WHY OUTSOURCE YOUR MEDICAL BILLING?

What Are There Real & Tangible Benefits?

Why outsourcing your medical billing can bring you peace of mind and increased prosperity?

Ask any healthcare provider practicing today and they will most likely agree that medical billing is one of the most important components of their medical practice. With ever changing health care laws, government and insurance regulations, rapidly expanding technologies, and the need to focus on quality assurance, it is getting harder and harder to stay ahead of the game. More importantly, the energy and time required to successfully manage this area of your practice means that you have less time and energy to spend on doing what you enjoy most- taking good care of your patients. Yet, failing to master the complexities of the billing aspect of your practice can negatively impact your financial health. Declining reimbursement has been identified by physicians as one of the primary factors that negatively impact profitability (Figure 1). Did you know that a recent online survey during April 2013 involving 5012 physicians [1] found that:

- ✓ Physicians are almost 2/3 more likely to see their practice profitability trending downward in the next year.
- ✓ Only 9% of providers described their staff, technology and processes for getting paid as 'very effective'.
- ✓ Fifty eight percent of providers spend 1 day or more a week on administrative work, not patients.

Are you one of them?

How are practices looking to improve their financial health and profitability?

Many physicians and healthcare providers are being proactive in turning the tides on these troubling statistics, and they are doing it by paying attention to three main areas in their practice: streamlining the billing process, improving technology and optimizing staff. And while these may seem to be separate and unrelated activities, they are actually all part of the same machinery that needs to be properly oiled in order to function with maximum efficiency for a maximum return. A qualified billing service can help you do just that.

There are a number of factors that affect the efficiency of your billing system and directly impact your practice revenue. These can generally be broken down into two large categories. The first area deals with factors over which you have direct control such as provider productivity, the volume of patients seen and the fees that you charge. The second area involves the efficiency with which you handle insurance claims, patient payments and collections. It is this second area that is the most challenging and requires a trained, professional staff that can monitor the ever changing landscape of state and federal regulations that govern the rules of 3rd party reimbursements. If you do not sufficiently oversee your practice's coding and billing patterns, not only may you not

receive the payments that you deserve, but you also make yourself vulnerable to fraud investigation, financial sanction, disciplinary action and exclusion from participating in government programs [2].

Which areas need to be targeted in order to optimize your billing strategy?

Maximizing claims reimbursement

Claims reimbursement comprises the largest share of most medical practice revenue. On the average, medical practices receive 45.1% of revenues from private insurance, 36.3% from Medicare, and 17.1 % from Medicaid [3]. Most healthcare insurers will pay "clean claims" within 30-60 business days after receipt of the claim [2], so proper processing of claims is essential to your bottom line. There are many reasons that claims can be denied (Figure 2), but knowledge of correct coding, knowing how to identify underpaid and avoid overpaid claims, and understanding how to appeal rejected claims are just some of the areas where expertise will increase your revenue and shorten the interval between submitting the claim and being paid.

- ✓ Knowledge of correct coding is one of the single most important factors for correctly processing claims, yet despite the evidence that trained coders are more likely to reduce denials and improve revenue, a survey of E/M documentation coding practices found that in nearly half of the practices, the clinicians were assigning codes [4]. This can be a risky business with documented cases of improper coding resulting in $50,000 to $100,000 annual loss in revenue [5].

- ✓ Identifying underpaid claims (which can be up to 6% of your revenue) and avoiding overpaid claims are important strategies that can save you time and money by capturing potentially lost wages and avoiding the lengthy process of investigating and reversing denials. Today, third party payers are adopting sophisticated data-driven analytical technology to identify discrepancies that suggest overpayment early in the claim review process [6]. Carefully reviewing individual health insurers' EOB (Explanation of Benefits) and RAs (Remittance Advice) is just one activity that can go a long way towards avoiding these pitfalls, and one that is considered vital to the financial soundness of your practice [7].

- ✓ Even with good billing strategies in place, a claims rejection rate as high as 10% is not uncommon, and this can be even higher the more complicated the visit. In addition, the cost of auditing and appealing a claim can range between $14.00 and $25.00 [6] . Though you want to avoid this on the front end by submitting "clean claims", a thorough understanding of the appeals process and the ability to quickly uncover the reasons behind rejected claims can minimize the amount of lost revenue.

Reducing your post-insurance balance

The balance due after the insurance companies have paid their portion can represent the largest part of your debt. Further, the magnitude of this debt is likely to continue to increase. In 2009, the percentage of workers with deductibles of $1000.00 or more had more than doubled when compared to 2006 [8] and co-payments have steadily risen. Effectively reducing this debt requires a multifaceted strategy that goes far beyond just trying to collect from your patients. In many cases, the root of the problem may be traced back to the third party payer. It is therefore helpful to have a dedicated resource working to identify unpaid claims or those that are outstanding beyond the usual limit, accurately discern the reason for denial, and efficiently working with appeals.

