

## RHEUMATOLOGY STRATEGY

# Billing Procedures Help Maximize Profit

**W**ith reimbursement levels declining and overhead costs rising, rheumatologists and other physicians are seeking ways to maximize net income. One important focus for these physicians is billing, collections, and accounts receivable management.

“The processes of billing, collections, and accounts receivable management are crucial to the financial success of any medical practice,” says John W. McDaniel, president and CEO of Peak Performance Physicians ([www.peakphys.com](http://www.peakphys.com)), practice management advisors in New Orleans. “In an environment of declining reimbursements and delays in claims processing, it is crucial that medical practices have sufficient processes to promptly submit and monitor the timely payment of all claims.”

### Submitting All Claims

“Practices that cannot successfully manage the billing and collections function will generate lower revenue than practices that have a reliable, focused, and aggressive billing process,” says David Rosenblum, president of Medical Transcription Billing Corporation (MTBC) in Somerset, N.J. ([www.mtbc.com](http://www.mtbc.com)). Failing to manage these functions can have a negative effect not only on physicians’ income, but on patient care as well. “Bringing in more revenue directly relates to the kind of services physicians can offer their patients,” Rosenblum says.

The key to the billing process is to

adopt a system—whether internal or outsourced—that captures all the necessary information and highlights problems or omissions before the patient visit. Rosenblum emphasizes that the optimal billing system will ensure the following:

- The practice submits claims for all patient encounters, and all submitted claims are clean.
- The practice collects payment on all claims submitted.
- Copayments are collected from patients at the time of the visit, and patients are made aware of their portion of the bill.
- The cost of the billing function is reasonable.

“Clearly, if a practice has 100 claims and only collects on 80 of them, the practice will not be profitable,” Rosenblum explains. The most common reason claims are not submitted is that they are incomplete. “A portion of claims may be missing some piece of critical information, such as patient demographic data, insurance information, or physician notes,” he observes. “A claim may need some attention, but it sits on someone’s desk until it falls off the radar screen. Either the claim is never submitted, or it is submitted six months later and is rejected for being untimely.”

Claims should be submitted as quickly as possible. “Many medical groups fail to get their claims out promptly,” Rosenblum says. “If physicians don’t bill quickly, they can’t collect quickly. Furthermore, the

longer an account remains outstanding, the less likely it is to be paid.”

### Optimizing Billing

A good billing system will maximize the amount of revenue collected at the lowest possible cost. Practices can assess their billing indicators and compare them with national benchmarks. According to the American Medical Association, the cost of in-house billing is about 10% of revenue collected; practices whose costs are higher than that rate should identify the reasons claims are not being paid and develop solutions that will increase the percentage of claims paid and reduce accounts receivable days.

Practices should track key performance indicators and benchmark the data both among members of the practice and externally. The Medical Group Management Association (MGMA) has performance and cost surveys that offer excellent data for this purpose ([www.mgma.com](http://www.mgma.com)).

A key indicator to monitor is accounts receivable days each month. If a trend analysis indicates that accounts receivable days are growing, the group has a problem. Physicians should pay particular attention to the portion of accounts receivable that are over 90 days old. “If accounts get old, they are obviously not being worked,” Rosenblum observes. “The older an account gets, the more difficult it is to collect.”

MGMA’s *Performance and Practices of Successful Medical Groups 2007 Report* indicates that an average of

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59% of total accounts receivable in single-specialty medicine group claims are collected within 30 days, 13.5% are collected in 60 days, 7% are collected in 90 days, 4.5% are collected in 120 days, and 14.5% spend over 120 days in accounts receivable. According to the report, best performing practices collect 66% of accounts receivable within 30 days, while only 7% are older than 120 days. For all practices, the average gross fee-for-service collection percentage is 47% (calculated as net fee-for-service revenue collected divided by gross fee-for-service charges billed). The report can be purchased through the MGMA.

Many practices outsource the billing function, a step that reduces the need for in-house billing staff and, therefore, can be less costly. MTBC does billing for its clients, and the costs are about 4% to 6% of revenue collected. Physicians may prefer outsourcing for other reasons as well.

"Our clients often tell us they are tired of dealing with personnel issues," Rosenblum explains. "In small practices, the person in charge of billing also has other responsibilities, meaning that bills may not be sent out promptly or denied claims will not be pursued aggressively. Practices of a size that justifies dedicated billing personnel have to deal with training, employee turnover, and vacation time. Because of their focus and the technology systems they use, outside billing firms can often collect a claim before the office staff could submit the claim."

Michael Guma, DO, a rheumatologist in solo practice at North Jersey Rheumatology Associates in North Arlington, N.J., finds that as physician incomes drop, the cost of administrative functions such as billing become more important. He outsources his practice's billing function to MTBC. "Billing tends to be very labor-intensive," he says. "It can be a costly function for a practice. For this reason, many small practices pre-

## The Importance of Submitting Clean Claims

**A** clean claim is one that includes all items of pertinent information. "A claim is considered clean when the billing staff verifies that insurance coverage exists, the procedure is covered, complete and accurate insurance and patient information is included, the coding is accurate, and the documentation supports the code," says David Rosenblum, president of Medical Transcription Billing Corporation (MTBC) in Somerset, N.J. (at [www.mtbc.com](http://www.mtbc.com)). "Ensuring clean claims is critical for reducing accounts receivable."

