Enhancing Your Podiatric Medical Practice's Revenue Cycle Management

Cash flow is the lifeblood of your practice.

BY MARK TERRY

Are you leaving money on the table? Many podiatric physicians running practices are. Healthcare is a complicated—okay, strange—type of business from a money perspective, with insurers often rejecting payment, questioning the need for services you've already delivered, customers (patients) not knowing how much their insurance covers, and often-changing and always-complicated coding issues.

Dr. Wishnie

"Most doctors do not pay attention to their reimbursements," says Peter Wishnie, DPM (Piscataway, NJ). "They pay little attention to it. They pay more attention to their patients, which is fine, but at the end of the day, they don't know how much money is coming in."

John V. Guiliana, DPM, MS, Medical Director-Podiatry for Modernizing Medicine, agrees, saying, revenue cycle management "is the single most important factor in a medical practice. Most doctors would say the most important factor is the quality of the care that you provide. But I would argue that you can't provide quality care without cash flow. So to me, the number one element for success is cash flow, which can then drive the quality of your care." Guiliana (with input from Peter Wishnie and Mike Crosby) proposes seven parameters to improve podiatric practice revenue cycle management.

Dr. Guiliana

1) Proper provider credentialing. Dr. Guiliana says, "The entire chain starts with proper provider credentialing. Unfortunately, we have many doctors who think that they can just bill under another provider's NPI number. You can't do that. You have to go through proper provider credentialing because everything flows from there."

Dr. Wishnie thinks this is a bigger issue for newer practitioners. "When you're a new practitioner, you need to get involved yourself and not rely on other people, so

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you understand the process. Once you understand it, you can delegate it, because now you know what's expected and you can hold them accountable. But when you start a practice, you need to have your tax ID, of course, and NPI numbers and all the various credentialing."

He adds that if you're buying another practice, you don't necessarily want to change the process because it could take months for everything to fall into place. "If you have a couple of months before you open, you should start immediately changing the tax ID number. But if you go to practice the next day and you have to get a new tax ID number, it's going to take you three to four months before you get paid."


Mike Crosby

2) Check for patient eligibility. Mike Crosby, Provider Resources (Brentwood, TN), says, "As soon as a patient calls in and sets up an appointment, you need to take the insurance information. The next step is, before they come for their visit, to verify that they do have the insurance they told you about and what it does and does not cover. Then when they get to the office, they sign their forms and if a deductible or copay is due, tell them how much that is before they're treated."

"As soon as a patient calls in, and sets up an appointment, you need to take the insurance information."—Crosby

And, of course, use your technology to verify that it is active insurance.

3) Understand coding and compliance. Coding and compliance aren't taught in medical school, generally speaking. Guiliana notes, "You have to outsource it."

There are essentially two approaches. "One, if you don't have a basic knowledge of coding and compliance, or you prefer to not deal with it, then you shouldn't be doing it internally," Guiliana says. The other approach, then, is to learn coding and compliance.

"The biller has to be knowledgeable about correct coding initiatives in order to reduce denials, which lead to further delays in those claims being adjudicated."—Guiliana

"Part of our responsibility," Guiliana says, "is to make one of those two choices. We can't just ignore it. We have to be compliant. We have to know how to code or the billers have to know how to code."

Crosby points out that you and the billers need to understand "what's really billable and how to bill it, whether it's bundled or unbundled. You have to have an understanding of what the CPT codes are telling you and what they're telling the payer."

4) Appropriate claims scrubbing/correct coding. Chances are, your billing is either conducted by someone in your practice, or an outside billing agency [See Sidebar on page 56: **In-House Billing or External Billing Service**]. As #3 suggests, as a physician you need to have a reasonable understanding of coding and compliance.

Guiliana says, "The biller has to be knowledgeable about correct coding initiatives in order to reduce denials, which lead to further delays in those claims being adjudicated."

Although coding and CPT codes are complicated, you as the physician needs to have a decent understanding of it even if you outsource it to staff or an outside billing agency.

5) Appropriate processes. Billing and collections should not be improvised. Create specific and concrete processes for billing, collections, claims, and adjudication. Crosby says, "Have a structure for the timing of submitting claims. What kind of timeframe is there from chart completion to submitting the information to the billing department to be reviewed and then to be sent out? If you don't get the chart completed and sign off on it, it can't be released. So you have to monitor that you're meeting the milestones set for the practice. For example, patients seen on Monday, charts completed no later than Tuesday, and the bill goes out on Wednesday after review."

Wishnie indicates that his financial administrator sends him several graphs every week, statistics that show the amount of money collected for the week "because now I can see the trends. Are we trending upward or downward? And then she would tell me why. So based on that, she also describes a weekly action plan, how we can maintain it, grow it, or get it back up, depending on the situation."

The administrator also includes data on the amount of money collected over the counter. Wishnie says, "The whole point of this this: let's say I have a great week seeing a lot of patients. I am building a lot of patients, but the money's not there. But the money from the insurance company is coming in. So maybe my front desk got too busy and didn't have the opportunity to properly ask

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the patients up-front for their co-pays and deductibles or any cash payment services. This allows me to know where the money line is being faulty."

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6) An appeals process. Of course, part of having a billing and collections process in place is having processes that deal with denials. Guiliana notes, "We know that insurance carriers look for opportunities to either partially pay a claim or not pay a claim based on a completely invalid reason. You have to have a firm appeals process and the appeals have to begin the minute you get those denials. There can't be any delay."

That refiling will hopefully lead to

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In-House Billing or External Billing Service

Some physicians prefer to keep their billing/collections in-house. Generally, a billing company takes 6%-9% of the monies they handle. For example, if your practice brings in $1 million annually, that comes to $60,000-$90,000. If you handle it in-house, and it's performed well, that could drop to maybe 3%, a savings of $30,000. That seems straightforward, but it may not be.

