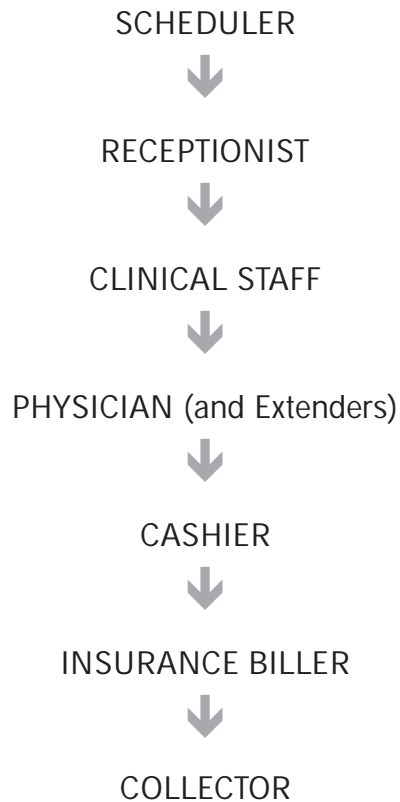

CHAPTER 2

CULTIVATING THE REIMBURSEMENT TEAM

As a practicing physician and a business person, you must remember this maxim – your entire practice is the billing department. Billing for the services you, the physician, provide is not just a job for the billing department. Every staff member plays a role in determining how well or how poorly the reimbursement management process works in your practice. There are responsibilities that go along with each of these roles. The schematic below illustrates the various positions in a medical practice and how they all must work together to assure efficient, effective reimbursement management. Let's discuss some of these positions and what role they play on the Reimbursement Team.



SCHEDULER

The Practice Appointment Scheduler is often the first point of contact for the patient and practice. This is the person who makes those first decisions regarding office collections. He or she sets patient expectations and conveys practice expectations. The Scheduler also communicates to the patient important pieces of information about billing operations and financial policies.

The information that the Scheduler gives to and collects from the patient often has a direct bearing on how successful the practice will be in collecting for the services to be rendered. Here are some areas of responsibility that bear review and monitoring:

- Can we see this patient? Are we a contracted provider for the patient's health plan? It is crucial that the Appointment Schedulers know the health insurance plans with which the practice contracts.
- Is pre-authorization required for the service the practice is to render? Does the scheduler know which of the services provided by the practice generally require pre-authorization from a third party carrier? If pre-authorization is required, whose responsibility is it to get that pre-authorization?
- Is the patient eligible for coverage, e.g., wellness services or preventive care? Again, who will take responsibility for securing this eligibility information?
- Have you provided financial responsibility information? Does the patient know what he or she will be expected to pay at the time of service?
- Will you mail a new patient information package?

RECEPTIONIST

You depend on the Receptionist to gather complete, up-to-date demographic and insurance information—the grist for claims.

- Do you regularly verify patient information sheets? This should occur at least annually, and more often if there are changes in such things as telephone numbers, emergency contacts, or health insurance coverage.
- The position should be a checkpoint for information previously conveyed or gathered by the scheduler: Has eligibility for services been checked/verified? Has a pre-authorization been received and recorded? Have you collected the patient's co-payment?

CLINICAL STAFF

Yes, the Clinical Staff has responsibilities for billing and collecting too! They must know the insurance plans accepted by the practice and the following things about those contracts:

- Do you know which ancillary services your practice can provide?
- If you do not perform lab/x-ray/physical therapy, where do patients go for these services (who has what contract)?
- Can you provide medical and surgical services on the same day for this plan (and get PAID)?
- Has the clinical staff appropriately recorded any services provided "incident to" a physician's service on the charge document, e.g., injections and immunizations, diagnostic procedures such as ECG, or spirometry?

PHYSICIAN (AND EXTENDERS)

Yes, you provide the service, and you, too, have some responsibilities to help the billing department operate more smoothly.

- Do you code your own services and code correctly?
- Do you understand the significance of assigning appropriate diagnosis codes to support the medical necessity of the services provided?
- Do you know what services might be "bundled" and/or not paid separately?
- Do you know which of your services may be denied for medical necessity because of diagnosis or frequency of service? Do you inform the patient and secure his or her consent for these services by having an advanced notice of consent and acceptance of financial responsibility signed before you provide the service?

CASHIER

This is often the last stop for the patient before leaving the office. Don't miss the opportunity to make one last check for accuracy on a number of things:

- Have you collected the right co-pay/co-insurance?
- Have you collected for non-covered services if appropriate?
- Have you checked the superbill/encounter form for completeness? Did you verify the patient had all the services marked on the form, did the patient have any services not marked, and is there a diagnosis available for each service? Now is the time to check with the provider if the form is not complete.
- One last chance — have you verified the patient's insurance company is current and correct?

