

Steering Clear of Billing Black Holes in Academic Medical Centers

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Reimbursement challenges cross all types of physician organizations, including academic medical centers where physicians and administrative leaders have a reduced degree of process-management control. This article discusses key processes that often result in lost revenues to an academic department, and how the department and academic billing entity can prevent those losses.

Key words: Academic; accounts receivable; collections; billing; reimbursement.

For academic department administrators, physician chairs, and even faculty physicians, discussions about billing often yield the description that “it feels like a black hole.” This is because academic billing is most often either centralized within a faculty practice plan organization or outsourced to an external billing company. In either scenario, department leaders do not have direct control or oversight of billing processes, staff, or the information systems used to manage and monitor collection performance.

The level of scrutiny and expectations for collection performance and financial reporting has intensified, requiring an increased degree of collaboration and communication across the reimbursement cycle.

In consulting on behalf of physician departments, we have seen a broad spectrum of strengths and weaknesses in the academic billing environment. In recent years, academic centers have been under increasing financial pressure to streamline reimbursement processes, utilize technology to aid communication and efficiency, educate physicians and staff about coding compliance and

documentation, and successfully communicate financial results to their affiliated departments. The level of scrutiny and expectations for collection performance and financial reporting has intensified, requiring an increased degree of collaboration and communication across the reimbursement cycle.

Given the established framework for limited operational control, what are the dangers and pitfalls that department leaders need to be aware of? What constructive questions can be put forward to billing organization decision makers to increase confidence in billing results, and build and maintain a supportive and collegial relationship? This article describes key academic reimbursement processes and typical problematic issues, and it concludes with a constructive question list.

KEY REIMBURSEMENT PROCESSES AND ASSOCIATED DANGER ZONES

The core reimbursement processes required in an academic setting are increasingly consistent with those required in private practices; the most successful academic organizations we’ve visited have integrated a more proactive financial approach. Examples of key strategic issues, and how we’ve observed clients succeed or suffer, are detailed in the following sections.

Appointment Scheduling

The effectiveness of appointment scheduling protocols drives the physicians’ time and productivity, and

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thus the department's bottom line. If patients are not screened appropriately and schedule templates are not maximized, the faculty member may be scheduled to see patients not appropriate for his or her specialty or subspecialty, or may not see the volume of patients that could fit into the schedule with improved staff training.

We've observed the highest levels of physician satisfaction and scheduling effectiveness in academic environments that decentralize scheduling within the clinical department, yet use a dedicated scheduling specialist or team. Organizations that use a centralized scheduling model, but apply specialty teams to schedule for unique departments, may offer an acceptable alternative, but require a strong emphasis on communication and staff training, as the physicians do not have easy access to the team assigned to support them.

Notably, many academic specialties continue to use a secretarial support model, whereby one or two secretaries are responsible for supporting only one physician and perform myriad tasks including appointment scheduling. In our experience, this model sacrifices patient accessibility and staff member effectiveness for physician comfort. We find the department is better served by creating functional teams, including appointment scheduling, that can support multiple physicians at one time.

Preregistration

The days when a scheduler could "register" a patient with only the patient's name and telephone number and the name of his or her insurance company are long past. Effective registration requires collecting a patient's full demographic and insurance history in advance of the visit. Under an academic secretarial model, we rarely find this being performed, because the secretaries are busy answering multiple calls and completing varied tasks at one time. Some successful organizations combine a decentralized scheduling model with centralized registration support, and develop a system whereby the patient call is transferred from the department-based scheduling team to a central registration staff. The department scheduler remains available to handle the next scheduling call, and the centralized organization has increased control over the information collected from the patient, and can provide focused staff training and oversight.

In one academic center we visited, a hospital-based pediatric specialty clinic did not have effective referral-management controls in place, and patients were repeatedly seen without their needed authorizations. Because denial and adjustment data were never studied, the department remained unaware of its resulting financial losses.

Verifying Benefits and Eligibility

Academic practices are increasingly using online tools and electronic means to check patient insurance eligibility and benefits, co-pay amounts, and referral re-

quirements. The objective of confirming eligibility is to reduce denials and ensure that claims are filed to the correct plan the first time. The additional step of checking benefits, co-pay amount, and referral requirements is one example of a private practice approach, because the goal of securing this information is to collect effectively from patients at the time of service—an expectation that was rarely enforced in academic centers in the past.

