

THE HEALTHCARE BUSINESS LETTER

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Win-Win Payor Partnerships

By James A. Muschler

Can we find common ground with payors in our mutual financial and quality arenas? Is there enough common interest between payors, providers and patients?

All parties will benefit from better alignment of incentives and interests.

Reduced Costs

Reducing inappropriate claim filings results in less paperwork and fewer denied claims being challenged because of inaccurate or missing information. When follow up activities on claims drops dramatically because these are now being paid as “clean/complete” claims, all parties save on claims filing, administration, adjudication and processing costs.

Increased Cash Flow & Collections

When the information exchanged between the parties is improved, claims processing becomes less complicated. The quantity of transactions decreases and the quality of transactions increases. When this happens, collections improve, reimbursements come faster (improved cash velocity) and net revenue grows.

Improved Payor Communication & Relations

When we improve the quality of our communications, we improve the quality of the relationship between the entities. Few healthcare professionals would disagree that relationships with the payors can be improved if we could get the standards that HIPAA mandates in place.

The foundation for communication and improvement to the current reimbursement system and structure has to be built on common interest - that common interest is the reduction of cost.

These key areas deserve special mention in this battle to reduce costs:

- Payors must commit to acting as “partner” with healthcare providers in quality initiatives.
- Reduced denials will reduce the costs of claims processing for all parties.
- Reduce costs of claims processing and the elimination of re-work improves net revenue.
- Scheduled and regular quality improvement meetings need to be attended by both parties.
- There must be increased interest in direct contracting with provider groups and hospitals.

When Payors and Providers Are Partners, The Contracts Have Real Value

When payors deny claims citing bundling, medical necessity, lack of authorization, and the mountain of other reasons, they save money by denying claims. What does this mean for you?

If you understand the payors pricing policies, you can reduce denials and maximize reimbursement.

Payors and providers must agree upon the utilization of a consistent denial management and peer review strategy. This strategy should minimize the costs of rework and waste from either party while maintaining the strength and depth of these important relationships.

Get Started in Building Partnerships with All Major Payors:

Step 1 - Referrals and Authorizations

Make sure you understand your carriers’ requirements in this area and prepare to meet and even exceed them.

- Does the carrier deny any services for which it has indicated an authorization was unnecessary?

If so, start getting those authorizations, anyway. Keep copious notes, including the date, time, name, and extension number of the person you spoke with to get the referral.

Step 2 - Medical Necessity

Be aware of your carriers’ medical necessity policies and prepare to discontinue, write off, or have patients pay for services that you know a carrier will not cover:

- What services are the carriers denying for medical necessity?
- Are denials valid?
- When appealed, does the carrier change the claim status to make payment?
- Does the carrier outline any policies regarding which services or under what circumstances will services be denied for medical necessity? How can you determine such before services are performed?

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Step 3 - Coding

Learn the carriers' coding policies and educate your coders and physicians about what to expect.

- What services do carriers deny due to incorrect coding?
- Does the carrier follow the coding guidelines, such as recognition of those modifiers established by the AMA?
- What services do they bundle?
- Does the carrier pay for multiple surgeries/procedures on the same day?
- What are its policies for consideration of services billed with unlisted procedure codes?

Step 4 - Coverage

When you conduct insurance verification and benefits eligibility, run a coverage check. This will help you and your patients plan for financial responsibility.

- Which of your routine services are covered by your carriers, and which are not?
- Are there services that you regularly perform for patients that are routinely denied?

Step 5 - Stalls and Denials

If you know your carriers' pricing policies, you will be better able to follow up on claim stalls and denials.

- Does the carrier acknowledge that it has received your claims, but holds them up them indefinitely for review?
- Do they advise you that a patient is indeed one of its beneficiaries, yet denies services rendered? This could indicate that a payor's database is not current.

Step 6 - EOBs

The EOB (Explanation of Benefits) is a notification which accompanies almost every payment voucher. It is the tool a carrier uses to tell the provider the reasons why they are not paying the full amount (or not paying at all). Deciphering an EOB may not always be easy. Many carriers have their own language. All use their own format for the EOB. In addition, since most carriers define benefits in different ways, many times the amount a patient is responsible for is written off due to confusion over these unclear facts. A monthly review of EOBs will help uncover coding problems and can provide a warning of potential issues with a particular carrier which oftentimes can be resolved with a phone call.

