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Part 2: Smart Ideas for Improving Collections and Reducing Denials

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Part 2: Smart Ideas for Improving Collections and Reducing Denials

Getting paid for what you do starts long before a claim leaves your billing office. And while some of the billing cycle can be out of your control, every office can take a few simple steps to optimize what it can control.

Your first step? Optimizing your encounter form.

Create a Relevant Encounter Form

The encounter form is an important financial tracking tool. Treat it with great respect, as if it were cash, not just an internal office form. After all, it is the source document that is essential to getting paid. And it usually can be improved, whether you are using an electronic or paper version.

Each year review the encounter form for both hospital and office services. Is it provider friendly? In other words, can doctors *easily* use this tool to document the patient's condition and the treatment provided?

Too often the encounter form is full of information that is never used by the provider or the staff. For example, it may list 100 ICD-9 diagnostic codes when the physician typically uses only 25. The same may be true with the listed CPT procedure codes. To determine the effectiveness of the encounter form, generate a report that reveals the top CPT codes used, listed by frequency. Do the same for the application of ICD-9 codes. As a rule of thumb, if codes are not applied at least five times a month, they need not be listed on the encounter form. Keep the encounter form simple and uncluttered by removing uncommon codes. Instead, use that space for providing instructions to staff or add a section for ordering off-site diagnostic studies.

Here are a few tips for making the best use of the encounter form to improve documentation and collection activities:

- ▼ Number the encounter forms to track and identify missing tickets.
- ▼ Limit the list of codes to the most frequently used.

▼ When possible print computer-generated encounter forms. With most practice management systems, the forms can be generated based on the appointment schedule.

- ▼ Include other information to help you get paid, such as:
 - ▽ Insurance plan
 - ▽ Amount pending payment from insurance
 - ▽ Amount owed that is the patient's responsibility
 - ▽ Aging of the account balance

Physicians and staff can use this information to make sure prescriptions and orders are covered by the patient's plan or to follow up on account balances at check-out, for example.

Stay on Top of Coding Changes

Update the encounter form every year to make sure it is serving the practice well and lists the most relevant codes. Review it near the end of the year for the next year's coding application. Audit the codes by comparing what's on the encounter form to the newest edition of the CPT and ICD-9 book. Review the CPT book for changes in coding applicable for your practice specialty.

If you are changing codes, that's a trigger to train physicians and staff on new codes. Don't risk denials by using outdated codes. In 2009 alone there are 290 new codes. There are 17 additions in the E&M section, 36 in the Surgery section, and 67 new codes in the Medicine section. Ninety codes were deleted in 2009, and more than 130 have been revised with different or additional wording.

Every practice needs an on-site coding expert. In a small practice it might be the physician. In a larger practice it is most likely a member of the billing and collections team. Make this an official designation and with it should come the responsibility to stay up on coding issues and educate staff of any changes. Staff that has influence over any part of coding selection, posting, billing, or collections need to be in the loop when it comes to on-going training with coding and billing regulations.

Your on-site expert should subscribe to newsletters and publications that provide continual updates on coding practices and legal regulations, ensuring she/he is up-to-date and aware of changes coming down the road.

An annual staff meeting used specifically as a billing and coding refresher is an excellent way to keep everyone informed and on board with helping the practice effectively optimize its ability to capture and improve revenue. At the same time, this truly enhances the resident coder's position with job enrichment and fulfillment — a great way to retain high-performing staff members.

At the same meeting, physicians can discuss new procedures they plan to perform or are performing so that staff understand what services physicians are providing and offer feedback on coding.

Everyone in the practice should feel comfortable asking questions when something documented on the encounter form doesn't look right. In fact, instead of considering it a nuisance, compliment staffers who ask questions. The employee who asks questions is conscientious and looking out for the practice, wanting to be sure she understands her job better and is doing it right. She will be a future star if allowed to shine.

Code it Right

Coding selection needs to be both thoughtful and accurate. Physicians who get in an E&M coding rut, selecting the same level of service for the majority of their patient visits, may need to readjust their thinking. Too many physicians take the low road, wanting to play it safe by picking the 99213 E&M code for the majority of their established patient office visits.

Code selection should accurately reflect the work that is done. The justification for higher levels of service should be based on patient symptoms and the complications they present at the time of the visit, which needs to be reflected in the selection of ICD-9 diagnostic codes. The CPT book clearly defines the examination and treatment criteria for each level of E&M coding. Common coding errors frequently result from physicians' fears of penalties for over-coding and their concern over the need to justify higher levels of E&M code selection.

