Tuning your Practice's Business Process and Performance
Illinois/Chicago Ophthalmology, March 2014

Tuning-up your Practice
Managing Billing & Collections Performance
for a Healthier Practice

- Identifying and patching common "holes" in the billing and collections process
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Key Tips in Each Area of the Billing Process

- Gleaned from our experience in
  - Consulting in hundreds of Ophthalmology practices
  - Billing for over 40 Ophthalmology practices

The Tips Fall into 4 Categories

- Structure for fulfillment
- Business Process "Front-End"
- Business Process "Back-End"
- Monitoring Performance

The Tips Address

- Efficiency
- Effectiveness

Structure for Fulfillment

- Document policies and procedures
- Verify credentialing and re-credentialing
- Manage your PM Software
- Coding resources and tools
- Insurance contract information
- Allowables in the PM software

Document Policies and Procedures

- Each step of the business process should be documented in detail
- "Working the System" by Sam Carpenter
- This process will
  - Establish the manner in which each step will be carried out
  - Identify areas for improvement and missing elements

Credentialing

- Verify credentialing status annually
  - Medicare
  - Medicaid
  - Non-Government insurances
- Use PECOS
- Establish a protocol for processing ANY and ALL communications from the carriers
- Develop a credentialing/Contracting matrix

Manage your Practice Management Software

- User tables
  - Insurance
    - By Product
    - Three Medicare carriers
  - Procedures -Separate entries for
    - Place of Service
    - Multiple procedures
    - Bilateral/Unilateral
  - Transaction codes
    - Payment types
    - Driven by reporting
  - Use the system for cash management and control

Coding Resources and Tools

- AAO Coding Coach
  - Paper
  - On-Line
- Comprehensive on-line coding products
  - Optum
  - AMA
- Comprehensive products include
  - CPT
  - ICD (9 & 10)
  - CPT/ICD crosslink
  - CCI
  - LCDs

Insurance Contract Information

- Develop a matrix
- By Plan
  - Credentialing by provider and location
  - Coding and adjudication rules
  - Claims submission rules
    - Timely filing
    - Appeals
    - Direct/clearinghouse
  - Co-payments/deductible
  - Verification availability and methods
  - Allowable payments

Contract Information in the PM Software

- Load all allowables for the major carriers
- Some clearinghouses/systems require allowable for auto-posting

Reporting

- Operations
- Management
- Addressed at the end

Business Process "Front-End"

- Patient Registration
- Insurance Verification
- Patient Arrival
- Charge-Capture
- Coding
- Fees

Patient Registration

- On-Line portal
- Mailed forms to new patients
- Early arrival for new patients
- Insurance card scanning
- Verify information at every visit
- Monitor rejections for registration errors

Insurance Verification

- Automated
  - Batch
  - Real-time
- Manual
  - On-Line
  - Phone

Patient Arrival

- Co-payment collection
- Demographics verification
- Insurance verification if not already complete

Co-Payment/Deductible Collection

- Track performance
- Co-payments not collected at time-of-service have a low probability of collection after-the-fact

Charge-Capture Process

- Charge-capture auditing
  - Missing ticket report
  - Testing equipment logs
  - O.R. Logs
- EMR Considerations
  - Test complete and correct transmission to PM system
  - Procedure mismatch between systems will result in missing charges

Coding

- What
  - What was provided – CPT
  - Why was it provided – ICD-9 (soon to be ICD-10)
- Who
- When
- Our recommendation
  - Coding should be done by the physician
  - The coding should be done in the exam lane
- What will be needed for ICD-10 – Tools for
  - Identifying the correct codes
  - Logistics for capturing the codes as charges

Fees

- The "retail" value you place on your services
- A place from which to give discounts
- Important to have all of your fees above the highest payor allowables
- We recommend you review your transactions to identify 100% payments (from contracted carriers) and to look for fees below your highest allowables
- We recommend you generate your fee schedule at a multiple of your current Medicare Fee Schedule

Charge-entry

- Where in the business process?
  - EMR
  - Checkout
  - Billing
- Claims review – more important with EMR
- Claims scrubbing – automated review
- Elements to review
  - CPT/ICD matching
  - Post-op global period
  - Modifiers
  - Carrier-specific rules
    - Bilateral vs. two lines
    - Eye exam codes vs. E&M
    - Etc.

