The Game of Medical Billing in Today's Cardiology Practice

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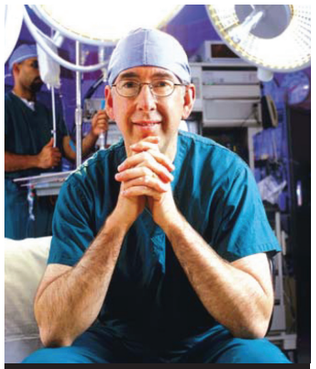
St. Francis Medical Center is a busy acute care teaching hospital which has consistently been recognized as top ranking for the outcome of cardiac surgery procedures and for the lowest mortality in the state. Dr. Glenn Laub, who is the Chairman of the Cardiothoracic Surgery Department at St. Francis, recently saw a 19% increase in his department's monthly collections. His department was able to achieve this with the help of Affinity Billing, a third-party billing service which consolidates billing services, tracks payer performance from a single point of control, shares Medicare compliance rules globally and much more. For tips on how to improve the efficiency of your department's medical billing, keep reading.



Dr. Glenn W. Laub, MD.

Increasing complexity of medical billing creates opportunities for the payers to benefit at the expense of the providers. Traditional asymmetric approaches to billing service automation are insufficient to ensure high billing quality. Systematic automation of both provider and payer sides of the billing process enables the providers to collect most of the moneys they earned.

Since the time of Hippocrates, physicians have dedicated their lives and minds to intensive study of the scourges of mankind. No matter their field, they have always been — and continue to be — specialists in the human condition. But lately, physicians are increasingly forced to divide their attention. Gone are the days when payment for services was a trifling afterthought. Almost overnight, medical billing has evolved into a complex game, requiring doctors to navigate the payers' playing field, which can seem like overwhelming bureaucracy and red tape. The payers' goal can at times seem to be to delay payment as long as possible, perhaps in the hopes that the doctor will forget the claim, or give up in frustration. A payment delay, even if legitimate, inures to the payers' benefit — the money can be invested and the business can profit. It is obvious that the objectives of the payers are quite different from the physicians. The payers are responsible to the patients and investors, not providers. They are experts in finance. Conversely, doctors' primary expertise is to practice medicine, not billing. Doctors are at a huge disadvantage as if they are an amateur player in a game where the payers make the rules, stack the deck, and own the tables.

In order to understand how bad the providers' financial situation is, it is important to recognize that in an average practice, 17.7% of accounts receivable are 120 days past due (Figure 1). In other words, about 1 in 5 procedures billed today won't get paid until four months from now.[1] Note that the likelihood of payment of an unpaid claim payment shrinks by 0.6 percent every day.[5] It follows that an unpaid claim that is 120 days overdue has less than a 48.5% chance of ever being paid. This may be good news for insurance companies, but it is certainly bad news for doctors.

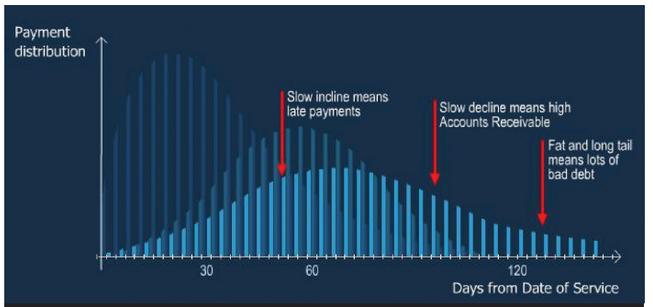


Figure 1. The likelihood of payment shrinks over time.

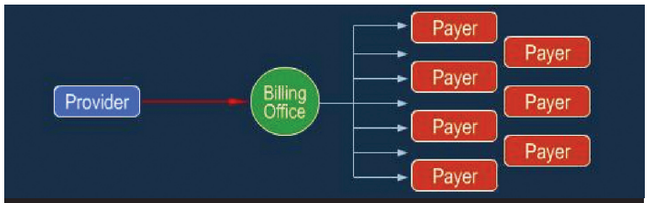


Figure 2. A traditional billing office sends claims and waits.

Importantly, the very fact that these statistics are news to some practices is part of the problem: many medical practices don't even know their basic financial parameters such as "AR past 120," though it is a standard metric in the industry. As a rule, medical practices seem to be uninformed when it comes to their finances, but it's a safe bet that any payer still in business knows exactly how much has been collected and how much is owed, down to the last penny.

