



10 Things a Billing Service Should Provide Your Practice

By Karen Zupko

Last week, a plastic surgeon from Tennessee called. He outsourced his billing six months ago and asked which reports the service should send him each month. To date, he had not received any reports, and cash flow was slow.

A client with a blended reconstructive and aesthetic practice engages a billing service that uses different software than the practice. A great deal of faxing, Federal Expressing and mailing is necessary to file claims. If staff have a question about a claim status or balance, they must call or email the billing service because they have no access to patient accounts. The billing service does not provide a computer-generated aged accounts receivable (A/R) report by payer, nor one that details patient and insurance carrier balances. The practice can't get a detailed adjustment report—only the monthly total—and past due account status updates are non-existent.

A Texas practice we work with has similar issues. Staff has “view only” permissions to its billing service's software system, but can't generate reports. The service frequently “doesn't receive” the faxed or scanned copies of face sheets, op notes, and deposit checks, creating a constant merry-go-round of redundant staff work and a ballooning accounts receivable.

Does any of this sound familiar?

When aesthetic plastic surgeons choose to outsource billing, it's often because the aesthetically- oriented staff lack reimbursement knowledge and experience, or claim to be “too busy.” The truth is, the paper-based and redundant systems required by many billing services end up eating into your staff's relationship-building time with patients anyway. Further, few services deliver any real value-added service beyond submitting claims. And based on the many service contracts we've reviewed, surgeons often and unknowingly assume a lot of additional risk.

With a little preparation and a list of the right questions, you can avoid most billing service snafus.

Beware of Separate Software

If the billing system's software is the same as yours, it's a green light to consider hiring them. If it's not, understand that *many staff*

Thinking About Outsourcing the Billing? Here are 10 Deal Breakers to Avoid

1. The company doesn't and won't use your practice software system—nor provide staff secure, real-time access to patient accounts.
2. There is no verification that employees receive initial and annual HIPAA training. The Business Associate Agreement (BAA) is non-existent, or lacks key clauses.
3. The service can't produce a written breach policy and the last year's security audit, both required by the HIPAA Omnibus Rule.
4. There is no written policy for how the company destroys PHI.
5. The service can't produce a written list of monthly reports and metrics they provide and review with clients. And they won't agree to a scheduled, monthly or quarterly phone or virtual meeting to review the data.
6. No one on the staff has attended a plastic surgery-specific coding course within the last year.
7. They can't provide written protocols for how they bill claims, manage denials, appeal incorrect payments, or follow up on past due accounts.
8. They don't offer customized write-off/adjustment, revenue, or payer categories in their software system. They resist your requests for modifications.
9. The company doesn't carry general liability insurance of at least \$1M.
10. The company doesn't have a minimum of \$1M in Errors & Omissions (E&O) coverage.

and operational inconveniences will occur if you ink the deal. Essentially, you are signing an agreement to be separated from your own data, and your staff will be out of the loop about everything that happens after the paperwork is sent to the billing service.

Two software systems are guaranteed to create obfuscated accounts receivable issues. When your data is dismembered, patients have two accounts: one in your system and one in the billing service's system. Because of the opportunities this creates for human error,

we frequently we find that accounts receivable and collections data from the billing service does not match the practice's books. And that's never a good thing.

Dismembered data issues are at the crux of nearly every billing process issue we observe in practices that have outsourced billing. Beyond the additional paperwork and faxing, key tasks such as performing financial counseling and collecting past due balances during the 90-day global period become challenging, because staff don't have easy access to real-time data. For instance, your staff need the details about carrier payments and remaining balances for patients who have undergone stage one breast reconstruction. This information is critical to counseling these patients about their remaining balances, as well as walking them through financial expectations as you plan stage two. Further, every time an insurance check arrives in the mail, practice staff must take the time to fax or scan it for the billing service.

10 Things a Billing Service Should Provide

Whether you are considering outsourcing, or already have a service, use this list to assess its efficiency, risk, and performance.

1. Real-time access to your data. Best case, the billing service uses the same software as the practice. If you are currently evaluating options, don't choose a billing service that uses a different system. If you already use a service that has different software, make sure the vendor provides secure, real-time access to your accounts. Often, this means establishing remote access with the billing service software system—a secure channel through which your team can securely login. Talk to your IT consultant for details. Without such access, you can't look up account balances, research patient accounts, or generate reports. And you shouldn't have to play “Mother, May I?” with your own data.

2. A complete and current Business Associate Agreement (BAA). It's alarming how many billing service BAAs are deficient, and how many physicians have not verified that the policies and procedures HIPAA requires of business associates actually are

Continued on Page 69

10 Things a Billing Service Should Provide Your Practice

Continued from Page 68

enforced. Beginning in the fall of 2013 the HIPAA Omnibus Rule required all vendors to have a written breach policy, conduct annual security audits, and provide initial and annual employee HIPAA training. Make sure your billing service is compliant.