The resident coder can help the providers have a better understanding of how to use the CPT book to determine the level of service, key components, and documentation required for specific coding selections. "One of the most confusing coding issues in E&M code selection for physicians continues to be the use of consultation and new

patient codes," said Mary Jean Sage, a coding and billing expert with The Sage Associates in Pismo Beach, Calif. "They think anytime another physician refers a patient to the practice it is a consultation. This is not the case."

Using modifiers is important to clearly identify treatment and improve the opportunity for the claim to be properly adjudicated for optimal payment.

The coding for consultations does not differentiate between a new and established patient, but does separately identify in-patient and office consultations. The consultation is a type of service provided by a physician whose opinion or advice is sought by another health care professional for a specific problem or condition.

Physicians and their staff need to understand that a referral from another physician is not a consultation unless the consulting physician is asked to provide an opinion or advice to the referring physician for a specific problem. "A consulting physician may initiate diagnostic and/or therapeutic services at the time of the initial consultation, if requested by the source that is asking for the consultation," Sage said. A consultation initiated by a patient or his family is not reported using consultation codes and requires selection of a different E&M visit code.

Coding for new patient visits is confusing to some physicians and staff. A new patient code is used for patients who are seen for the first time or who return to the practice after more than three years — unless the patient's return falls under the restrictions and requirements for billing for a consultation.

Modifiers are additional code indicators used to reflect unusual circumstances about what occurred during the patient's visit. Using modifiers is important to clearly identify treatment and improve the opportunity for the claim to be properly adjudicated for optimal payment.

Modifier 51 is used to report multiple procedures by the same provider. This requires applying a discounted fee adjustment for multiple procedures performed on the same day. It does not require adjusting the fee on the first procedure, so practices should list the most complex (and highest cost) procedure first. A modifier should not accompany this first procedure.

Modifier 24 is used for an unrelated E&M service by the same physician on the same day during a post-op-

erative period. Modifier 25 is applied to an E&M code when a procedure that qualifies for global surgery concept is performed on the same day as the E&M service. Modifier 50 is used for bilateral procedures, and Modifier 22 is used for unusual procedures. Most insurance carriers require a written report to support the need for using Modifier 22. You should explore other categories of modifiers for proper billing. This is another reason you should develop a resident coder in the practice and provide him with continual education and updates in coding and billing requirements.

Those are the most utilized modifiers in the typical ambulatory practice, but there are many others used to distinguish variables in what services that patient received. Physicians and billing staff need to be familiar with these codes and should examine potential application of the codes that would help the practice get paid.

New CPT codes have emerged in recent years to address other care management issues such as behavioral intervention and counseling. There are two smoking and tobacco cessation codes: 99406 for three to 10 minutes and 99407 for more than 10 minutes. Alcohol abuse codes are 99408 for 15 to 30 minutes and 99409 for more than 30 minutes. “Keep in mind these codes are used to identify services provided. It does not mean you will get paid for these services,” Sage said. “Although some payers are covering these services, the payment amount allowed varies. It is important to understand the payers’ specific practice guidelines. For example, with smoking cessation Medicare allows two attempts a year and as many as four visits for each attempt.”

Some carriers are now paying for online medical E&M services (CPT 99444), but few, if any, are covering telephone E&M services (CPT 99442). Medicare considers this a noncovered charge. Both of these codes can only be used when the patient generates the request. With this in mind, practices should not be spending time coding and billing for telephone services, unless they are willing to charge the patient for the telephone consultation.

“Since there are so many coding nuances and variable guidelines and restrictions, it would be wise for the practice to obtain a signed ABN (advanced beneficiary notice) for Medicare patients and adopt a similar form for non-Medicare patients to complete when they agree to receive some of these potentially nonreimbursable services,” suggested Sage. This way, patients know when they are responsible for payment for services they may have assumed would be paid by the insurance company. It also helps the practice collect appropriately from patients for noncovered services.

Submit Clean Claims, Reduce Errors

Proper coding and timely, accurate documentation strengthens your entire billing and collection performance. Revenue cycle management is greatly enhanced when the practice submits clean claims — claims that are not bounced back to the practice after being scrubbed by the payer or clearinghouse for errors.

Three common errors can lead to rejected claims, according to Sage:

1. Upfront data collection and data entry errors resulting in listing the wrong subscriber number or submitting the claim to the wrong carrier. Train staff properly. If you have six different Blue Cross payers, they need to understand how to identify where each claim goes;
2. Set-up that fails to include the National Provider ID for each provider in the practice; and
3. Coding discrepancies, including an error with the two-digit place of service code and failure to properly line up ICD-9 diagnosis and CPT service codes. The diagnosis code selected should validate the reason the service is performed.

