The ROI of IT: Best Billing Practices

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MGMA HEALTHCARE CONSULTING GROUP

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We’re Not IT Masters...Yet

“Even if they have computers, most physician practices are still miles away from the ultra-efficient paperless office”

Toth C. Medical Economics Magazine, April 2002.

Ten years later and we’re still mired in paper processes!
Objectives

- Learn tips from better performing practices
- Identify new business practices to integrate into operations that enhance your bottom line
- Identify technology tools that automate operations and enhance service to your patients
- Discuss internal benchmarks and monitoring protocols
Best practices to stop losing money: What it means to you

Better performing practices use benchmarking to answer the question: “How are we doing?”

- Benchmarking is a process of measuring key performance indicators and comparing with national averages and better performers

- Key items to benchmark include:
  - Medical revenue vs. operating costs
  - Average days in accounts receivable
  - FTE support staff per FTE physician

- Better performers:
  - Benchmark routinely
  - Automate processes

*FTE=Full Time Equivalent
Typical benchmarking questions from physicians

- What should the average days in A/R be?
- How many staff should we have per doctor?
Staffing turnover surprise

<table>
<thead>
<tr>
<th>Turnover</th>
<th>Better performers</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and clinical support staff</td>
<td>22.54%</td>
<td>18.82%</td>
</tr>
<tr>
<td>Billing/collections and data entry staff</td>
<td>12.50%</td>
<td>11.54%</td>
</tr>
</tbody>
</table>

Performance and Practices of Successful Medical Groups: 2011 Report
Based on 2010 Data
Case Study

- Our billing is inefficient
- Benchmark key performance indicators (KPI)
  - Better performers
  - Practice data
- Investigate gap areas to determine the “why”
How to sell what we learned

- Too much paper shuffling
- Manual posting of third party reimbursements
- Ineffective contract management
- Underutilization of technology and services
- Increased staffing
### Better Performer KPI (Performances and Practices of Successful Medical Groups - 2009; Orthopedic Surgery)

<table>
<thead>
<tr>
<th>KPI</th>
<th>Better Performers</th>
<th>Case study data</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of A/R &gt;120 days</td>
<td>10.69%</td>
<td>36.18%</td>
</tr>
<tr>
<td>Days gross FFS charges in A/R</td>
<td>29.40</td>
<td>51.51</td>
</tr>
<tr>
<td>Adjusted FFS collection %</td>
<td>100.00%</td>
<td>97.33%</td>
</tr>
<tr>
<td>Patient accounting support staff/FTE physician*</td>
<td>0.87</td>
<td>1.09</td>
</tr>
<tr>
<td>Total medical revenue per FTE physician</td>
<td>$1,242,630.00</td>
<td>$1,073,456.00</td>
</tr>
<tr>
<td>% of claims submitted electronically</td>
<td>95.00%</td>
<td>81.00%</td>
</tr>
<tr>
<td>% of claims denied on first submission</td>
<td>4.00%</td>
<td>19.00%</td>
</tr>
</tbody>
</table>

*Includes coding, charge entry, cashiering.
The Gap sells the investment

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted fee-for-service charges 1/1/09-12/31/09</td>
<td>$27,445,597.05</td>
</tr>
<tr>
<td>Net fee-for-service collection 1/1/09 – 12/31/09</td>
<td>$26,712,131.52</td>
</tr>
<tr>
<td>Practice Net collection rate</td>
<td></td>
</tr>
<tr>
<td>Better performers net collection rate</td>
<td></td>
</tr>
<tr>
<td>Expected revenue at BP net collection rate of 100%</td>
<td>$27,445,597.05</td>
</tr>
<tr>
<td>Revenue Gap</td>
<td></td>
</tr>
</tbody>
</table>

What this means to Practice: If Practice had collected like orthopedic better performing practices, an additional $733,465.53 would have flowed into the practice. ($29,338.62/FTE physician)
Report how quickly accounts transfer to the patient

• Review cycle times for claims submission and reimbursement
  ○ Most practice management systems maintain a date of entry, a date of service and a date of submission.
  ○ Do providers submit charges on a timely basis?
• Determine how much time lapses between date of entry and date of submission
  ○ Should you process claims more frequently?
• Monitor time from date of submission until date of reimbursement
  ○ Identify payers slow to process payments
Automate charge capture

- **Scan encounter forms**
  - 30 percent to 70 percent time savings

- **Use the Internet, smartphone...make it easy!**
  - Reduce cycle time for hospital-based services

- **Best practices for charge posting lag time**
  - 24 hours for office service charges
  - 48 hours for hospital service charges
Preparation in anticipation of the appointment

“The further an error travels along the revenue cycle, the more costly revenue recovery becomes. Some industry experts charge a cost of $25 to rework a claim.”