Increasing payment from self-pay patients

Even though self-pay patients may be a small part of your practice, evidence suggests that for the average practice, 60% of the amount owed by patients is never collected. When implemented in a consistent fashion, a few simple strategies can reduce this loss of revenue stream:

- ✓ Clearly communicate your financial policies to your patients.
- ✓ Have an efficient system to:
    - Confirm insurance eligibility verification and
    - Obtain prior authorization
- ✓ Consistently collect co-pays at the time of the visit.

Diversifying the use of technology

In 2009, when the HITECH Act (Health Information Technology for Economic and Clinical Health) authorized incentive payments through Medicare and Medicaid to physicians who adopted an electronic health record system, the number of physicians using electronic records jumped from 48% in 2009 to 72% in 2012 (Figure 3) [9] . But in addition to incentive payments, EMR/EHR can also help to optimize revenue through several other avenues by facilitating such key functions as:

- ✓ Credit card processing at the time of the visit.
- ✓ Electronic verification of insurance eligibility.
- ✓ Patient reminders.
- ✓ Documentation of the details of patient encounters.
- ✓ Linkage of diagnoses to appropriate procedure codes.
- ✓ Production of key reports.
- ✓ Electronic claim submission and claim tracking.

What are the benefits to you of hiring a professional medical billing service?

A medical billing service can help you save time and increase your profitability by reducing billing expenses and increasing revenues. They provide you with access to a well-trained staff dedicated to processing claims in the most efficient manner and who are current in their knowledge of changing regulations that may directly impact your reimbursements. In addition, a qualified billing service can help you assess other parameters within in your office practice that can better streamline efficiency. Basically, a good medical billing service will allow you to concentrate on your patients while increasing your bottom line.

How should you evaluate a billing company?

You should carefully consider a number of factors before deciding to hire a billing service. *Ask them* if they:

- ✓ Provide easy access to a designated billing specialist.
- ✓ Give a quick response to all of your concerns and have a system set up for consistent, effective communications.
- ✓ Offer timely and accurate reports.
- ✓ Provide recommendations to maximize front office practices in order to streamline services and increase efficiency.
- ✓ Have a policy of open communication and transparency so that you feel that you are still in control.
- ✓ Charge between four and eight percent of the paid claims and a decrease percentage as the number of paid claims increase.

Overall, how well a billing company is performing can be assessed by monitoring days in A/R, your net collection rate and the percentage of A/R over 120 days. You should expect to see a decrease in the number of days in A/R and an increase in your revenue.

Additional free resources available for members of the American Medical Association for evaluating a billing company:

1. Data ownership issues for the physician practice and a medical billing service
2. What is a medical billing service

How do you know if you might need a medical billing service?

Take this brief assessment to help you determining if hiring a professional billing company would benefit your medical practice.

- Are you working without professional coders as part of your billing staff
- Is there too much turnover in your billing staff
- Are you waiting too long for claims to be paid (more than 60 days)
- Are too many of your claims being denied
- Are fewer than 95% of your claims paid after the first submission
- Are you worried that your net collection rate is decreasing or will decrease in the future
- Do you lack a system of monitoring key business indicators of revenue performance on a monthly basis
- Are you having too many problems with hardware, software and IT issues
- Would you like to spend less time on administrative issues and more time with patients
- Do you wish you had an easier and quicker way to check insurance eligibility and benefits
- Do you wish you had a better system of collecting co-pays and deductibles

If you answered **yes** to most of these questions, you might benefit from using the services provided by a medical billing company. Choosing the right company can provide you with benefits that go beyond the ***peace of mind*** you will experience when you are confident that your billing and reimbursement practices have been optimized. Fewer staffing needs and hiring concerns can give you a greater sense of ***freedom*** and ***independence*** so that you can focus your energies on managing the clinical aspects of your practice. You can experience a greater sense of ***privacy*** about issues surrounding your personal income and financial health, and increased ***flexibility*** to expand your practice.

You may find additional helpful information by visiting the American Medical Association- Practice Management Center

ABOUT OLYMPUS MEDICAL MANAGEMENT

Olympus Medical Management is a practice management and medical billing company with over 10 years experience in claims submissions and collections from government and private insurances. The company has a proven track record for getting 95% of claims paid after the first submission and for realizing a 15-25% increase in collections for their average client with a drop in A/R below 35 days.

