Tinsley, Reed. “Streamlining Medical Practice Reimbursements.” *Career Pulse* December 1994: 38-41.

Streamlining Medical Practice Reimbursements

Physicians must* actively *manage* their *medical practices for reimbursement to* operate *efficiently.

Reed Tinsley, CPA

Now that national health care has been postponed for at least another congressional session, physicians can redirect attention to their own practices. In many parts of the United States, health care reform and its potential consequences to physicians have assumed lives of their own. Integrated delivery systems have spontaneously generated as health care providers respond to reform and a changing marketplace.

These changes have caused the physician practice unit to suffer. Many physicians have forgotten that their own medical practices are assets that require daily attention. Like any other business in the United States, the bottom line is a simple combination of maximizing revenue and containing operating costs. Unfortunately, market pressures, such as the expansion of managed care, cause overhead to rise and revenue to decrease. Although market changes may affect revenue, many practices lose money unnecessarily. Potential revenues are lost simply because the billing and reimbursement process is inefficient. Physicians today must pay strict attention to the business aspects of their practices.

The key to revenue enhancement in a medical practice is to streamline the reimbursement process. Four factors are important for practice reimbursement to operate efficiently: 1) hiring a qualified office staff, 2) prompt and accurate billing, 3) capturing and coding services correctly, and 4) monitoring reimbursements.

HIRING A QUALIFIED OFFICE STAFF

An important yet often overlooked aspect of the reimbursement process is hiring qualified employees to collect and bill for services. Hiring decisions can mean the success or demise of a practice financially. There are several key points for a practice to consider when hiring office employees.

Advertisements for the position must accurately reflect the requirements. Any advertisement for a new employee must effectively communicate what skills the practice requires, such as specialized computer knowledge. If a practice is in a large city, an advertisement that indicates the practice location is helpful to weed out candidates.

Resumes must be reviewed carefully. These factors must be considered: Has the prospective employee changed jobs often? Are references included on the resume? Does the resume communicate specific job experience? If the practice requires certain skills (eg, computer experience), parallel experience should be indicated on the resume.

A candidate’s references must be contacted. Most candidates’ resumes include only good references. Because of legal reasons, a primary reference will be hesitant to say anything negative about the candidate. To find an honest reference, the primary candidate should be asked about other employees with whom he or she has worked. Often these secondary references can more honestly evaluate the candidate’s job performance.

Situational questions should be asked when interviewing a candidate. The candidate should be

presented with circumstances that occur in the practice and asked how the problem should be handled. This interviewing technique quickly differentiates prospective employees. If the position involves billing, the candidate should also be interviewed concerning the various levels of office evaluation and management Current Procedural Terminology (CPT) codes. Specific questions must also be asked concerning Medicare billing, insurance verification, and precertification.

A practice must be willing to offer competitive salaries. If a practice is unwilling to fairly compensate an employee, the best candidate may not accept or may not be hired and the practice will suffer.

THE BILLING PROCESS

Many issues influence the billing process on a daily basis and directly affect a practice's ability to streamline reimbursements, including claim filing, preauthorization, and electronic billing. An office must capture a patient's correct insurance information each time the patient receives services. Incorrect or incomplete information on the claim form delays or eliminates reimbursements. Within the managed care arena, failure to obtain preauthorization for select services affects reimbursement. Electronic billing is an important tool for streamlining reimbursement because most insurance carriers do not accept an electronically transmitted claim unless it is perfect. If a paper insurance claim is filed incorrectly, the practice must investigate, correct, and refile the claim. Wasted effort may be eliminated by filing the claim correctly (or electronically) the first time.

Practices must file insurance claim forms on a timely basis. Insurance claims should be prepared and mailed to the insurance carrier within 5 to 7 working days from the last date of patient service or hospital discharge. A practice may test how rapidly claim forms are prepared and mailed by surveying a random sample of at least 25 claim forms from the unpaid insurance file. To track the claim form, a worksheet must be prepared that includes the following headings: 1) patient's name, 2) preparation date, 3) last date of service, 4) time difference. The preparation date is obtained from box 31 of the claim form; the last date of service is from box 24 (a) of the claim form. The difference in days must be documented and an average calculated for the overall sample. If the average is more than 7 days, the practice has a problem completing claims, which results in impaired cash flow and accounts receivable.