- Eligibility verification & copay and deductible status
- Automate via batch submission of daily schedule
  - Web-based payer sites issues
- Note/alert for reception
Denials cost the practice

- Physician generates 200 claims/month
- 8% average denial rate = 16 claims
- $40 per appealed denial in time and resources
- = $640 month or $7,680 year

Source: Cost to appeal denial, analysis by Susanne Madden, The Verden Group
<table>
<thead>
<tr>
<th>Patient collections</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traditional cycle</strong></td>
<td><strong>Best Practices cycle</strong></td>
</tr>
<tr>
<td>• 3-5 statements</td>
<td>• 2 statements (0 &amp; 30 days)</td>
</tr>
<tr>
<td>• 1-3 letters</td>
<td>• 0 phone calls</td>
</tr>
<tr>
<td>• 1-2 phone calls</td>
<td>• 2 letters (60 &amp; 75 days)</td>
</tr>
<tr>
<td>• 9 months to collection agency</td>
<td>• 3 months to collection agency</td>
</tr>
</tbody>
</table>
Collection industry says...

- Only 5% of accounts over 90 days past due will ever pay voluntarily
- It is estimated that accounts which are...
  - 90 days past due are 90% collectible
  - 180 days past due are 67% collectible
  - 1 year old are 40% collectible
Front-end best practices

- Patient ID validation
- Eligibility verification
- Service authorization
- Critical data element validation
- Screening for assistance and charity funding
- Estimated patient financial responsibility
- Collection and payment plan
- Real-time claims adjudication
Basic Eligibility

Step 1 - Select payer

Step 2 - Select how you wish to search

Member ID

Step 3 - Enter search criteria  * indicates required fields
Eligibility inquiries submitted for specific service types/procedure codes that are not supported will receive a generic response for the service type 30-Health Benefit Plan Coverage indicating member is active/inactive based on the service date submitted.

* Member ID
* Service Type
* Health Benefit Plan Coverage
* Service Start Date
* Service End Date

Step 4 - Begin search

Send to Payer

Disclaimer - Pre-certification decisions certify medical necessity only and do not guarantee payment of the related claim. Pre-certification does not certify that the member's benefit plan covers the requested service or that the member is eligible for coverage on the date of the service. Benefit plan limits and eligibility are subject to change and will be determined at the time that the applicable claim is processed for payment.
Advanced Eligibility

Step 1 - Select payer

Step 2 - Select how you wish to search

Step 3 - Enter search criteria * indicates required fields

Subscriber ID
Secondary ID Type
Secondary ID
Group Number
Patient Account #
Subscriber Last Name
First Name
M.I.
Suffix
Date of Birth
Gender
City

State
Postal Code

Service Types

1. Health Benefit Plan Coverage
   Add Service Type

Procedure Codes

1. CPT/HCPCS
   Add Procedure Code

Diagnosis Codes

1. Code
   Add Diagnosis Code

<table>
<thead>
<tr>
<th>Date Type</th>
<th>Start Date</th>
<th>End Date</th>
<th>Place of Service</th>
<th>Edit</th>
</tr>
</thead>
</table>
Batch Eligibility

Batch Import Request

The Import Request feature is used for submitting a large number of patient requests that have been grouped into a single file or 'batch'. The Import Request feature uploads the patient requests stored as a file on your computer and then imports that file for batch processing.

The following steps are recommended for the first-time user of Import Request feature:

**step 1.** Click [here] for the import file format details. You may print out the document for your convenience.

**step 2.** Download the sample import data corresponding to a transaction type and payer.

- **Tax:** Check Eligibility
- **Payer:** All Payers

**step 3.** Export the patient eligibility search data from your Practice Management system into a file. Check with the vendor if you need help on your Practice Management system.

**step 4.** Now you are ready to try out your first import file. Just click [Proceed to Next Step] button.
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File Import

Step 1 - Select the batch to contain the imported records
Current batch: 

Step 2 - Locate an import file
Click the "Browse..." button below to locate the import file. (If the file is larger than 500KB, please split it into smaller files.)