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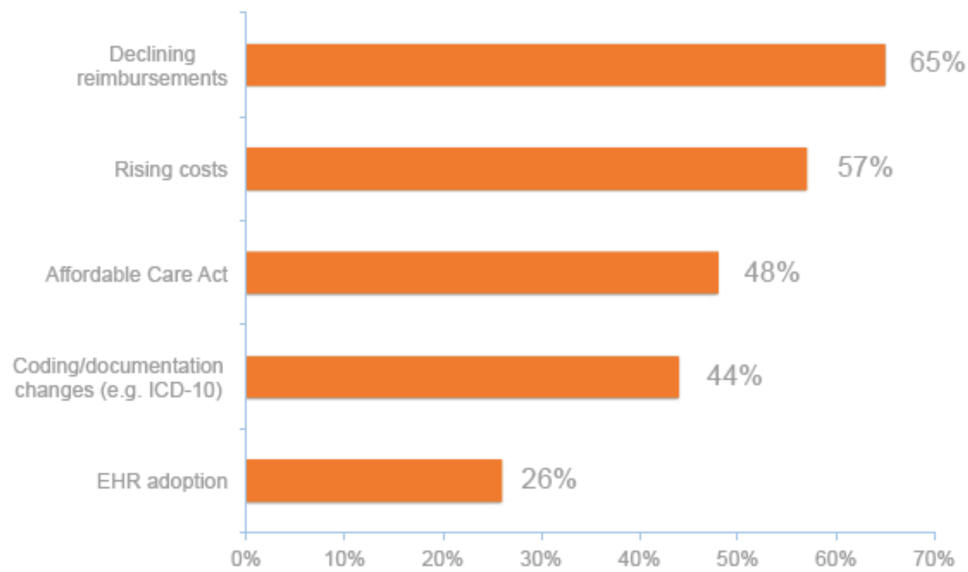
Figure 1. Issues with a negative impact on practice profitability



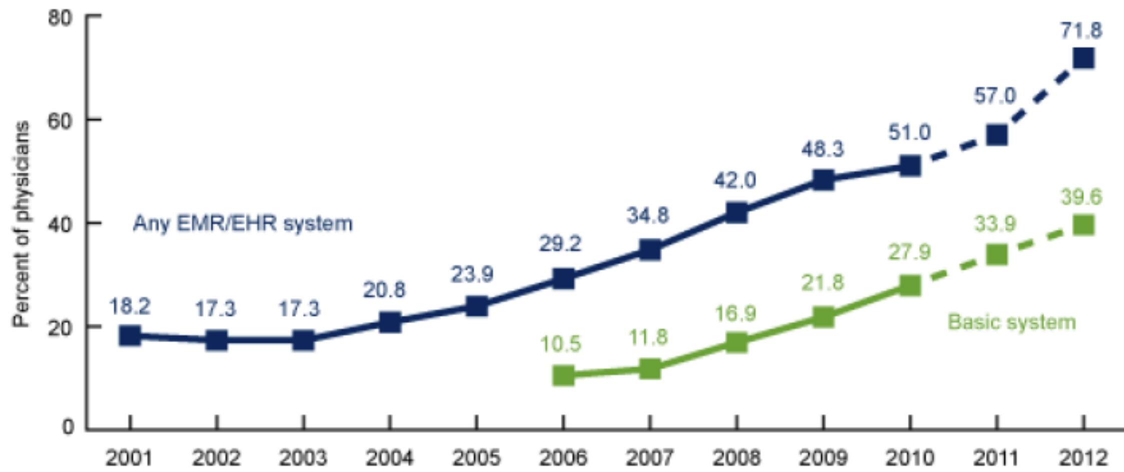
Adopted from " Tracking The Operational and Financial Health for US Physician Practices"- Practice Profitability. 2013 Edition- Permission pending

Figure 2. Reasons for denial of billed services

Top reasons health insurers deny physicians' billed services			
Private health insurers	**% of denied services**	**Medicare**	**% of denied services**
Non-covered service	50%	Non-covered service	31%
Patient not eligible for benefits	25%	Claim lacks information	23%
Claim lacks information	9%	Claim sent to the wrong health insurer	16%
Prior authorization required	5%	Not medically necessary	14%
Claim sent to the wrong health insurer	4%	Patient not eligible for benefits	13%
Documentation required	3%	Documentation required	1%
Source: National Healthcare Exchange Services 2007			

Adopted from "American Medical Association 2008. Follow That Claim: Claims Submission, Processing, Adjudication and Payment. National Healthcare Exchange Services Data, 2007". Permission pending

Figure 3. Percentage of office-based physicians with EMR/HER systems: United States, 2001-2010 and preliminary 2011-2012.



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