Charge Review

- Quality check
  - CCI
  - Modifiers
  - Diagnosis/procedure matching
- Complete information
  - Patient demographics
  - Insurance
- Track the quality of the review
  - Denials
  - Rejections

The Back-End

- Claims submission
- Rejection Management
- Denials (should be worked as received)
- Payment-posting
- AR Management
- Patient balances

Claims Submission

- Electronic
  - Clearinghouse
  - Direct
- Paper

Clearinghouse Rejections

- Batch
- Individual
- Critical that clearinghouse reports are reviewed regularly

Receivables Management

- What is expected and when
- A process in place for identifying
  - When a claim is not paid when expected
  - When a claim is not paid in the amount expected
- Payment posting
- Rejections management
- Corrections/resubmissions
- Appeals
- Insurance follow-up
- Patient balance billing

Receivables Management

- Going back to the insurance matrix as the source of expectations
  - When
  - How much
- Design your receivables management process based on those expectations

Payment Posting

- Maximize auto-posting
- Work denials as received
- Use automated tools for measuring payment adequacy
- Post all payments within two working days to avoid timely filing denials
- Know the payer rules and appeal denied claims that should have been paid based on the contract rules

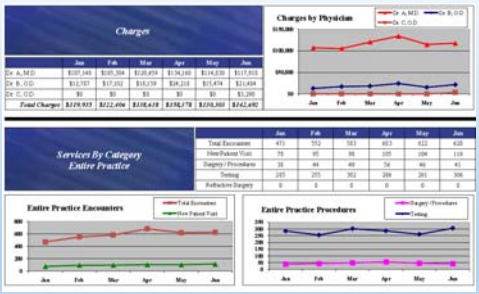
Insurance Follow-Up

- Again, base your follow-up timing on what you know about each insurance
- Is your practice waiting 60 days before following up on un-responded claims?
- If so, change the schedule
  - Medicare – 21 days
  - Most PPOs and HMOs at 30-45 days
- Each open account should be touched at least each month

Monitoring Performance

- Charge-capture - missing ticket report, testing equipment and O.R. logs)
- Productivity
- Collections performance – assessing the percentage of the allowable amounts collected (primary billing performance measure)
- Accounts Receivable (AR)
  - AR > 90 days as a % of the total (benchmark is < 15%)
  - Patterns in the buckets (watch for balances "marching across")
  - Date of service vs. date of last activity
  - Days in AR

Vivid Display – Productivity



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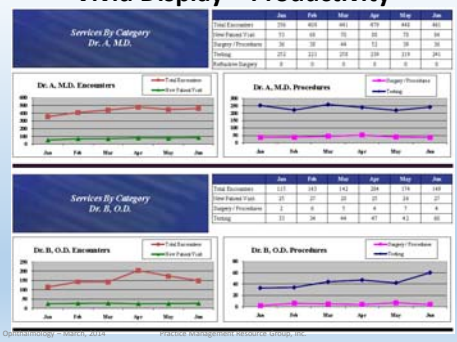


One more Productivity Measure
Income per Encounter

- For simplicity, use office encounters
- Should be run against internal benchmarks
- Post-op visits – Include or not but be consistent
- Run the data with and without optical income
- Generate quarterly

Business Office Performance

- Collection Performance
- Accounts Receivable
- Days in AR

Collection Performance

- A report of the percentage of your charges that are ultimately collected compared to what is possible to collect (defined as the payer's contracted allowable)

Data Pitfalls

- Services included in a payer's totals that pay differently than the contracted services
- For example, refractions (for Medicare patients, they pay at 100% of the charge)
- Refractive surgery
- These services must be isolated and excluded from the calculations
- System reporting that does not show payments based on the charge carrier

The Set-Up for Effective Monitoring

- Computer Software Set-up
- Accurate charge-entry
- Calculated collection targets
- Effective and accurate management reporting

Understanding Collection Performance Reporting

- Correlating payments to charges
  - Can / How does your system accomplish this
- Where are posted payments reported
  - For example, are Medicare patient co-payments reported under Medicare or Patient Pay
  - If a patient has a Blue Shield MediGap, is the co-payment reported under Medicare or under Blue Shield?
- Errors and charge-adjustments

Collection Performance - The Key Report Goes by Many Names

- Collection Analysis
- Insurance Payment Analysis
- Procedure Analysis
- The common characteristic:
  - Charges by insurance for a specified time period
  - Payments against those charges as of the date of the report, with enough time elapsed (at least 120 days) to allow for the bulk of the payments to be received.