Don't Send Staff to Play this Game Part-Time

The complexity of medical billing is consistently underestimated by medical practices everywhere. Providers and payers are playing tug-of-war on opposites sides of the same claims, but the payers have made significant investments in infrastructure and personnel, akin to coming equipped with special gloves, drying agent for the mud, and erythropoietin for the players on their team. Providers, on the other hand, are playing in the worst of conditions. Except for the initial claim submission, they are completely passive at every step. They wait for the payer to review the claim, wait to receive the errors, wait for the review of the corrected submission, and wait, and wait (Figure 2).

In the medical practice this "waiting" can be difficult to appreciate, because everyone is busy with new submissions, resubmissions, and reconciliations — there is always a mountain of work to do. There is little time to take a more active role. So how can everybody be so busy if so little is getting done? Several reasons: the work is boring and the error rate is high (45–55% on average),[2] resulting in a significant amount of the staff's time expended on resubmitting claims so error-ridden they had should probably not have been submitted in the first place. It is not a problem with specific individuals, because many medical practices are struggling with the same issues, but rather the process. After all, anyone's eyes would glaze over while filling out a claim form. These forms sometimes seem designed to perpetuate error — again, the deck is stacked.

Smarter Players Can Beat the Odds

The rules of the game will not change in the foreseeable future, and the payers will continue to own the tables for at least that long, but today's medical practice is not doomed to lose every hand. More and more practices are learning that by playing the game smarter, they can spend less time thinking about collections and more time with patients. What's the secret? It boils down to finding errors before the payer even knows the claim exists. This is no small task, but operations/research-types

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have identified major trouble spots in the process and have made dramatic improvements in a variety of ways. The results speak for themselves; typical practices have seen AR past 120 of less than 5%, and as much as 19% improvement in monthly collections.[3]

The most popular way to get immediate improvement is to start filling out and submitting claims electronically. An electronic claim can be automatically checked for the most common errors: format, missing content, medical necessity, demographics, and eligibility before submission. A medical practice with an electronic claims system can at least take an active role in spotting errors instead of waiting around to hear from the payer. But as many practices have discovered, installing a new system is no magic bullet. Many are surprised to find that the time-savings introduced by the electronic system can be a wash because the staff has to struggle with the system itself, managing software upgrades, system crashes, etc. Even when everything is running smoothly, collections are still late or missing, and there is no easy way of reporting on their whereabouts.

The fundamental problem is that just installing an electronic claims system only automates the provider's side of the process. It's like typing up an email, only to print it out and send it by first-class mail. The analogy can be made even more apt if the computer was bought for this express purpose. The secret to getting paid quickly is automating the payer's side too. It sounds absurd, but it's not an impossible strategy, especially since the payers already have electronic systems of their own. Payers need to keep track of claims from thousands of practices, after all. The real obstacle is finding the right way to connect the payer's system with the provider's system automatically, and to leave the post office for good. Industry insiders call making such a connection between two different systems a "handshake" (Figure 3). It's a tricky task requiring ongoing effort, so no shrink-wrapped software product can offer it. Even among companies that specialize in medical billing services or software, there are few with the right blend of billing experience and tech savvy to tie providers and payers together. *Caveat emptor.*

The practices that have found high-tech medical billing specialists have reaped many benefits. Along with dramatically reducing the error rate of submitted claims by catching and fixing them upfront, the delivery time of each submission is cut to zero (Figure 4). Claims stop spending time shuttling back and forth between payers and providers and get paid sooner and ultimately more often. The best billing companies have systems that include on-demand reports that calculate reconciliations, discover problematic claims automatically, and allow providers to check on the status of individual collections. Armed with accurate numbers and detailed analyses, providers can put pressure on payers if necessary.

The real win, of course, is that the process is just less work and less worry about things that shouldn't even require work and worry in the first place. Though medical billing has evolved into a complex game, medical practices don't have to play along the usual old way. By drafting specialists with experience and technology to optimize their billing process, doctors and staff can spend less time with payers and more time with patients.

Example: Undercharging Errors and Payer Compliance Violations

To illustrate how a payer may benefit from billing complexity at the provider's expense, consider a medium-size cardiology practice seeing 1,000 patients per month with an average claim paid at $268.

