to that level?

John: One of the funny things with percent-of-collection pricing is that physicians tend to dicker for a few percent, when the difference is really minimal. If you are comparing a 8% and...
Revenue cycle management encompasses everything from patient registration to eligibility to authorization to coding. It cleans claims. Credentialing, contract analysis—all of those things are involved. Lots of products don’t offer the same thing. Looking, for example, at a practice management system that’s going to be able to integrate into an EMR that’s going to help you with the clinical side of that billing process is very important as well. Many RCM products are becoming more consolidated so that you can buy everything in one shot and have one vendor supporting it all. But it’s not typical, not yet anyway, so having the right revenue management system is important.

For most practices, it’s critical to hire outside consultants with the expertise to guide them in those decisions. Buying it because their friend down the street has it and thinks it’s wonderful—but he has no clue how they’re using it or what it’s really doing for the practice—is not the way to make a decision.

Revenue cycle management is really the combination of all the technology and processes. It’s probably half technology and half process because it’s all about being able to report and manipulate the process as you go along. Setup never ends. You’ve got to continue to change how things are done.

The banks, clearinghouses, practice management systems, IT support, client service people, practice manager, front-desk person, eligibility, coding, the doctor— it’s everything associated with data creation to the point where the balance due is zero, and today no one owns that whole space and does it very well. In fact, I would say no one owns the whole space, so it’s an alignment of partners. And one of the challenges for a practice is getting this alignment.

Definitely check customer lists, but also hire a consultant who’s done it before. Invest that money to make certain that you get the blueprint of what’s going to happen.

Let me give you an example. Registration in an oncology practice is done at the place of service, and verification of benefits is done there also. Well, turnover at the front desk can be quite high. So, the authorization number on 47 CPT codes at $1,200 a pop for one payer was in the wrong spot. Forty-seven times $1,200 is a lot of money. And on each claim, they called the payer to appeal. Thirty minutes a pop, 47 times. You never get to the end of it. Ideally, instead of working denials, train the front-desk person to put that authorization in the right field. That’s revenue cycle management.

Technologically speaking, how does an RCM system tell you that a specific payer needs a specific set of codes or some other information to pay on the first pass?

Well, some systems come pre-loaded with some information, and some of it you have to learn through process or through past EOBs. More vendors are creating these incredible databases of not just payer-specific, but plan-specific information. That data helps us automate the process. Revenue cycle management services are so valuable if practices do their own cost analysis of billing. What’s our first-pass denial rate? What’s it cost in lost opportunity because we’re not doing the analysis on the EOBs after the fact, and building our own database?

Our clearinghouse did that for us. It tells us by payer where there’s a problem, so we can fix it in the system. Going forward, you’re not sending out claims that get denied. This is done daily, so it’s very small amounts. It’s a new job for the billers. Plus, probably 85% of our payers remit electronically. That way, we have specific denial codes, and two weeks after submission, we can follow up on the claim, not six months later when A/R is out of control and it takes twice as many people to follow up manually to fix the claim.

We don’t have any billers—none, zero. We have analysts, and they look at everything in A/R every day, and at why it’s there. That’s the right question for physicians to be asking.
What I’m hearing is that this is not necessarily because of the price. It’s more the mentality of the practice and the sophistication of the ability to do an ROI analysis.

**Rosemarie:** Right, they haven’t looked objectively at their costs.

**Implementation**

**Pamela:** So if you’re going to buy a product or service that is meant to improve your entire revenue cycle management, your entire process, what do you need to be prepared to do to get the most out of that system?

**Rosemarie:** You have to stand in front of the mirror with no clothes on. You have to be self-critical about your process. Most practices have been doing what they’ve done for the last 10, 20, 30 years, so it’s time to change. That’s a hard thing to do alone, and it’s sometimes hard to listen to that vendor/adviser, implementer, whoever, because they don’t really understand you. But you, you have to take off your clothes.

**Pamela:** And you can’t just blame genetics.

**John:** It’s going to give you the same old results much faster when you put new technology in without changing the process.

**Jeff:** You have to educate the staff, bring them in at the selection phase. You have to say, “You’re a stakeholder. You’re important, and you’re going to help us select a vendor.” The problem is, some of the people who might be candidates for the committee are going to be out of a job. You have to prepare everybody honestly.

**Pamela:** Or I often hear of practices simply not replacing staff who leave — or redeploying staff — so they enjoy the efficiency in a less threatening way.

“You have to stand in front of the mirror with no clothes on. You have to be self-critical about your process.”

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**GOOD BILLING STAFF STILL KEY**

**Bette:** We’ve talked about the skills and the knowledge base of your staff, but we didn’t really talk about how you overcome the lack of that knowledge when you hire people, and how to hire people you can retain. Technology helps retain good people.

**John:** We do testing, and we do a lot of training. I think you really have to grow it from within. You have to figure out what you really are looking for. For us, it’s more reporting skill sets than anything else, and knowledge and communication, not necessarily billing expertise.

**Rosemarie:** I’m thinking about how you have analysts instead of billers. Part of this is a mentality, an approach to wanting to find the answer to the mystery. Almost more an attitude than a skill set.

**John:** It is. What type of personality skills do you need? Finding them is very important, and then paying them — because an analyst gets paid a lot more than a biller, and there’s a substantial difference in productivity. There’s a substantial difference in communication both in the organization and outside. It’s a different model.

**Rosemarie:** We need to talk about paying, recognizing that there’s real value in having the right person in that job. All we see is money going out of our pocket. No one wants to have to deal with collections and ask people for money. And then we have to, but we haven’t trained the staff to ask for money.

**Bette:** We have a 30% patient base with no insurance. That means self-pay, no-pay. So we deal with this every day, and we have special people who are precollectors. Every single self-pay patient gets a phone call every 30 days. And we put them on budget plans. We find other means for those patients within the community if they really are indigent and can’t pay us.

**Revenue cycle management is really all about marshalling your resources, and thinking about some of them — your billing staff, for instance — in new ways. Innovation in process and technology is the name of the game for better collections.**

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**Not sure where to start your billing reform?**

**HERE IS A QUICK GUIDE:**

First assess how your billing works today. What are the costs — staff and technology — as a percentage of total payer remittance (or payer reimbursement) each month?

Next, take a look at your billing processes. Where do breakdowns occur? What can improve? And can technology fix those problems?

If you use a clearinghouse or billing service, how are the results and your relationship with client service? Are technology and service available to immediately identify and resolve issues? Do you have the information you need to improve processes or reduce denials?

If you are not using more advanced billing technologies, explore a few. Analyze expected return vs. cost in relation to what you currently spend on paper-based processes and what you lose to poor billing and collections.

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Navicure is a leading provider of Web-based account receivables management solutions that help physician practices increase practice profitability through improved claims reimbursement and staff productivity. Serving thousands of physicians in practices nationwide, Navicure’s solutions automate receivables processes, including patient eligibility verification; primary and secondary claims reimbursement; rejected and denied claims management; electronic remittance posting; claims and remittance reporting and analysis; and patient statement processing. Based in Duluth, GA, Navicure was ranked #1 among the Deloitte Fast 50 in 2007. Navicure was ranked 40th nationally among the 2007 Deloitte Fast 500. For more information, please visit www.navicure.com.

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