One verification challenge in an academic setting is the need to research specialty-specific benefit information. For example, many payors utilize both primary care and specialty co-pays, and the shared information system must be configured to accept both amounts. Selected subspecialties, such as psychiatry, may have unique benefit structures and require actual telephone contact with the payor; their verification needs cannot be met with volume-oriented online or electronic tools.

In many cases, eligibility verification can be performed as a pre-visit, centralized activity. In others, such as with patients with Medicaid, eligibility can be confirmed only on the date of service. This requires that staff in the patient care setting have access to online or electronic tools for real-time Medicaid confirmation and that they be trained to use them.

Time-of-Service Collections

Another challenging black hole in academic billing is time-of-service collections. Challenges stem from variations in front-end staffing (centralized vs. department-controlled), the financial audit controls, and physical space issues. In one academic center we visited, patients were instructed to stop at a centralized desk to register and pay their co-pay, but then checked in a second time in a departmental suite. If patients bypassed the first step, staff in the suite registered them anyway, but the suite-based staff did not have authority to collect payments. As a result, patients could avoid paying co-pays, leading to increased post-visit billing costs and financial risk to the organization. Further, in most academic centers, prior balances are rarely monitored or requested during subsequent visits; as patient-responsibility balances increase, conducting in-person financial discussions will be essential to controlling the accounts receivable (AR).

Presurgical Financial Counseling

In our experience, few academic centers have established surgical financial counseling protocols that match those in the private setting. Although financial losses from indigent and uninsured patients are a comparatively increased challenge, there is often room for improvement in financial screening for patients undergoing elective surgery.

In one organization we visited, physicians had performed elective joint replacement surgery for patients who did not have coverage; as a result, both hospital and department collections were put at risk.

Review of insurance explanation of benefit remittances may reveal that patients are responsible for growing deductibles and co-insurance amounts, or that they're covered under health savings accounts with even greater than typical deductibles. This means that department staff members need to take extra steps to obtain payment for a service that was once paid by the insurance carrier. Private practices typically apply a surgical deposit of 25 to 50 percent of the patient's responsibility and set a budget plan for the balance.

Surgical Precertification

Historically, many academic departments relied on the hospital to perform clinical precertification of surgical procedures, and payors offered a single authorization for both services. Increasingly, however, payors require separate professional and facility authorization, requiring that the department or centralized organization establish a separate team for this process.

Charge Capture and Coding

In an academic center, charge-capture procedures are often complex, given the varied locations and sources of physician productivity. Office services may be performed in a centralized ambulatory center or off-campus locations. Physicians in medicine specialties may perform the professional component of hospital-based services that have a technical component reported by the facility. Coding responsibility varies from the physicians and mid-level providers to coders who abstract code assignment from operative notes or ambulatory and hospital records.

Understanding the account management structure in an academic setting is often the deepest and darkest black hole, and where department leaders have the least confidence.

Once you've assessed "Who does the coding?" it is essential to understand how training, compliance protocols, and coding and reimbursement guidelines are applied. In one organization with specialty-assigned coders, we found the coding backlog was so great that surgeries were being billed long after plan-mandated filing deadlines of 60 or 90 days. Combined with other process breakdowns, these losses represented 6% of the department's total charges in one year.

Within surgical and procedural specialties, understanding coding guidelines and differentiating them from payor-reimbursement guidelines is an ongoing concern. Too often, payment guidelines, including Medicare's Correct Coding Initiative, are confused with coding rules, leading coders to not report services that were provided

by the physician. We've observed examples where the billing organization grew tired of posting adjustments for payor-specific bundled services, so discontinued billing for them. As a result, the department lacked valid CPT frequency data and could not compare collection results consistently.

Tracking Missing Charges

Charge capture tracking is an essential reimbursement cycle step, and a frequent black hole in academic systems. More successful entities use automated appointment scheduling for all services, including surgery, and reconcile charge entry to scheduling with a missing-encounter tracking report. If the organization instead uses separate scheduling and billing programs without a reconciliation link, or schedules surgeries with a paper schedule, it may be reduced to reconciling charges through manual counts.