Practices differ when it comes to whose responsibility it is to enter charges. Some assign this job to a front office cashier (also known as a check-out clerk), while others batch up encounter forms for the business or billing office to process. No matter whose responsibility it is, there should be a check and balance system in place to verify all charges are captured for all patients.

INSURANCE BILLER

Tasks and responsibilities for this position vary. Remember, the claim generation process starts when the charges are posted for a service. However, claims must be reviewed for accuracy and completeness before they are actually generated or sent out.

- Does the person in this position know:
 - ◆ ALL the plans for which your practice is a provider?
 - ◆ What is considered a “clean claim”?
 - ◆ How to appeal for additional payment of denied or underpaid claims?
- Do you mail or transmit insurance claims at least once a week?
- How do you handle the day-to-day correspondence from the insurance plans?

COLLECTOR

Sometimes the Collector and the Insurance Biller are one and the same, while other times these duties are divided among several people. No matter the organization of your billing department, someone needs to be responsible for follow-up after claims generation and must bring each patient account to a zero balance. This position must:

- Know how to comply with the rules and regulations of each contracted plan and how to read the remittance advice or explanation of benefits from each.
- Know what the expected payment is for each of your services from each of your insurance plans.
- Know how to determine what is billable to the patient or another third party and what needs to be written off for contractual adjustments.

This position should also have the responsibility for:

- Checking and monitoring your explanation of benefits. You may be losing money due to inaccurate payment processing.
- Improving basic accounts receivable management.
 - Track percentage of accounts receivable in four categories:
 - ◆ < 30 days
 - ◆ 31-90 days
 - ◆ 91-120 days
 - ◆ 121+ days
 - Monitor percentage of charges written off to bad debt
 - Calculate days in accounts receivable
 - Implement critical financial management for diverse payer mix of managed care contracts
- Using your computer system/MIS for reimbursement and financial analysis:
 - Reasons for payment denial by major carriers
 - Collection rates by individual payers
 - Payment timing trends
 - Contractual allowances and bad debt levels
 - A/R aging by third party payers
 - Reimbursement by procedure – determine cost effectiveness
 - Reimbursement by payer – determine which are your best and worst contracts

SOMETHING FOR ALL

The number of staff members you have in your billing department will vary according to practice size. As you can see, however, there are many aspects of effective reimbursement management that occur outside the actual billing department. It is important that you build a reimbursement team that not only shares work, but shares information as well.

People who work the accounts receivable need to communicate with the front office staff and charge entry people about what they see on the payment denials and requests for further information that flow through the billing office. A regularly scheduled meeting to discuss A/R and insurance payment issues will encourage this form of communication and sharing of information. Cross-training among the staff members can be advantageous as well.

PUT YOUR BILLING POLICIES AND PROCEDURES ON PAPER

If you lack a manual of billing policies and procedures, there is a much greater likelihood that your office will experience billing dysfunction. Staff will tend to depend on word-of-mouth to explain how things are done. This allows a lot of bad habits to get passed on to new employees. Additionally, it allows individuals to do things their own way, resulting in a number of different ways to do one task, such as work a rejected claim. It also fosters individual standards and timelines for getting things accomplished or resolved. For example, if the standard for entering charges is “as soon as possible,” this could mean two weeks in a poorly run operation, while most experts will agree that no more than 24 hours should go by before a charge is entered.

You can begin to develop this manual by reducing to paper the steps required to get a claim out the door and paid. Follow the process displayed in the Reimbursement Team schematic at the beginning of this chapter and ask yourself what happens from the time the patient calls to make an appointment until the service is provided and the patient’s account is brought to a zero balance.

You may purchase model policies and procedures from the Medical Group Management Association (www.mgma.org). You will want to customize the policies for your specific practice, but the models are a good starting point.

If you need assistance in developing a billing policies and procedures manual, consider utilizing the services of a medical business or practice management consultant. You can access the names of consultants in your area by visiting the Practice Resources page at www.yourfp.org/cafp or access the FP Assist Program (a clearinghouse of management consultants) at www.aafp.org/fpassist.

IN-HOUSE vs. OUTSOURCED BILLING

Expect to pay between 8% and 10% of your collections for the associated costs of billing and collecting. It is critical to monitor your billing operations and monitor associated costs accordingly. The pros and cons of in-house versus outsourced billing should also be weighed. While in-house billing gives you better control of your collections operation, it requires dedicated space for activities that do not generate income. For a more in depth discussion on this subject, see the March 1999 issue of *Family Practice Management* available online at www.aafp.org/fpm.