All aspects of claims filing for certain services must be investigated. In a claim that includes both office and hospital charges, a practice may be preparing and mailing claims within a 7 day average; however, timely filing of hospital charges may be a problem. The practice must investigate the reason hospital charges are not being filed on a timely basis.

COMMON CAUSES OF DELAY IN FILING CLAIMS

Insurance claims are not always prepared or mailed on time. The following are the most common causes of delay and the corresponding solutions.

Problem. The office staff responsible for billing is not experienced in filing insurance claim forms for a medical office.

Solution. As previously discussed, it is essential to hire the most qualified office employees— this point cannot be overemphasized. Billing staff positions are highly specialized. The billing staff must know CPT and ICD-9 coding (from the *International Classification of Diseases, 9th Revision)* and understand the myriad of rules pertaining top managed care, Medicare, Medicaid, and other insurance programs. A staff inexperienced in these areas of billing takes a longer time to prepare insurance claim forms, which affects reimbursement

Problem. There is a lack of communication between the physician and the billing staff regarding what services the physician provided while treating a patient in the hospital.

Solution. The physician needs to capture hospital charges in a timely manner. She or he must record

charges while at the hospital or office as soon as possible after the services are provided. (Capturing and coding charges are discussed later.)

Problem. The office waits for the hospital or other facility to file its insurance claim first to avoid having the patient's deductible apply to the physician's services.

Solution. This policy delays claim filing and impairs cash flow. Physicians must implement and monitor an office policy that allows collection of the deductible as soon as possible after (or even before) the service is rendered. Hospital-based physicians should seek an arrangement in which payments for the practice are collected by the hospital's billing office.

Problem. The physician wants to review all insurance claim forms before they. are mailed but does not do so on a timely basis.

Solution. If a physician is confident that the billing staff are correctly preparing claim forms and not over-looking any charges, a final review by the physician is not necessary. The best solution is to hire an experienced billing staff. Otherwise, if the physician insists on reviewing claims, the billing staff may speed the review process by demonstrating how the delay is negatively affecting the practice and its cash flow.

CAPTURING AND CODING CHARGES

Any error or failure to properly capture or code services rendered by a physician directly affects reimbursement To compile and bill a physician's hospital charges accurately, it is important to develop an effective form of communication to capture charges. From the physician's communicative record, the charges and related fees for the hospital can be determined, and the patient and/or insurance carrier can be billed in a timely manner.

A physician's communication of hospital charges may take many forms. If surgery is performed, an office may have to wait for the operative note to know exactly what services were rendered by the surgeon. For hospital visits, the office does not know what services the physician provided in the hospital until the physician informs the office by written or verbal communication. Unless specific charges are accurately communicated, they will be lost. The office could bill the wrong level of service or not bill a charge at all because it was not effectively communicated.

The physician should document the charges on paper, use a hospital charge card, or use a surgical charge sheet whenever possible. If the physician is unwilling to write down the charges, the physician and billing staff must meet soon after the service is provided to discuss and document the most recent charges.

Coding Services

Whether a patient visits the practice or is treated in the hospital or another facility, the physician must communicate to the patient and/or insurance carrier exactly which services were rendered and why. CPT codes communicate exactly which services were provided. ICD-9 codes communicate the reasons for providing services. Medical practices repeatedly lose reimbursement because of simple coding errors. To avoid coding errors, a practice should do the following:

Code hospital visits correctly. Undercoding or over-coding could occur if the physician is unaware of the definitions of each inpatient evaluation and management code. If a practice has not done so before, it should conduct an internal education program involving the physicians, nurses, and billing staff. The most common clinical situations that occur in the office should be identified and matched with the definition of the appropriate evaluation and management code. This procedure will enable the entire medical practice staff to appropriately code for specific situations.

Identify and bill consultations. Certain medical specialties are referral-based practices. In some situations, a referring physician may attend to a patient with a symptomatic problem that requires final diagnosis and subsequent treatment If a patient is sent to a practice with an unknown problem and a report is sent back to the referring physician, the visit should usually be coded as a consultation and not an office visit Initially, the receptionist should identify why a patient has requested the appointment Receptionists should be counseled on the CPT definition of a consultation and how to reflect consultation charges on a superbill. A physician must also be aware of CPT definitions and make a point to evaluate whether the visit should be coded as an office visit or consultation.