Procedure Analysis

- Charge-frequency by CPT code
- Allows you to adjust the charges for those procedures which will have reduced payments
  - Surgical assist
  - Secondary procedures
- Or increased payments
  - Refractions
  - Refractive surgery

Procedure Analysis Adjustments

- Refractions
- Other Non-Covered services
- Drugs and supplies
- Surgical assist
- Multiple procedures

Generate an "Insurance Payment Analysis" Report

- At least three months of charges
- Last date of service at least 120 days prior to the report
  - If we are in November, the report would have charges for May - July, and payments against those charges as of today
- The elapsed time can be modified for a particular payor-class
- For example, Medicaid may require 180 days
- Generate a procedure analysis
- Quantify and adjust the charges for those procedures for which reduced payments are expected
- Calculate the collection target for those charges
- Compare to the actual collections

Example

Pay Class	Charges
Indemnity	$89,541
FFS Managed Care	$984,953
Workers' Comp	$44,771
Medicare w/ Suppl.	$2,417,612
Medicare w/o Suppl.	$373,826
Medicaid	$134,312
Medi/Medi	$373,543
TOTAL	$4,418,558

- The question to be answered is what % of those charges can be expected to be collected?

Example, Cont.

Pay Class	Charges	Charges at Contracted Rates	Actual Coll'n	% of Target
Indemnity	$89,541	$85,064	$77,397	90.99%
FFS Managed Care	$984,953	$659,919	$629,592	95.40%
Workers' Comp	$44,771	$22,386	$19,745	88.20%
Medicare w/ Suppl.	$2,417,612	$1,208,806	$1,156,735	95.69%
Medicare w/o Suppl.	$373,826	$186,913	$154,268	82.53%
Medicaid	$134,312	$42,980	$31,589	73.50%
Medi/Medi	$373,543	$149,417	$146,382	97.97%
TOTAL	$4,418,558		$2,215,708	

Other Collection Analyses

- Zero-pay line items
- Underpaid line items
  - No-co-payment
  - Co-payment only

Accounts Receivable

- A report of what has not yet been resolved (collected or adjusted)
- Variations in AR reporting
  - "Date-Of" AR measurement from
    - Service
    - Charge-entry
    - "Aging" or "Last Activity" date
  - Net or Gross receivable

Accounts Receivable

A/R By Carrier Type

Insurance Type	Total $	%	Current	31 - 60	61 - 90	91 - 120	121 - 150	151 +
Not Insurance Type Specific	$294	0.2%	$294	$0	$0	$0	$0	$0
Blue Cross	$28,169	18.2%	$21,875	$2,687	$2,201	$360	$613	$432
HMO	$5,539	3.6%	$4,739	$324	$0	$200	$246	$30
INDEMNITY	$5,160	3.3%	$2,014	$776	$1,655	$154	$266	$296
Medicaid	$11,226	7.3%	$5,292	$2,518	$676	$1,507	$301	$932
Medicare	$3,518	2.3%	$2,793	$477	$0	$109	$0	$139
Medicare Supplemental	$3,473	2.2%	$2,987	$159	$149	$18	$160	$0
Medicare W/ Medicaid	$10,801	7.0%	$7,021	$2,060	$608	$834	$278	$0
Medicare W/ Supplement	$64,095	41.5%	$50,549	$4,541	$1,360	$3,675	$3,556	$414
Other Federal/State	$215	0.1%	$215	$0	$0	$0	$0	$0
PPO	$19,936	12.9%	$15,382	$1,972	$409	$573	$747	$853
Workman's Compensation	$1,979	1.3%	$1,121	$858	$0	$0	$0	$0
TOTAL	$154,404		$114,281	$16,373	$7,057	$7,430	$6,167	$3,096
Total Aging Bucket %			74.0%	10.6%	4.6%	4.8%	4.0%	2.0%
Other								
Patient Responsible	$18,264		$7,872	$4,363	$1,591	$2,276	$335	$1,827
Pat Resp Aging Bucket %			43.1%	23.9%	8.7%	12.5%	1.8%	10.0%