Track your error ratio to identify the most common mistakes and take corrective actions to improve claim submission for prompt payment. Collect data on both the source of the problem — types of errors — and the number of claims and dollar value represented. This information will help you find trends in

Denial Management Matters

- 30 percent of the 15 billion claims submitted annually in the United States are denied
- Of that 30 percent, 15 percent (675 million) are never resubmitted
- Medicare denies about 11 percent of all claims submitted
- 40 percent are never resubmitted
- According to data from Medicare, 65 percent of the claims carriers reviewed on appeal result in increased payments
- Experts: 70 to 80 percent of appealed claims are eventually paid

Sources:

1. Healthcare Business Advisors, LLC, Albany, N.Y., 2002 report.
2. Centers for Medicare and Medicaid Services, February 2000 download. www.cms.hhs.gov.

practice performance and set specific goals for improvement. Set your own expectations and create your own best practice performance criteria. A well-run practice should be experiencing a less than 2 percent error rate. In other words, for every 100 claims, fewer than two claims should be rejected.

When clean claims are submitted, payment is expedited by third party payers. The second component of getting paid is the request for payment from the patient — your patient statement.

Best-Practice Billing Process

The sooner you bill for the service, the better your ability to get paid. See Table 1 for expectations.

Practices with electronic health records that post charges in real-time are expediting the billing process, so these timeframes will get even tighter within the next few years.

As stated previously, it is expected that less than 2 percent of the insurance claims will be rejected. You could also use a charge audit to examine billing performance. If the audit uncovers errors in reporting charges or posting, these indicators could be used to set improvement benchmarks. The practice, of course, would need to take responsibility for conducting follow-up audits to monitor progress. This would be an excellent method to improve and manage billing processes, as well as to ensure effective coding compliance measures are in place.

Make it Easy for Patients to Pay

We've discussed the criteria for submitting clean claims, but it's also important to identify the key components for a clean patient statement.

Producing clean patient statement begins by verifying the patient's address at each visit. The design of the statement and the information included is also critical. Too often patients receive a statement from their doctor that they find confusing, which can delay payment.

Make it easy for the patient to understand what actions you want them to take when they receive their statement. Here are a few ideas to make the patient statement more meaningful:

1. Clearly state what services have been rendered during the statement cycle.

TABLE 1. Benchmarks for Charge Entry and Claims Submission

	Charge Entry	Claims Submission
Office services and procedures	1 - 2 days	2 - 3 days
Hospital visits	2 - 5 days	3 - 6 days
Surgical procedures	5 - 7 days	6 - 8 days

2. Inform the patient of what is outstanding from the insurance company, when it was billed, and any payment activity.
3. Separate patient balances.
4. Provide aging of patient's balance.
5. Use message area properly to indicate
 - a. What actions are expected from the patient, such as paying statement within 30 days.
 - b. Dunning messages for accounts that have aged beyond the first statement cycle.
6. Include the phone number they should call if they have questions.
7. Provide an area for them to make payment by credit card or online.
8. Provide a return envelope for mail-in payments.

Consider implementing four separate payment cycles, divided alphabetically, so that 25 percent of the patients owing money get statements each week. This will even out the flow of phone calls from patients with billing inquiries and the distribution of payments. The staff work flow will also be more evenly distributed and better managed.

The practice should generate patient statements on demand after receiving an insurance payment that transfers the remaining balance to the patient. Patients will most likely receive their explanation of benefits around the same time you post payment, so sending a statement corresponds nicely to keep them informed and expedite payment.

Better Manage the Accounts Receivable

The value of accounts receivable can be confusing, and physicians sometimes assume that the total accounts receivable, A/R, will eventually end up being collected. However, if the practice typically adjusts 30 percent of the charge due to third party reimbursement contracts, then only 70 percent of the accounts receivable has the potential of being collected.

Of course the actual maximum collectible amount is less than 70 percent due to occasional courtesy or bad

TABLE 2. Achieving Target OTC Collection Goal

Over-the-Counter Payment Goal	Average Daily OTC Collections	Payment (% of Patient's Balance)	Payment (% of Patients that Paid the Visit Copay)
Historical Performance	\$810	12%	55%
30-day target		50%	80%
60-day target		70%	100%
90-day target		90%	100%

debt write-offs, even in the best-run practices. Collections quickly discount when they age.