We visited one nonacademic but hospital-based organization that had 50,000 missing encounters for all specialties. Elaborate tracking systems were in place to count the in-process encounters within the coding and data entry departments, but the core issues of increasing staffing levels and eliminating process delays were ignored.

Accounts Receivable Management

Understanding the account management structure in an academic setting is often the deepest and darkest black hole, and where department leaders have the least confidence. In our experience, the best collection success results from a framework where large-volume tasks such as claim processing and even payment posting are centralized, but where account follow-up is assigned by clinical specialty.

A critical factor in account follow-up, whether centralized or specialty-specific, is how staff members are trained to manage their assigned accounts.

Particularly in specialty departments, we find that coding requirements are too complex to communicate across the large organization, and improved results come from layering specialty-assigned AR follow-up over a payor-assigned model for medical services. In this approach, team size may range from one specialist to many, depending on the size of the department. Within a larger specialty team, staff could be assigned by payor or clinical subspecialty.

In one client organization, three staff members are responsible for working the AR of 19 surgeons, but they achieve superior collection results due to their focused understanding of the specialty. In another academic department of the same specialty, an external billing company had assigned only one team member to manage the

claims of 10 physicians, resulting in an impossible workload, long delays to research unpaid claims, and comparatively poor collection performance.

A critical factor in account follow-up, whether centralized or specialty-specific, is how staff members are trained to manage their assigned accounts. Ideally, AR reports or electronic queues should be programmable so that claims print or display in descending dollar value according to aging “buckets” of 0–30 days, 30–60 days, 60–90 days, etc. As suggested previously, prioritizing account follow-up by payor group will help staff to increase efficiency. Staff can inquire about multiple claims during the same phone call or check claim status electronically on multiple accounts at the same Web site.

Low-Payment Tracking and Modifier-Driven Discounting Policies

As organizations grow in size, it is often increasingly difficult to manage and communicate contracted payment rates, and to audit actual payments against them. Many organizations do not have a strong link between managed care contracting and the billing group, leading to lost revenues.

Specifically, if contracted rates are not input into the information system, it is unlikely that incorrectly paid claims will be identified and appealed. Often payment-posting staff members are not informed of payor-specific discounting policies for surgery and thus do not question discounts that are inconsistent with the plan’s stated guidelines.

In organizations that replace real-time payment auditing with retrospective data mining, we often find that deficiencies are not identified and become lost in volumes of claims data. While financial losses are sometimes not large in the scope of the entire institution, they may be significant for a specific department or division.

In one client organization, staff members had access to a spreadsheet tool that they could use to compare actual payments with contracted rates, but there was no protocol to apply the tool to surgical claims. Through retrospective review, we found numerous cases where a workers’ compensation carrier did not pay services at the state-mandated rate.

Denial Tracking and Appeals

As an increasing number of government and private insurance programs support electronic remittance for payment, many organizations have been able to integrate and automate denial reporting. Unfortunately, not all are structured to communicate the denial trends to the affected department, so that process changes can be instituted.

Simple and clear data are essential to effective denial reporting. While payors may use a myriad of edit explanation codes, these must be translated to a concise list of reason categories for interpretation—no small reporting feat.

In one center, the centralized entity developed an array of denial reports, but the data were presented only in dollar values, not in frequency counts, decreasing interpretive ease. Large-dollar surgical denials were reported in the same format as low-valued office services, resulting in a skewed comparison.

One of the most challenging denial issues is how staff members respond to coding bundling rejections. When staff members assigned to work claim denials lack a base of coding awareness, we find that denials are not appealed appropriately. Successful organizations provide a direct support link between account follow-up staff and coding specialists, oftentimes having coders write the appeal letters.

Reporting and Communication

Several common academic information systems offer a wide array of reporting capabilities and features. The best offer clear and concise reports that include both financial data and tracking indicators that measure collection performance.

We commonly find that the issue is not the volume of data available, but how the data are packaged and presented, and how the physicians and administrators are trained to interpret the information.