AR Danger Signs
Not Good

Current	31-60	61-90	91-120	121-150	151+	TOTAL
$500,000	$250,000	$210,000	$170,000	$120,000	$395,000	$1,645,000
30.40%	15.20%	12.77%	10.33%	7.29%	24.01%	100.00%

Balances "marching across" the buckets

Over 31% > 90 days

AR Danger Signs Better

Current	31-60	61-90	91-120	121-150	151+	TOTAL
$500,000	$120,000	$27,000	$13,000	$3,500	$7,800	$671,300
74.48%	17.88%	4.02%	1.94%	0.52%	1.16%	100.00%

- Notice the drop-off in the percentages in the buckets from current to 151+ with only a small balance > 151
- AR > 90 days = 3.62%

AR Reporting – Date of Svc. vs. Last Bill Date

- Your system must have the flexibility to choose
- Example of "churning" claims (re-submitting without correcting)

Last Bill Date							
Days ->	Current	31-60	61-90	91-120	121-150	151+	Total
	$911,503	$253,195	$50,639	$25,320	$12,660	$12,660	$1,265,976
	72%	20%	4%	2%	1%	1%	100%
Service Date							
Days ->	Current	31-60	61-90	91-120	121-150	151+	Total
	$278,515	$227,876	$202,556	$113,938	$88,618	$354,473	$1,265,976
	22%	18%	16%	9%	7%	28%	100%

AR Reporting – Date of Service vs. Last Bill Date (with effective claims management)

Last Bill Date							
Days ->	Current	31-60	61-90	91-120	121-150	151+	Total
	$1,114,059	$50,386	$49,500	$19,496	$15,825	$16,711	$1,265,976
	88.00%	3.98%	3.91%	1.54%	1.25%	1.32%	100%
Service Date							
Days ->	Current	31-60	61-90	91-120	121-150	151+	Total
	$1,071,395	$67,730	$52,158	$23,421	$20,256	$31,016	$1,265,976
	84.63%	5.35%	4.12%	1.85%	1.60%	2.45%	100%

Days in Accounts Receivable (Days in AR)

- A metric that measures AR, controlled by charges
  - Practice A, $55,000,000 in total AR
  - Practice B, $1,500,000 in total AR
  - Which practice has the healthier AR?
- Days in AR takes the total AR and divides it by the average daily charge
- Therefore, Days in AR is a measure of how many days of charges are outstanding (in AR)

Days in AR – The Formula

- Days in AR = Total AR ÷ Average Daily Charge
- Average Daily Charge is generally calculated by taking the total charges for the past three months and dividing by the total number of days in those months.

Example of Days in AR Calculation

- Total AR = $500,000
- Total charges last three months = $1,393,139
- Days in those three months = 92
- Avg. Daily charge = $1,393,139 ÷ 92 = $15,143
- Days in AR = $500,000 (total AR) ÷ $15,153 (avg. daily charge) = **33**

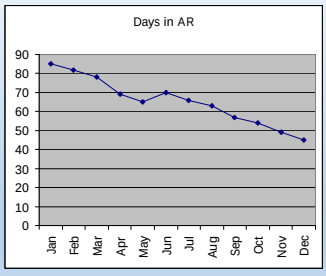
Days in AR – What Effects It?

- Low charges (lower avg. daily charge)
  - Vacations
  - Illness
  - The impact is accentuated in smaller practices
- Stoppages in collections (Medicare)
- Slow payers (e.g., Medicaid)

Days in AR – Adjusting the Data

- Exclude outlier payors
  - Capitation
  - Medicaid
  - Other artificially slow payers
- Exclude both the AR and the charges
- Be careful with "net" vs. "gross" AR
- A useful benchmark is 45 days

Days in AR - Display



Summary

- Approach the business of your practice as a clinical exercise
- Collect Objective data
- Review the metrics
- Understand the sources of the data and information
- Adjust for confounding factors
- Compare to the benchmarks (mostly internal)
- Identify the sources of performance below expected