Managing accounts receivable begins with good financial controls, including written financial policies and a process for holding staff accountable. The policies should strive to optimize revenue recovery and clearly outline what the practice considers acceptable in terms of patient payment timing and extended payment plans for large balances. It should also cover the standard procedures for monitoring and responding to delayed insurance payments.

The perfect time to collect from patients is when they are in the office, and employees should be committed to asking for the entire balance on the account at the time of the visit. It's easy to see how well this is being done once you have the information standards for improving over the counter (OTC) collections.

The most effective way to achieve the target OTC collection goal is to establish graduated expectations for improvement over a specific period of time. See Table 2.

Each week monitor staff's performance with OTC and share the results. Continue to encourage and praise them as they progress. Some practices offer bonuses when staff hit certain targets as an incentive to improve collections.

If staff struggle to hit the targets, provide additional support to teach them the skills necessary to overcome

obstacles and obtain patient payments. At the same time recognize that not every employee is right for this position. Some people just can't get comfortable asking patients for money. Know when you need to shift a different person into the position before someone feels inadequate.

The key indicators for a well managed A/R are the number of days in accounts receivable and the amount aged more than 90 days. These indicators help you monitor payments, identify red flags in practice performance, and recognize when assertive collection actions should be considered. See Table 3.

The amount aged more than 90 days should be no more than 15 percent of the total A/R. Payments should be in A/R 45 days if the practice is billing insurances accurately and promptly and holding patients to high payment standards. Also, staff should be enforcing these standards:

- ▼ Require patients to pay copays and their share of costs at the time of service.
- ▼ Collect patient balances over the counter when the patient returns to the office.
- ▼ For patients that are not in treatment, expect payments within 30 days of receiving patient statements.
- ▼ Clearly define what payment plans are acceptable for large balances, but require the entire balance paid within

six months. These plans should be agreed upon, put in writing, signed by the patient, and enforced by the collections department.

Holding a tight reign on the A/R is important because of the discounted, shrinking value for aged receivables.

- ▼ 30-day value = 95 percent
- ▼ 90-day value = 75 percent
- ▼ 180-day value = 30 percent

You can see why it's so important to be more assertive in collection efforts. Collection efforts should focus on active patients and ac-

TABLE 3. Benchmarks for Percentage of A/R Over 120 Days Old

	Better Performers	Others
All Multispecialty	9.82%	18.30%
Primary Care Single Specialty	7.45%	17.60%
Orthopedic Surgery	9.79%	14.35%
Surgical Single Specialty	7.67%	13.71%

Source: Medical Group Management Association. 2008 *Performance and Practices of Successful Medical Groups*.

counts that are aged between 30 and 60 days.

Monitoring insurance payments is an essential part of managing the collection process.

Have the billing staff generate an outstanding claims report and pinpoint accounts that have not been paid within 30 days of billing. Then start making inquiries — you have waited long enough. If there is a reasonable cause for the hold-up, get it resolved.

It is equally important to audit claims payment. Too many practices assume the claims have been adjudicated properly, and too many insurance companies know you won't question their payment errors that reduce reimbursement. Staff needs to know what the allowable amount is for each payer for the top 25 codes utilized in the practice. The payers are usually cooperative with meeting a request promptly, as long as you keep the code list reasonably short. Management should audit claims payments periodically to hold staff accountable for properly handling the payment and making the correct contract adjustment.

If your practice fails to establish written revenue recovery standards, you are jeopardizing the ability to improve cash flow and optimize revenue.

Using Collection Agencies

Practices frequently ask when they should turn an account over to a collection agency. The answer is simple: As soon as it becomes evident the person responsible for payment is ignoring your request for payment. If the person has not responded to two inquires, one written and one phone call, you are headed for trouble. The sooner you get it into the collection agency's hands the more likely the agency will be able to recover the revenue. Give the patient a 15-day notice and if they don't respond with full payment, send it to collection. You can't give a notice and fail to act on it. This is considered a threat and is in violation of federal collection regulations.

Payer Contract Performance

It's the practice's responsibility to evaluate and monitor the performance of the third party payers and hold them to the terms of the contract. I am amazed at how many times practices don't have their contracts and related fee schedules or know where they are. How can they be sure they are getting paid correctly and that the terms of the contract are not being violated? Without a copy of the contract and supporting documents, physicians and staff

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cannot enforce the contract and have no means to hold the payer accountable.

Analyzing payment performance for your existing contracts will give you an understanding of its financial value to the practice.