Too often we find that billing leaders are frustrated when departments question them about financial performance and state, “but look at all the information we provide.” In these cases, we commonly find that the issue is not the volume of data available, but how the data are packaged and presented, and how the physicians and administrators are trained to interpret the information. Drowning the department in detail does not necessarily add value. Greater collaboration is achieved when data are presented in a readable, understandable format (i.e., legible font with clear data descriptions) and accompanied by interpretive commentary.

For example, if the physicians in a department do not submit charges in a timely manner, and charges are comparatively low for the reporting period, it is essential that the billing entity point out the negative impact of that practice. Similarly, if the billing entity is having difficulty with a particular payor, it will be important to highlight that fact for effective interpretation of the plan’s AR indicators.

We’ve found greater departmental satisfaction with billing performance when the billing entity assigns a designated liaison or analyst who is responsible for assessing monthly financial information, meeting with the department leaders, and working with the centralized staff to resolve issues. This reduces the need for the department administrator to monitor operational details and reduces the likelihood that specialty-specific issues will be ignored.

QUESTIONS FOR THE CENTRALIZED OR OUTSOURCED BILLING ENTITY

Appointment Scheduling and Registration

If centralized, who schedules our physician appointments? Did the department contribute to template development, and do the physicians have access to the schedulers to report feedback and ways they can improve scheduling decisions? If decentralized, does our departmental structure allow assigned scheduling staff members to respond to patient inquiries in a timely manner?

Are new patients preregistered, and how are referral authorization requirements managed? How is Medicaid eligibility confirmed?

Verification of Eligibility and Benefits and Precertification

Do we verify patient insurance eligibility and benefits in advance? How often is coverage verification updated?

Is the professional portion of surgery precertified separately from the facility service, and who performs this task? Are denials occurring due to lack of surgical precertification?

Time-of-Service Payment and Presurgical Collections

Do we effectively collect co-payments, deductibles, and co-insurance at the time of service?

For elective surgeries, do our payor benefit trends show that we need to implement presurgical deposits?

Coding and Modifiers

Who performs our office, diagnostic test, and surgery coding? What coding/bundling standards are applied? If the physicians initiate code selection, followed by review from a coding specialist, how are code and modifier changes approved by the physician? What training and experience do the assigned coders have in our specialty? What educational opportunities are offered to ensure they understand the services being performed?

Account Management and Appeals

Are contracted rates input in the information system, and how do we audit to ensure that claims are paid

correctly? Does the audit process recognize multiple-procedure-discounting guidelines?

Are claims being denied as bundled, lacking medical necessity, or lacking supporting documentation? Do explanations of benefits show line items with zero payment? How are denials identified and flagged for follow-up?

How many staff members are assigned to work our accounts? How are they organized, and are specialty nuances incorporated into the follow-up model? What specialty training or resources exist to address staff members' questions?

Do staff members have access to tools that outline payor-reimbursement guidelines (e.g., Medicare's Correct Coding Initiative, Medicare and carrier bulletins, Part B News, etc.), in order to direct their appeal efforts effectively? Do coding specialists or physicians participate in writing appeal letters for surgical claims that outline why additional payment is justified?

Do staff members have access to Internet-based resources that will support their efforts to be proactive and efficient? Are staff members trained to navigate the World Wide Web to access Medicare and other payor guidelines, such as local carrier determination parameters?

How is staff performance measured and monitored? How many accounts are staff members expected to work each day or week? Are the targets being met? How do staffing levels compare with other academic billing organizations?

Reports and Data Monitoring

What data are reviewed each month for our department, and how are problem issues identified and communicated?

What indicators are used to measure collection performance, and are data reviewed only for the organization as a whole, or by clinical specialty?

How can the department access nonstandard reports in a timely manner?

What analytical support is offered by the billing entity to assess collections and accounts receivable management? Who will ensure that problem issues are identified and resolved?

Reporting claim denial and corresponding non-contractual adjustments is also key to collection success. Common problems include missed filing deadlines,

missed follow-up deadlines, missed referrals, lack of precertification, lack of medical necessity, coding bundling, and incorrect diagnoses. ■