Bill the inconvenience codes. Certain insurance plans still pay for inconvenience codes; however, Medicare does not. CPT 99050 is for services requested after office hours, beyond the basic medical services. A physician should bill CPT 99052 when services are provided between 10:00 PM and 8:00 AM. CPT 99054 is for when the physician provides services on Sunday or a holiday.

Bill critical care as it occurs. Many physicians believe they can only bill critical care if they visit the intensive care unit If a patient is in distress and the situation meets a critical care definition, it should be billed as such without hesitation.

Use CPT modifiers when appropriate. Modifiers are used when the services as described by CPT must be further defined. Modifiers clarify how or why a doctor performs a particular service. A physician must be familiar with all CPT modifiers and when to use them.

Verify diagnosis codes. If a claim is filed and the insurance plan delays payment, an incorrect diagnosis code may be at fault A CPT code communicates which service was provided; the diagnosis code communicates the reason for providing the service. Coding must always be at the highest level of specificity, including use of all five digits if necessary.

Use the two new CPT codes for Care Plan Oversight Services. These new codes (99375 and 99376) are overlooked by many medical offices. The codes allow a doctor to bill for services such as revision of Care Plan, review of patient status reports, and communication with other health care professionals involved in patient care. These services are reported separately from codes for office, hospital, home, nursing facility, or domiciliary services.

MONITORING REIMBURSEMENTS

The final step to successfully streamlining reimbursements is to monitor how the practice is paid. On a periodic basis (preferably monthly), the practice's administrator, billing staff, accountant, or outside consultant should review the Explanations of Benefits (EOBs). EOBs, which accompany the reimbursement check from the insurance company, provide the practice with a wealth of information. This information includes how quickly insurance companies are paying claims, how they approve practice charges, whether charges were denied, and any discounts deducted from billed charges. The EOBs review is one of the most important but often neglected duties in a medical office.

Reimbursements from Insurance Companies

EOBs must be reviewed to determine how insurance companies are actually reimbursing the practice. The practice should review cases in which the insurance company, especially managed care companies, am proved all of a billed charge for payment This indication is generally a red flag that the practice's fees are too low. When a practice signs up with a preferred provider organization (PPO), it generally agrees to accept a discounted fee in the range of 20% to 30% less than the practice's regular fee schedule. However, managed care plans will pay the lesser of the amount billed or the contracted fee. When a managed care plan or any other insurance plan (including commercial-type insurance) approves 100% of the billed charge for payment, it is a signal that the practice's fees are too low. The physician might consider revising fees for a select number of CIT codes or possibly the entire practice fee schedule. A

practice should not lose money simply because its fee schedule is too low.

The practice staff should also analyze EOBs to determine how quickly insurance plans are reimbursing the practice. Analysis should discover if problems exist with specific insurance companies, if there are problems receiving payments for specific services, and whether the practice's billing staff is effectively pursuing unpaid insurance claims. The practice should analyze a sample of EOBs and compare the E0B control date with the last date of service provided. The control date is usually in the upper right or left corner of an EOB. The average turnaround should be no more than 30 to 45 days. If the turnaround time is more than 45 days, the practice should investigate the reason behind the delay. This task is accomplished by first determining if unpaid claims are resolved by the staff on a timely basis and if insurance claim forms are prepared and mailed within 5 to 7 days from the last date of service.

Payment Denials

One of the most crucial tasks when reviewing EOBs is to discover payment denials. A sample of EOBs should be inspected for all approved charges of zero. Was payment denial the result of an error by the practice billing staff or by the insurance company? If the error was made by the insurance company, the staff must ensure that the claim can be refiled or appealed.

Billing and Collection Staff

The physician may also use a review of the EOBs to evaluate the billing and collection staff. If EOBs reveal numerous denials and a lengthy payment turnaround time, it could be caused by an inexperienced or inefficient billing staff. These questions must be asked of the staff Do they understand how to prepare an insurance claim form? Are they experienced in CPT and diagnosis coding? Do they know how to read an operative note? Are they familiar with Medicare billing rules? Are unpaid insurance claims pursued and resolved? Negative answers to these and other related questions negatively affect practice reimbursement

CONCLUSION

Many facets of a medical practice affect reimbursement. Reimbursement is directly related to physician compensation, and physicians cannot afford to ignore the business aspects of their practices. Successfully streamlining reimbursement demands daily attention to details and an active role by physicians in managing
their practices.