First, estimate how much it costs to see a patient by dividing the prior year's operating expense by the total number of patient visits. Next, add expected profit margins to this cost. For example, if the national benchmark for your specialty is 35 percent net profit, then add 35 percent to the cost of seeing a patient to determine the reimbursement required to maintain a prudent and profitable practice.

Example:

Cost to see a patient	\$ 74.15
Expected net profit + 35 percent	\$ 25.95
Required average reimbursement	\$100.10

Then compare the insurance allowable charge for the

Facts About Collections

Some tips about using collection agencies:

- Only 5 percent of accounts over 90 days past due will ever pay you voluntarily
- It is estimated that accounts that are:
 - 90 days past due are 90 percent collectible
 - 180 days past due are 67 percent collectible
 - 1 year old are 40 percent collectible

Why patient collections matter, too:

- Annual growth in consumer-directed plans (provider reported) — 5 percent to 20 percent
- Annual growth in bad debt write-offs due to consumer-directed plans (provider reported) — 40 percent to 50 percent
- Percent of providers complaining that eligibility information from payers is inaccurate, incomplete, untimely, or unavailable — 80 percent
- Percent of providers who feel they are getting the information they need to manage consumer-directed plans — 10 percent

Source: Nav Ranajee, MBA, John C. Osberg, MHA, Robert E. Gross, MBA, and Steven S. Lazarus, PhD. *The Impact of Consumer Directed Healthcare on Providers*, The International Journal of Medical Banking, Feb. 1, 2009. <http://www.mbproject.org/journal/?p=47> Accessed 3/26/2009.

practice's major payers. List the practice's 10 highest volume CPT codes and compare the top payer's reimbursement of these codes. Finally, calculate the average reimbursement for each of these payers based on the reimbursement for the selected codes.

Compare this amount to the payer's average payment performance and to the practice's required payment and you will be able to determine which contracts are financially rewarding and which ones should be either renegotiated or cancelled.

A business cannot provide a service that does not offer a reasonable profit. Of course, there are special circumstances, such as assuming a lower reimbursement for a payer such as Medicaid, as long as this is a conscious economic decision that represents a small portion of the practice and does not threaten the financial viability of the practice.

Payer Relationships

Some physicians do their own contracting while others delegate some or all of this responsibility to managed care organizations (MCO) through a centralized management service organization (MSO) or an independent provider association (IPA). Physicians who have released the contracting control to a third party have done so out of convenience, fear, or concern about the ability to obtain the best contract terms on their own. These third parties may or may not be effective at representing physicians and obtaining favorable fee schedules or payment terms. Furthermore, they sometimes fail to provide the practices with copies of the contracts and the associated fee schedules.

Physicians have allowed insurance plans to dictate the fees and terms of contracts in the past, but that doesn't mean they need to do so in the future. It's time to take back the control. Scrutinize every contract you are considering. Don't let the emotions of the situation get the best of you, even if the insurance company appears to be a major player in town.

Fees are negotiable. Ask to see the plan's fees for the top 20 to 25 codes utilized by the practice — and don't

sign the contract without this information. You risk financial vulnerability if you don't know how much you will be paid and when. If you don't ask for more, you're not going to get it, and that must be done before signing the contract.

Don't assume that you are locked into the terms of some boilerplate contract that's being passed around to all the doctors in town. Learn to say no to terms that aren't acceptable. For example, a contract may require physicians to submit their claims within 60 days of service, but may not specify a time limit on when the payer actually pays the physician. Why would a physician agree to those terms? Of course there

is some protection if your state has legislation that requires the insurance plan to pay claims within a certain number of days. Check with your state's "Prompt Payment Laws" before you agree to a contract that does not specify payment terms.

It's not just the contract itself, it's also the relevant documents mentioned in the contract that need to be examined. Physicians need a clear understanding of the grievance process in the beginning — not once a problem emerges. Review the plan's quality assurance and utilization management procedures. Find out what the plan expects from the practice and what the practice will be agreeing to if the contract is finalized. What are the call coverage requirements and what are the in and out clauses? Also get a clear understanding of the medical liability the practice will own under the contract. Does it include a hold harmless clause to protect the physician and the practice? It's wise to have the contract reviewed by your malpractice carrier and/or lawyer in advance. The practice must protect its own interests!

Indeed, it is important to recognize that a medical practice is a business. It requires operational and financial management, and improving collections is a primary component of running a smart practice. ■

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Judy Capko is a healthcare consultant, speaker, and author of the books "Secrets of the Best Run Practices" and "Take Back Time — Bringing Time Management to Medicine."