

Automation in the Business Office

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The Case for Improvement

Despite its important role to translate physicians' work into income, the business office is not immune from pressures to cut costs in a medical practice. The business office of a medical practice draws this scrutiny even as the volume of administrative work and the cost of related labor are skyrocketing. Attempts to reduce costs by assigning lower-salaried, inexperienced workers to handle billing and collection responsibilities are ill-advised. Employees must have sufficient understanding of insurance and payment rules to ensure timely and accurate payment for clinical services.

Many medical practices face a costly challenge: cutting expenses in the business office, primarily labor costs, creates a short-term benefit, but it can also cause the practice's bottom line to crumble as the remaining infrastructure and workforce simply cannot effectively manage the revenue cycle.

The nature of the work in the business office has shifted as well. Since the dawn of Medicare in 1965, medical practices have become increasingly focused on collecting payments from insurance payers. Over the past decade, especially within the past five years, the focus has shifted back to collecting payments from patients. The two forces driving this shift are the dramatic growth in the ranks of uninsured, and employers transferring more financial responsibility for healthcare to their employees.

The result? A higher percentage of the practice's revenue comes directly from patient payments, with estimates that patients will account for 30 percent of the revenues of a medical practice by 2012. (See Figure 1.) This shift in revenue source, which is already underway, puts medical practices under pressure to either adapt the workflow within their business offices to these new collection demands or suffer the losses caused by collections under-performance.

The challenges of collecting from patients are relatively straightforward: expense and lack of success. The medical practice's average cost of collection per encounter is about \$7, but it's much higher if you have

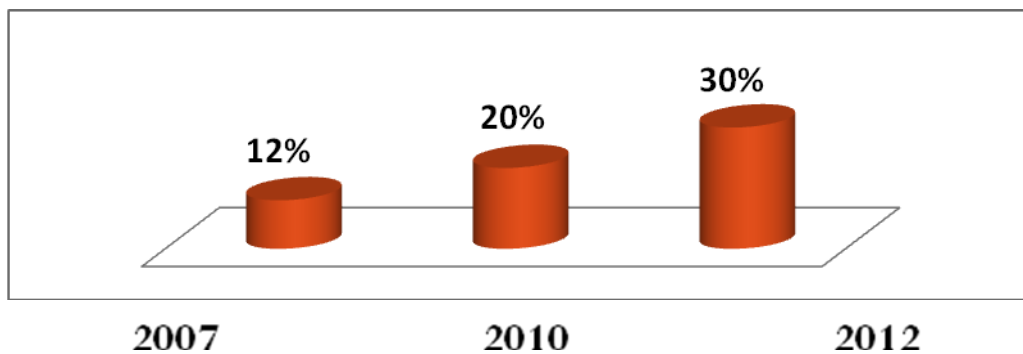
Medical practices face increasing challenges to the viability of their revenue cycle. The challenges include:

- Higher patient responsibility – More employers and self-insured patients are seeking to control rising healthcare premiums by selecting plans with higher deductibles, coinsurance, copayments and annual out-of-pocket costs for covered beneficiaries.
- Healthcare reform – While it may eventually eliminate the prospect of uninsured patients, reform will bring new challenges. Payers may seek new ways of managing patient benefits and reimbursement as national healthcare reform limits their abilities to control costs by refusing policies to certain people. Verifying insurance coverage, benefits eligibility and authorizations will become vital to receiving patient payment.
- Revenue cycle management – The entire process of billing and collections needs to be as streamlined as possible in order for practices to control overhead expenses in an era of declining reimbursements. High performing practices seek to enhance their bottom lines through revenue cycle improvements, rather than make cuts.

to chase a patient for the funds.¹ Most practices do have to pursue patients after their visit: NaviNet, Inc., found that 49 percent of medical practices were unable to estimate the amount due at the time of care, other than the copayment.² The more startling statistic is this: industry research reveals that collection rates range from 50 to 70 percent for insured patients and fall to just 5 to 10 percent for self-pay patients.”³

As the amount of collections-related work continues to grow and shift into new areas, a financially healthy practice can sink into illness very quickly.

Figure 1. Patient Responsibility as a Percent of Total Revenues



Source: 2007 & 2013: *The 'Retailish' Future of Patient Collections*, Celent, February 2009, <http://reports.celent.com/>
2010: *MGMA Practice Perspectives on Payment – 2009*, <http://www.mgma.com/patientpayments/>, Median data reported.