3. Solid and current plastic surgery coding knowledge. Does the billing service team understand how to bill for an appeal DIEP flaps, burns, or complex repairs? Our strong recommendation is that person who knows the most about the procedures performed—the *physician*—be the one to select the codes. But billing service staff must be capable of providing feedback and offering suggestions about the codes submitted, based on Explanation of Benefits (EOBs) data received from insurance plans. And coding expertise is also required in order to effectively appeal denials. All of this means that the folks at the billing service must have up to date knowledge about coding for your specialty.

Although free, general payor and Medicare Webinars are helpful, they are not a substitute for plastic surgery specific coding education and expertise. As a customer, you should expect that the company you've entrusted for billing hires employees who have current (not five years old), specialty-specific expertise. Providing you with feedback about whether your documentation needs strengthening or your coding is errant also requires specialty expertise. Ask the billing service for documentation that indicates its investments in plastic surgery education. Ask who is trained, how often, and who taught the courses. KZA offers regional, coding and reimbursement workshops and customized Web training sessions for plastic surgeons.

4. Insurance. What happens if the billing service consistently bills incorrect modifiers or violates the False Claim Act? What if it has a data breach? If either untoward event occurs, the billing service needs to be covered by Errors & Omissions and general liability insurance, respectively, with a minimum of \$1M coverage for each policy.

5. Reports. Insist on reports from the software system, not Excel spreadsheets, which contain exported data that can be manipulated to the company's advantage.

Expect the following reports to be delivered like clockwork each month, by the 5th or 6th day of the month that follows the data period:

- **Aged Accounts Receivable by Payer**, with insurance and patient balances shown separately.
- **Detailed Write-offs and Adjustments**, with categories so descriptive that you know exactly what the charges were written off to. Examples of descriptive adjustments: *Modifier 25, Patient Ineligible on Date of Service, and Past Timely Filing.*
- **Credit Balances.** If credit balances are accurate, they are a liability. Ask the billing service to verify them, then refund the plan or the patient within 30 days. Warning: If deposits for aesthetic surgery are not isolated, and they appear on the A/R report, the total A/R is deflated by the amount on the Credit Balances report.
- **Large Account Status.** Billing services respect what their customer inspects. Ask them to deliver account management notes and next steps for the ten biggest accounts, every month.
- **Accounts that Were Appealed**, with an accounting of "wins" and losses.

6. Monthly metrics. Metrics indicate how well the billing service is doing its job. Review A/R every month against the benchmarks shown.¹ These metrics can vary by payor mix and subspecialty. Motor vehicle accidents, Worker's Compensation, and burn cases often take longer than 25 days to pay and drive up the total amount of A/R that's > 90 days old.

	Days in A/R	Percent A/R	Net Collection Ratio > 90 Days
What it Measures	Average number of days to collect an account.	Amount of A/R older than what's considered "likely collectible."	Percent of "collectible" receivables that have been collected. (Net of contract adjustments and bad debt.)
Performance Standard	25 days or less*	15% or less	98% or better

7. Service fee differential for pre-operative collections. We believe in paying the billing service for work that they have done. But if *your* staff is performing financial counseling, collecting patient deductibles and

co-insurances, and posting these into your software system, you should not be required to pay a commission or service fee on those amounts. Negotiate a fee differential for pre-operative payments, and never pay a service fee on your aesthetic procedures. This is especially important if patients have used CareCredit or are set up on a recurring payment plan—both of which require no billing service action or intervention.

In one practice we visited, the surgeon's staff collected the patient's portion prior to surgery, and the billing service was charging its full service fee for simply posting it into their software system. We argued that the surgeon's staff had already done all the heavy lifting—and in fact, made the billing service's job easier, since there was no patient portion to collect after insurance paid.

8. Timesavers and technology tools. Relying on phone calls, forms, and paper-based systems indicates the billing service is stuck in the past. Here are a few best practice technologies to insist on: electronic follow up queues, which improve the efficiency of managing unpaid accounts; electronic funds transfer (EFT) which reduces paper, lost checks, and theft; electronic remittance advice (ERA) which significantly speeds payment posting; and payor portals, which provide an automated, online channel for appeals and denial management.

9. Best practice follow up protocols. Good billing services don't sit passively

and wait for claims to be paid. They act on unpaid claims at 30 days or less. They have procedures for chasing payer underpayments until resolved. Ask your billing service to

Continued on Page 71

The Best Asset Protection

Continued from Page 70

plans. Once again, non-qualified plans are generally not used for asset protection purposes, but they may have such benefits—depending on how they are structured.