Cons of External Billing Companies

• **Many billing companies, in addition to charging on a percentage basis, charge a set-up fee that can run anywhere from $500-$3,000.** This makes it unlikely you will jump to a competing vendor because you'll have to pay the fee again. In addition, many deploy contracts for a specific period, and breaking those contracts can cost you money.

• **Billing companies, like help desks, may outsource their work overseas.** Getting someone on the phone or troubleshooting a problem isn't as convenient as having someone working directly for you that you can contact 24/7 if you had to (don't, but you could). This is one of the reasons cited by Wishnie to have billing and collections in-house, as well as being assured that there's a single source working on your account, rather than several people.

• **Billing versus collections.** Wishnie distinguishes between billing and collections, saying, "I don't like the term 'biller' because if you're looking for a biller, you're going to get someone who's good at billing. I need a collector. My people actually call patients and insurance companies to collect money they owe us. Many billing companies don't call patients, they send out statement after statement after statement every 30 days, but no one's calling them and asking them when they should expect payment."

• **Big fish, little fish.** A common complaint about billing services is that they don't chase down money. Since they are paid on a percentage, their energy goes into handling bigger customers and bigger claims. A 7% fee on a $10,000 surgery or hospital stay is significantly more money than a 7% fee on a $1,000 procedure.

• **Lack of control.** Similar to being able to access your accounts and billers when you want or need to, physicians may feel they lack control over external billing companies. Wishnie points out that even though billing companies may work for you, it may not always feel that way. It's important, either way, to demand transparency and set up regular reviews of billing and collections, from weekly to monthly.

Pros of External Billing Companies

• **Billing is complicated and changing constantly.** It requires at least one skilled person on staff who is both educated on it and continues to stay up-to-date on procedures. Billing services presumably do that. Guiliana says, "I look at it this way: If I had an electrical problem, I wouldn't try to fix it, I would hire an electrician. I have an accountant because I don't have an accounting degree. Those are things I outsource."

• **You probably start off that way.** Billing is a learned skill, not taught in medical school, so if you're a new practitioner, you probably have to hire a billing company anyway. Rather than go through the steps to educate yourself or staff members, it may be easier to just stick with what works.

• **Time savings.** If you don't have to spend energy and staff hours on billing, it frees you and staff members up for other activities. A professional billing service can also streamline your billing and collections processes.

• **Reliability.** Practices differ on the number of people performing billing, but if you only have one or even two people billing, vacations, illness, accidents or turnover can leave your practice scrambling. **PM**

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adjudication and payments. It is somebody's responsibility to efficiently post those payments and immediately get the secondary insurance—if there is a secondary insurance—or to get the patient statement processed. "The timeline here," Guiliana notes, "should be as short as possible. The longer it takes for the patient statement to go out, the greater the chance that it's never getting paid."

7) Complete oversight of accounts receivable management. In addition to knowing what's going on in your practice's finances, it's important to understand what these facts and figures mean. Guiliana notes that he will hear doctors say, "'My account receivables are through the roof.' What exactly does that mean? Because I would want my account receivables to be through the roof as long as all the claims are current, right? It means I'm busy. The reverse can be catastrophic—if I have no account receivables. So I would want my account receivables to be high as long as the preponderance of it is current."

Most practices should aim for below 50 days to get a claim paid. If your days in A/R number is greater than 50, you have a possible bottleneck somewhere in the system.

The Other Key Metrics

That's only one set of key metrics you can track in your practice. The four most important are:

1) Days in A/R. How long does it take to get your average claim paid? Most practices should aim for below 50 days to get a claim paid. If your days in A/R number is greater than 50, you have a possible bottleneck somewhere in the system. The formula for days in A/R is: (total A/R divided by gross annual charges) X 360.

2) Accounts Receivable report (A/R). Most billing software places outstanding revenue in divided time categories. National benchmarks that you can measure against are:

Percentage of Claims	Days in A/R
52%	0-30
16%	30-60
7%	60-90
5.5%	90-120
17.7%	120+

Source: *Medical Group Management Association (MGMA)*

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3) Claim rejection rate. Claim rejection rate refers to claims that have been rejected immediately by the clearinghouse on the front end. It may be because of simple demographic errors, claim data error, missing diagnosis, etc. Claim rejection rates should normally be lower than 4%.

4) Denial rates. Claim denials are claims that have been accepted by the clearinghouse but have been denied by the insurance company. Claim rejection rates should be below 8%. A very serious issue related to denials is that 50-60% of all denials are never worked to adjudication, basically lost revenue.

The Lifeline of Your Practice

Crosby believes that there are two key components of a thriving medical practice. "One is revenue cycle management and the other is one's new patients. Patients generate bills and bills generate payments. So being effective and efficient in your revenue cycle management is critical."

"The important thing to understand about revenue cycle management is making sure that somebody in the practice knows all of the necessary information and is paying attention to it."—Wishnie

There are a number of factors, but the key aspects of improving revenue cycle management are education and processes—understanding the details of appropriate coding, billing, and developing procedures and processes to handle and monitor those activities.

"The important thing to understand about revenue cycle management," Wishnie says, "is making sure that somebody in the practice knows all of the necessary information and is paying attention to it." **PM**

Mark Terry is a freelance writer, editor, author and ghostwriter specializing in healthcare, medicine and biotechnology. He has written over 700 magazine and trade journal articles, 20 books, and dozens of white papers, market research reports and other materials. For more information, visit his websites: www.markterrywriter.com and www.markterrybooks.com.