Step 3 - Select how you wish to process the import file
- Save to batch - Save the inquiries into the current batch.
- Test import file - Only check your import file format. (Recommended for new users)

Step 4 - Select how to convert patient records to patient requests
- Best match - Convert to the best matching search option.
- All matches - Convert to all matching search options.

Step 5 - Choose an action
Start Import | Cancel

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Back-end best practices

- Stratification of self-pay accounts
- Proactive review of self-pay accounts for coverage
- Proactive claim status monitoring
- Monitor contract reimbursement and terms
  - Details count!
  - Eliminate underpayments
“The biggest benefit of the kiosks is the ability to verify benefits and decrease denials.” — Robert Kaufmann, MD, Kaufmann Clinic, Atlanta, Ga.

- 90 percent decrease in claims denials
- HIPAA 270 inquiry and 271 response
- Copay, co-insurance, deductible amount met
Patient self-service

- Increases patient satisfaction
- Reduces internal costs

<table>
<thead>
<tr>
<th>Task</th>
<th>Approx duration</th>
<th>Cost *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance verification via payer Web site</td>
<td>2 minutes</td>
<td>$0.40</td>
</tr>
<tr>
<td>Insurance verification via payer Web site including log on</td>
<td>2 – 4 minutes</td>
<td>$0.40-$0.80</td>
</tr>
<tr>
<td>Insurance verification via telephone</td>
<td>5 – 7 minutes</td>
<td>$1.00 - $1.40</td>
</tr>
</tbody>
</table>

*Based on $9.00/hour, $12.00/hour with benefits which is $0.20/minute. Generally the hourly rate is higher when performed by RCM staff.
### Copayments collected at time of service

<table>
<thead>
<tr>
<th>Percentage of Copay</th>
<th>Better performers</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-100%</td>
<td>50.00%</td>
<td>33.92%</td>
</tr>
<tr>
<td>75-89%</td>
<td>27.20%</td>
<td>25.15%</td>
</tr>
<tr>
<td>50-74%</td>
<td>12.40%</td>
<td>17.54%</td>
</tr>
<tr>
<td>0-49%</td>
<td>10.40%</td>
<td>23.39%</td>
</tr>
</tbody>
</table>

Performance and Practices of Successful Medical Groups: 2011 Report Based on 2010 Data
Patients’ share of medical bills skyrocket

<table>
<thead>
<tr>
<th>Change over past 6 years</th>
<th>Percentage</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers spend increase</td>
<td>40%</td>
<td>$8,000/employee</td>
</tr>
<tr>
<td>Employee out-of-pocket and payroll costs increase</td>
<td>82%</td>
<td>$5,000/year</td>
</tr>
</tbody>
</table>

2012 Aon Hewitt Associates 2012 Health Care Survey (survey of 3,000 plan participants).

2007: Patients responsible for **12%** of their healthcare bills.
2012: Patients will be responsible for **30%** of their healthcare bills.

- “The ‘Retailish’ Future of Patient Collections” Celent.com
At the Point of Care
What can your clearinghouse do for you?

- Patient statement production and mailing
- Paper claim handling costs $3 to $6 per claim
  - EDI costs? $1 or less
- Electronic remittance saves time (equals money)
  - Days to hours and hours to minutes
  - Case study (1995):
    - Payer with 30 percent of practice’s volume implemented ERA
    - Manual payment posting took five days each month
    - ERA reconciliation took 4.5 hours each month
    - Labor savings: $7,668 annually ($1,917 per FTE physician)
Cheaper to outsource patient statements

- Supplies and postage to send patient statements?
  - Forms (paper, envelopes, printer ink, sales tax: 3 @ 19¢ each x 1200 statements/month) $228
  - Postage (postage @ 45¢ each x 1200 statements/month) $540

- Time and labor cost to manually send your statements?
  - Staff time and labor to prepare statements manually (printing, folding, stuffing, and delivery @ 4 minutes @ $12.75/ hour per statement x 1200 statements/month) $1,020

- Other hidden costs when sending your statements manually?
  - Equipment (printer equipment and maintenance ) $37

- Total monthly costs $1,825 for 1,200 statements

- Opportunity cost?
Effective use of resources: Automate

- E-statements
  - Costs just 58 percent of the price of a paper bill to produce
    - Gartner Group, HFMA, and HH&N Research
Patient online bill payment

- On your statement: “Pay online at www.patientpayonline.com”
- Pay a monthly service and transaction fee
- 10 percent reduction in accounts receivable
  - Increased cash flow
Billing Information

To pay your account balance with your credit card, complete the fields below and click continue.