Front-office staff should be responsible for collecting all of the requisite patient demographic information and third-party payer data necessary for billing. Also, the staff should ensure that these data are updated during every patient visit. This step is important because patients may move, change jobs, or work for employers that change insurance contracts.

After reviewing the typical problems in medical billing, MTBC has found that the biggest source of denied claims is insurance eligibility. "In many cases, physicians either see a patient who does not have coverage, or—more likely—the practice does not have the right coverage information," Rosenblum observes. "Many claims are rejected as a result; the staff has to find out the right information and then has to resubmit the claim."

Some billing companies, including MTBC, will verify insurance eligibility before a patient visits the office. This step ensures that administrative staff know before the patient arrives whether the insurance information on file is correct.

Here's how it works at MTBC. "Each evening, the patients on the following day's schedule are submitted for eligibility verification so that when the practice opens the next day, all patients' insurance coverage has been confirmed," Rosenblum explains. "Administrative staff can check with patients who have not been confirmed to see if the information on file is incorrect or if coverage has changed. For walk-ins or same-day appointments, eligibility can be confirmed on a per-patient basis."

Verifying eligibility is a fail-safe measure that addresses a common reason for claim denials. "This system means that there is no chance of providing the service, submitting a claim, and then finding out that the patient did not have insurance eligibility," Rosenblum explains.

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fer to outsource their billing." Using MTBC, Guma pays only 4% of collections, compared with approximately twice that amount with his previous billing company.

### Collecting Data

Another benefit of outsourcing billing is the ability to access detailed information at any time. "Some billing companies may not provide customized billing reports to practices, or may provide them several

weeks after the request," Guma notes. MTBC's Web site allows him to request detailed reports that help him make strategic decisions. "For example, I can select an insurance company, a code, and a time frame, and find out what I've collected from that company on that code," he says. "I can also look at how fast I am getting paid by certain insurers. I can get this information any time, any day of the week." Such reports help practices decide whether to continue with cer-

tain insurer relationships, he adds.

Rheumatologists interested in outsourcing the billing function should look for certain critical characteristics. "One is integration," Rosenblum says. "Practices have a number of systems in addition to a billing system, such as a patient scheduling system, an appointment reminder system, and maybe an electronic medical record. But these systems don't fit together on their own. The billing vendor should provide an integrated practice management system or be able to interface the billing system with systems from other vendors."

A second issue is the ability to view information on collections. "Accessibility of billing information is very important, particularly since most of the physician's day is devoted to patient care," Rosenblum notes. "An Internet-based billing system is convenient because it allows physicians to access information and review practice performance from any location."

Third, the system should have a flexible reporting system. "The system should be able to organize information so that the physicians can get customized reports that serve the practice's specific purpose," Rosenblum says. "For example, a multiprovider practice that distributes revenue based on the number of patient encounters should be able to request a report that breaks down patient encounters by physician."

The vendor also should have sufficient manpower to collect hard-to-collect claims. "No matter how efficient and effective the billing process, there will always be some claims that are difficult to collect," Rosenblum continues. "The vendor needs staff that can devote time to aggressively and quickly resolving denied claims." Billing companies

can provide that manpower.

For Guma, it is important for rheumatologists to compare the costs of their internal billing functions with those that different billing vendors offer so that a practice can make cost-effective decisions. "Vendors charge based on a percentage of collections, but it is important to know what components of the bill they are including," he says. "Suppose a practice does a lot of infusions. Some vendors may charge a percentage of

the infusion services only, while others may charge a lower percentage but include the costs of the medications the practice purchases for infusion. Therefore, it is critical to calculate the real cost of the billing service and consider other benefits, such as reporting, before entering into a relationship with a vendor."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

## Expert Advice: Collect From Patients Up Front

**E**ach patient should pay his or her copayment at the time of service. "It is very difficult to obtain copays once patients leave the office," says David Rosenblum of Medical Transcription Billing Corporation. "The practice can send the patient a bill for the copay, but the patient may have forgotten that he or she did not pay the copay and dispute the bill." MTBC's billing system allows practices to print out a form stating that the patient did not pay the copay. "The patient initials it and takes home a copy, while the office retains proof that the patient didn't pay," Rosenblum says.

Another issue is that many claims are partially paid, meaning that outstanding balances are due from the patient. "Often, claims are not completely paid because of patient deductibles," Rosenblum points out. "Furthermore, claims may be rejected due to patient ineligibility. Either way, the patient is responsible for that balance."

To address this issue, MTBC and other medical billing companies offer real-time adjudication. "This system allows the practice to determine exactly what the deductible is before the patient leaves the office," explains Rosenblum.

Typically, a practice will perform a service, collect the patient's copay, submit the claim, and then find out the patient has not met his or her deductible and so owes that amount to the doctor.

"Now the practice has to bill the patient," Rosenblum says. "But the patient is confused, and calls the practice to ask why he has to pay a portion of the bill. This is problematic because patient balances are the hardest dollars to collect. Real-time adjudication allows the practice to inform the patient at the time of the service that the patient will be responsible for a portion of the bill. There are no surprises for the patient or for the practice. Furthermore, the practice can collect the amount due from the patient or hand the patient a bill before he or she leaves the office."

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