- Review EOBs collectively and by carrier group, against a copy of the claim as it was filed and then against the chart
- Determine if an event or documentation, done differently, could have motivated the proper reimbursement.

Step 7 - Denials and Delays

When a claim is not paid in 30 days, it is time to initiate an inquiry. Some carriers require inquiries be made by letter. Others accept inquiries by telephone call. Keep a record of your inquiry, including whom you communicated with and when.

When an error is made, challenge the payment if you feel you provided the service and it was medically necessary. If you discover an error in claims submission, resubmit the claim with written correspondence and a cover letter indicating that it is a corrected claim.

Common Reasons for Denials and Delays

Errors/Lack of documentation

- the claims adjudicator/adjuster down-coded the claim for lack of documentation
- data entry error
- Pre-certification not completed
- Information is missing or incorrect
- The wrong mailing address for the carrier's particular benefit plan was used
- The claim had white out, staples or other problems associated with it.

Payment not received

- claim is "lost"
- Pre-certification was not completed

Multiple units paid as one

- data entry "missed" the number in the unit column

Multiple units not paid

- carrier ignored the total claim
- carrier lumped additional services within one code
- carrier doesn't recognize unbundling

Overall reimbursement drops

- recalculation of allowable
- possible data error — compare CPT code submitted to code paid (and then make an inquiry)

Step 8 - Precollection

Utilize a specialized, flat-fee precollection service on claims which have not been paid within 45 - 60 days. Use a precollection program proven to substantially reduce your internal billing costs while greatly increasing your cash-flow. Our accounts receivable management experience will help. It is important that these collection letters originate from the state you are located in - it is best not to utilize nationwide precollection services. What are the most common in-house collection costs associated with collecting outstanding receivables?

- *time*
- *repeat billings*
- *phone calls*
- *letters*
- *stress and aggravation*

How much would you spend doing the same activities (letter/phone calls/aggravation) over that same period of time? Studies have shown it costs the typical healthcare organization almost \$20 to work an account for 120 days! All those statements and phone calls really start to add up.

Converting Receivables to Cash: More Than Clear and Accurate Claim Filing

“Clearly, the revenue cycle isn’t a department; it’s a collaboration of interdisciplinary processes and systems.” Or so says Chuck Lund of Cap Gemini, Ernst & Young. During the entire series of programs and workshops at HFMA’s “Revenue Cycle Strategies” held at Caesars Palace in Las Vegas, the “fully integrated business office” model was echoed by all who took the podium.

If you want your practice well-positioned for the future, think about these issues:

Contract Management

Is your current evaluation and review process of the contracts, their terms, clauses and payment methodologies being offered a good predictor of the actual financial performance of those contracts?

This scenario is common to many healthcare providers. Though the options are plenty, too many healthcare business professionals know too little about assessing the actual bottom-line profit (revenue) being generated by each payor agreement. The reason is simple: the actual costs being created by the contractual “detail” in these agreements are difficult to measure and properly allocate. For example, many contracts have strict billing requirements, making the revenues being generated by the services described in the agreement difficult to collect (i.e., pre-authorization requirements, medical necessity limitations, special or unique documentation requirements and unreasonable filing deadlines).

Assuming that our future in this business of medicine brings more strategic carve-outs related to specific health services, or creative contracting with an increase in niche marketing; these more complex billing and reimbursement arrangements can significantly add to our costs of providing care. When this happens, we will need to gain much better control over the data and information we currently take for granted. Then, after we have received our new contracts for review, we must ask better and more detailed questions to ensure the profitability of our agreements.

Patient Satisfaction

What would your patients say are the strengths and weaknesses in handling patient financial matters?

Patient satisfaction is one of the most common, and most manipulated, measures of quality in a managed care environment. If your organization is to remain attractive to the patients it serves you need to know what your patients think and then consider changing those things that bother them the most. You can acquire this information through patient-satisfaction surveys, or possibly even from your health plan partners (your contracted payors), but you will need to

work with the entities or organizations who are developing and distributing these surveys to reduce or eliminate the bias which permeates most of our industries surveys.