C. Captive Insurance Companies (CICs): CICs are used by many of the Fortune 1000 companies, for a host of strategic reasons. In a medical practice setting, the owners actually create their own properly-licensed insurance company—to insure various types of risks of the practice. These can be economic risk (that reimbursements drop), business risks (that electronic medical records are destroyed), litigation risks and even medical malpractice (keeping some risk in the captive and reinsuring the rest). If it is created and maintained properly, the CIC is like any insurance company -- established in a real economic arrangement with its insureds. Also, CICs can enjoy tremendous creditor protection (+4/+5) if the ownership is structured properly.

D. Cash Value Life Insurance (CVLI): CVLI policies are purchased by millions of Americans each year for their tax benefits (generally, tax-free growth, can be accessed tax-free and pays income tax free to heirs), for family protection and for estate planning purposes. Nonetheless, in many states, the cash value can enjoy the top (+5) protections. In this way, an aesthetic plastic surgeon can purchase a product that is widely recognized as a part of a financial plan and enjoy (+5) protections easily.

Conclusion

Many physicians who have implemented generic asset protection plans may be disappointed if they are ever attacked—as they may be ignored by courts that see no economic substance. On the other hand, those who implement techniques such as those described above may be pleased—not only will their protection be upheld, but they may build significant wealth along the way. The authors welcome your questions.

SPECIAL OFFERS: To receive a free hardcopy of *For Doctors Only: A Guide to Working Less & Building More*, please call 877-656-4362. Visit www.ojmbookstore.com and enter promotional code ASAPS04 for a free ebook download of *For Doctors Only* or the shorter *For Doctors Only Highlights* for your Kindle or iPad.

David B. Mandell, JD, MBA, is an attorney and author of five national books for doctors, including, "For Doctors Only: A Guide to Working Less & Building More," as well a number of state books. He is a principal of the financial consulting firm OJM Group www.ojmgroup.com along with Jason M. O'Dell, MS, CWM, who is also a principal and author. They can be reached at 877-656-4362 or mandell@ojmgroup.com.

Disclosure:

OJM Group, LLC. ("OJM") is an SEC registered investment adviser with its principal place of business in the State of Ohio. OJM and its representatives are in compliance with the current notice filing and registration requirements imposed upon registered investment advisers by those states in which OJM maintains clients. OJM may only transact business in those states in which it is registered, or qualifies for an exemption or exclusion from registration requirements. For information pertaining to the registration status of OJM, please contact OJM or refer to the Investment Adviser Public Disclosure web site www.adviserinfo.sec.gov.

For additional information about OJM, including fees and services, send for our disclosure brochure as set forth on Form ADV using the contact information herein. Please read the disclosure statement carefully before you invest or send money.

This article contains general information that is not suitable for everyone. The information contained herein should not be construed as personalized legal or tax advice. There is no guarantee that the views and opinions expressed in this article will be appropriate for your particular circumstances. Tax law changes frequently, accordingly information presented herein is subject to change without notice. You should seek professional tax and legal advice before implementing any strategy discussed herein.

10 Things

Continued from Page 69

explain the logistics for collecting past due balances. If they passively mail three paper statements at 30, 60, and 90 days, that's a problem. An effective billing service proactively calls patients to take a payment over the phone or set up a payment plan. Many surgeons are surprised to learn that some companies only send three statements, at which point, practice staff are expected to step in.

Request the details about how the service selects and submits old accounts for write-off. Documentation should include detailed notes and a clear directive that's based on good judgment. Nothing should be sent to collections without physician approval.

10. Recommend improvements. A high performing billing service explains how better coding and documentation would improve compliance, speaks candidly about how to avoid denial patterns, and provides proactive suggestions for improving collections. Remember, you are paying the billing service to work for *you*. Although they should not change your coding without approval, billing service employees should point out any routine coding mistakes that run up the receivables, review monthly reports, and provide suggestions that keep the accounts receivable in check.

If you plan to outsource billing, perform due diligence, choose a quality partner, and be cautious about signing with a company that doesn't use your software. Countless practices express their disillusionment, disappointment, and frustration with billing services during our firm's reimbursement and coding workshops. Many say they ended up bringing billing back in-house. As one doctor recently shared, "It was an expensive experiment."

Download a detailed Billing Service Checklist at karenzupko.com.

Karen Zupko, President of Karen Zupko & Associates, Inc., is an internationally sought-after speaker, author, and practice management consultant. For more than 30 years, she has been advising and educating plastic surgeons on management and marketing issues, including personnel, billing, technology, coding, and practice expansion.

1. Suggested benchmarks are derived from our firm's work with hundreds of plastic surgeons, nationwide.