If the practice administers 50 different procedures and works with 50 payers, then 1,000 monthly charges require selection from 2,500 unique fees defined by contractual agreements or "reasonable and customary pricing" ("Allowed") for every CPT-Payer pair. Without provider-side automation of the billing process, the provider charges the same fee for each CPT code across all payers, reducing provider's pricing complexity down to only 50 CPT-specific charges ("Billed"). Using uniform Billed for every CPT code to reduce fee complexity necessitates routine over-charging (Figure 5), increases the risk of under-charging (when Billed is below Allowed), and costs an average practice ~2% of its collections (~$64,320 annually).[4]

On the other hand, the 1,000 payments (Payment = Billed – Adjustment) arriving monthly from 50 different payers must be compared too to 2,500 unique thresholds for every Allowed amount. However, without payer-side automation, a review of 1,000 monthly Explanations Of Benefits is impossible, creating an opportunity for "occasional computer error" to the payer's advantage. In our example, if half of the payers arbitrarily shrink the "Allowed" by just 20% for only 10% of random claims, annual practice losses add up to $32,160, or $96,480, including undercharging errors.

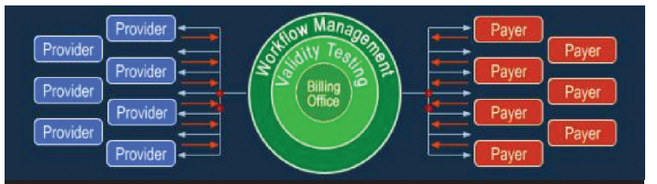

Figure 3. An automated "handshake" between provider and payer enables tracking of payer's performance from a single point of control, sharing compliance rules and massive economies of scale.

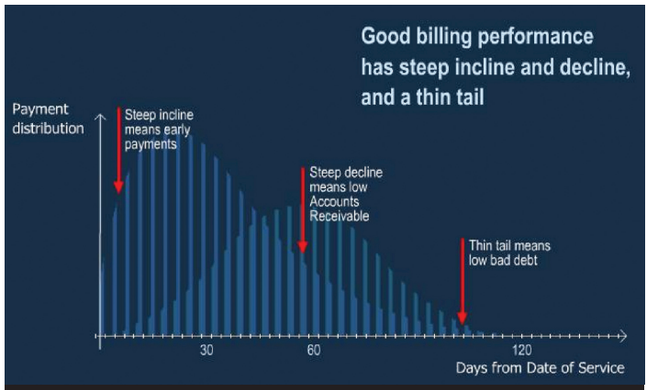

Figure 4. An advanced billing office automates both the provider and payer sides of the billing process and collects more money for the provider.

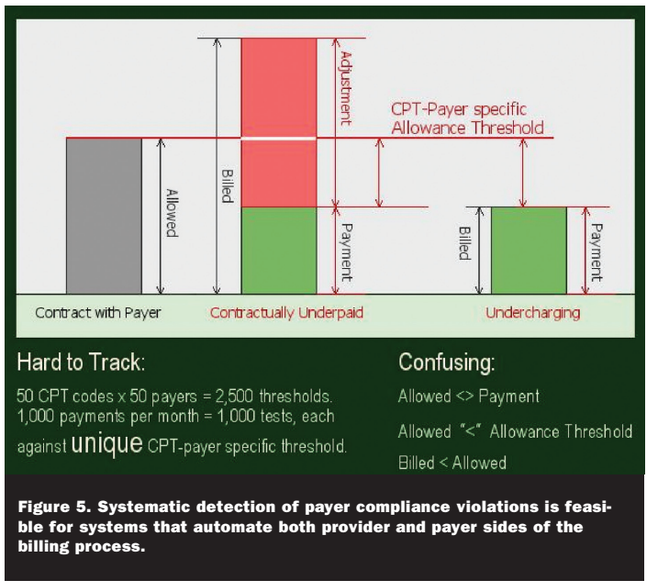

Figure 5. Systematic detection of payer compliance violations is feasible for systems that automate both provider and payer sides of the billing process.

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Editor's note: Yuval Lirov, PhD has disclosed that he owns significant share of and holds CEO positions in both Vericle, Inc. and in Affinity Billing, Inc. mentioned in this article. Dr. Laub has disclosed that he has no financial interests in any commercial companies mentioned in this article.

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