In addition, you should also ask for input from your employees, referring physicians, professional colleagues and community members. You would be surprised at the volume and quality of ideas you can get from your own inner circle, which often can implemented by those same people, saving the organization thousands of your hard earned dollars.

Human Resources

Our next question: If you were starting again today, would you hire these same people to do the job?

All healthcare organizations, of any size, have individuals in each department who are not what we would deem “team players.” Some individual, although great when we hired them, have not adapted well to the new skill set demands or quality standards we now know are here to stay (privacy, security, technology and corporate compliance).

Retaining excellent staff members has become an increasingly difficult and costly proposition. As so it is, in this HIPAA compliant, federally monitored, and exceedingly competitive-in-nature environment, we cannot just move (allocate) these long-time employees and individuals into new jobs with different responsibilities where the qualities that yourself (or the prior practice management) had perceived the skill set or professional service fit.

Process and Procedure Manuals

What specific process or procedure would you most like to update or change in your business office reimbursement strategies?

The answers we get to this question runs the gamut. They range from the entire information management system itself, to the process of scheduling patients and collecting money at-the-time-of-service. Whatever your orientation, consider the importance of altering and improving those specific processes that most impact the organizations bottom-line revenues, reimbursements or net collection success rates.

Your organization must be allowed to approach the future with great efficiency and effectiveness in the performance of those key business functions and tasks that surround your area of specialty. If you cannot make the necessary changes all at once, at least get yourself started by taking those smaller steps now, which could include the outsource of those business office procedures not considered “core functions” by your patients. For example: the follow up on insurance denials (not due to medical necessity) could be outsourced because your patients would not consider that to be your organization’s “core business function.” Any denial deemed due to ‘medical necessity’ questions should always be handled by your internal people, including members the medical staff involved in delivering the patient care.

Reimbursement, Billing and Collections

What are your gross and net collection rates? The gross collection rate tells you what percentage of your total charges you actually collect. When used alone this number can help you predict future collections at your practice, but this information is most useful when compared to your net collection rate. The net, or adjusted, collection rate tells you what percentage of your charges (minus contractual adjustments and bad debt write-offs) you collect. If you know your organization’s net collection rate, you can then assess your collection staff’s performance. If you know your gross and net collection rates for each specific payor in your practice, you can identify which payers are problematic and gauge practice productivity.

Contracted Payors vs Commercial Insurance, Personal Injury and Workers’ Comp

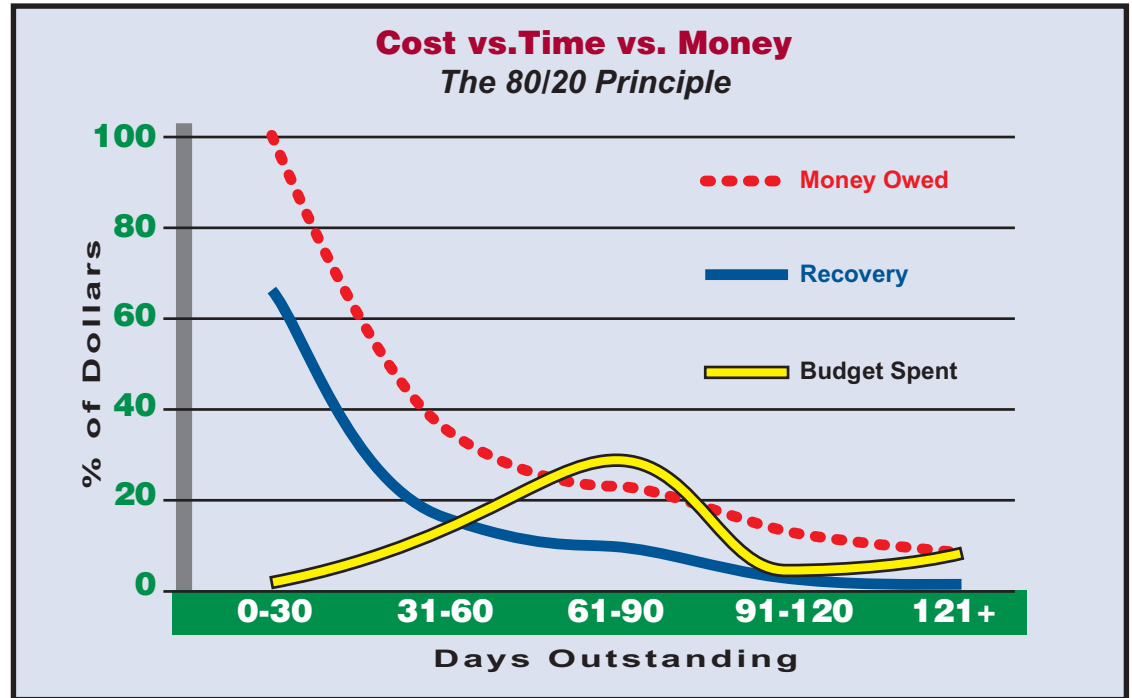
What is your current payor mix? Your payor mix identifies the percentage of charges, payments and patients attributed to each of the major insurance plans with which you participate. Knowing these percentages will help you identify and evaluate your practice and measure the financial performance of contracted carriers. For example, you might find that a certain payor currently represents 20% percent of your total patient base, 22% of the charges and 17% percent of payments received. Knowing this, you can draw some strong conclusions regarding the productivity of this payor organization for your practice.