- Billing Name:
- Billing Address:
- Billing City:
- Billing State:
- Billing Zip Code:
- Credit Card Number:
- Expiration Date:
- CVV (On back of card):
- Phone Number:
- Payment Amount:

* Required
** Email Address is for the delivery of a receipt only.
+ As it appears on your credit card

<< Back  Cancel  Continue
Auto-post

- Explanation of medical benefits available electronically
  - Eliminate manual filing and retrieving
    - Approximately one to one and a half hours per week per FTE provider
  - Reduce hassle factor and space for storage
## ERA Summary By Day

### Search Criteria:
- **Claim Date Range:** 8/14/2012 - 8/21/2012
- **Provider Tax ID:** < Empty >
- **Site ID:** < Empty >

<table>
<thead>
<tr>
<th>Claim Received Date</th>
<th>ERA Received Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/14/2012</td>
<td>143</td>
</tr>
<tr>
<td>08/15/2012</td>
<td>199</td>
</tr>
<tr>
<td>08/16/2012</td>
<td>35</td>
</tr>
<tr>
<td>08/17/2012</td>
<td>56</td>
</tr>
</tbody>
</table>

**Totals:** 433

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Page 1
ERA Search Payment with Results
### Primary Care
#### 2011 Report based on 2010 Data, Median Per FTE Physician

<table>
<thead>
<tr>
<th>KPI</th>
<th>Paper records/charts</th>
<th>EHR</th>
<th>Hybrid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total supp staff FTE</td>
<td>4.60</td>
<td>4.00</td>
<td>3.57</td>
</tr>
<tr>
<td>Total RVUs</td>
<td>16,238</td>
<td>11,375</td>
<td>13,131</td>
</tr>
<tr>
<td>Patients</td>
<td>2,272</td>
<td>2,758</td>
<td>1,798</td>
</tr>
<tr>
<td>Total operating cost (% of med rev)</td>
<td>67.94%</td>
<td>67.54%</td>
<td>59.69%</td>
</tr>
<tr>
<td>Days gross FFS charges in A/R</td>
<td>38.96</td>
<td>31.11</td>
<td>66.84</td>
</tr>
</tbody>
</table>
## Bottom Line Effect of IT expenditures on profitability

Total medical revenue after operating cost per FTE physician.

<table>
<thead>
<tr>
<th>Total IT expense/FTE physician</th>
<th>&lt;$10,000</th>
<th>$10,001-$20,000</th>
<th>$20,001-$30,000</th>
<th>&gt;$30,001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multispecialty</td>
<td>$230,968</td>
<td>$313,900</td>
<td>$320,854</td>
<td>$358,991</td>
</tr>
<tr>
<td>Cardiology</td>
<td>$574,732</td>
<td>$483,426</td>
<td>$587,402</td>
<td>$648,955</td>
</tr>
<tr>
<td>Ob/Gyn</td>
<td>$324,286</td>
<td>$407,244</td>
<td>$417,891</td>
<td>*</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>$584,433</td>
<td>$600,135</td>
<td>$598,869</td>
<td>$675,938</td>
</tr>
</tbody>
</table>

MGMA Cost Survey Data April 2010
Billing department audit

- Process for returned claims and statements?
- How are zero payments (deductibles) posted?
  - Transfers to the patient?
- How are denied claims posted and tracked?
  - Transfers to the patient?
- Process for underpayments?
  - Get the patient involved?
- How are rejections tracked and resolved?
  - Transferred to the patient?
- Process for credit balances?
  - Refunds timely?
- Review of bad debt, write-offs, etc?
- Small balance billing? Write-off?
Summary

- Don’t be an ostrich, but don’t be Chicken Little either!
- Change is evolutionary, not revolutionary
- Do you have the tools for today? And the expertise to use them?
- Do it right the first time
- Monitor, monitor, monitor
- Cut your losses — outsource to experts
  - You’d refer a patient to a specialist, wouldn’t you?