Monitoring your organization’s shifting and changing payor mix will also help you measure and forecast your organization’s financial performance trends and help you make good decisions while avoiding becoming overly dependent on any one specific payor.

For information on future HFMA programs, including the **Revenue Cycle Strategies** series, contact the HFMA (Healthcare Financial Management Association) at (800)252-4362, extension 2.

They also hold their **Annual National Institute (ANI)** focusing on healthcare business management strategies each year. HFMA's 2004 ANI is scheduled from June 27- July 1 in Nashville, TN at the Gaylord Opryland Resort and Convention Center. For more information, or to register, call (800) 252-4362, extension 2, or go to HFMA's web site at: www.hfma.org.

MONEY vs. TIME - This graph shows the life cycle of your aging receivables. You can see that as time lapses and the account remains uncollected, it depreciates in value. Statistics support the fact that patients who wait 90 days to pay their bills are making conscious decisions not to pay you.



This graph illustrates the premise of an effective Precollection System. It is simply a case of the "80/20" Principle - you are spending 80% of your in-house billing/collection budget to collect only 20% of the dollars owed.

Your in-house efforts up to 60 days have recovered 62.9% of the money owed, and spent 24% of your fixed budget to collect it. Healthcare organizations' inhouse efforts lose 36% of their effectiveness after the 60th day of delinquency and over 72% after 90 days!

Precollection is a more cost-effective solution after an account has aged 60 days. Even if you only collect the same amount of money that your in-house efforts would have collected during the same time period,

the outsourced receivables would still be collected more cost-effectively because of how quickly these receivables depreciate in value after 90 days. The average healthcare organization loses 1/2 of 1% of the value of its A/R each day. How much are you losing each day you continue doing the same thing as before?

It's important to collect your money quickly.

A typical practice spends 40-50% of their fixed budget to collect 3-5% of the money owed, and will budget 2-5% to bad debt each year!

At 61 days past due, practices lose 36% of their in-house effectiveness.

At 91 days, in-house effectiveness has deteriorated by 72%

For information about precollection services that perform well on insurance stalls and claim underpayments, call DPS, Inc,'s collection specialist,

Jerry Lissner at **(630)638-3294**.

Or go to their web site: www.ARsolutions.com

They offer no-cost evaluations and can provide you with a few ideas that can make the time invested extremely valuable.



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Mr. Muschler, the editor of *The Healthcare Business Letter*, is actively involved with the research and development of business-related CME courses. In addition, Mr. Muschler has been widely published in both healthcare business journals and industry publications. He also currently serves on the editorial advisory board of Practice Pointers and Managed Care Strategies.

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