Don't let pressures to cut costs hurt your medical practice's performance. Automation offers a viable alternative to cost cutting. Although it often requires an initial investment, and possibly some ongoing maintenance costs, automation can provide the infrastructure that gives your business office the capacity to manage higher volumes of work without requiring costly additions of new staffing resources.

¹ *The Physician Billing Process*, Deborah Walker Keegan, Elizabeth Woodcock, and Sara Larch, Medical Group Management Association, 2009.

² "Credit Card Acceptance in Your Office" survey conducted by NaviNet, April 2009.

³ *U.S. Healthcare Payments: Remedies for an Ailing System*, Patrick Finn, Thomas Pellathy, and Shubham Singhal, McKinsey on Payments, April 2009.

The focus of the business office is the revenue cycle – a function that begins long before the business office submits a claim or prints a statement. In this white paper, we examine the revenue cycle from start to finish in order to determine the most opportune points to automate. The steps observed in high performing medical practices are identified throughout.

Verification of insurance coverage. Before the patient with an appointment even walks through the door, the revenue cycle has begun. By gathering a limited amount of information during the scheduling call – a “mini-registration,” as it’s often called – administrative staff help to establish the framework for the first technological solution: insurance eligibility determination. The opportunities for automation include:

- Using Web-based technology. With access to many payers, the staff can determine the patient’s insurance eligibility by accessing the payer’s database of beneficiaries via the Web. (See *Figure 2* for discussion of a multi-payer portal.) Insurance coverage can be checked, confirmed and rechecked at several points in the patient flow process: at scheduling or pre-registration, patient arrival (registration), time of service (on-site, either before or after the service is delivered), and billing (before submitting claims to the payer, and even after, in the event that incorrect data is discovered).
- Compiling reports. Establishing a system to obtain insurance eligibility allows staff to compile reports of patients for whom coverage is confirmed – and those for whom it is not. Practices can then assign staff to follow up with patients for whom coverage does not match their registration data. These patients can be contacted to determine if alternative coverage exists, or to commence a discussion of the practice’s policy for financial responsibility with patients who have no insurance coverage.

Figure 2.
Multi-Payer Portal Offers Added Value

With access to many payers, the practice’s staff can determine the patient’s insurance eligibility and benefits by accessing the payer’s database of beneficiaries via a Web portal. However, Web access is not in itself true automation. In fact, most medical practices must access a multitude of payer portals – each with a different log-in requirement, verification steps, and data entry and retrieval process. For the promise of obtaining up-to-date information, staff are forced to manage multiple electronic interfaces and processes for insurance verification – tasks that are likely to delay workflow.

The solution many practices find is to use software that funnels these multiple payers and their unique processes through a single multi-payer portal. Interfacing the scheduling module of the practice’s management system with the portal provides highly efficient automation opportunities.

- Ensuring timely verification of insurance coverage. Although an insurance check can be run at the time of scheduling, high performing practices check coverage two to three days in advance of the appointment. Why? Patients may have changed coverage between the scheduling call and the encounter – a span of time that can number in weeks, if not months. To ensure payment, insurance coverage must be verified for the date of service, not the date the appointment was scheduled.
- Confirming benefits. High performing practices extend verification beyond insurance coverage and seek to determine eligibility for benefits as well. This more extensive check is particularly beneficial for practices that have scheduled patients for a specific service. Administrative staff with secure, real-time access through a multi-payer portal can quickly obtain current and accurate benefits information for patients.
- Capturing advance authorizations. As with insurance verification itself, automation can simplify the process of obtaining prior authorizations, precertifications and referrals for services. For scheduled surgeries, procedures, diagnostic testing and any other services requiring advance authorization, high performing practices obtain all necessary certifications. Leaving the telephone and fax machine behind, these practices request these advanced authorizations through a multi-payer portal. Many payers accept not only the request, but also any required supporting documentation. The status of each service can be checked automatically, ensuring that no authorizations are left aside.

Pre-service financial clearance. Verification of insurance coverage for all encounters and, in many circumstances, benefits eligibility and prior authorizations, construct the framework for optimal patient collections. These confirmations also prove advantageous for patients and their relationship with the medical practice. Effective strategies to ensure financial clearance include:

- Obtaining information. High performing practices position themselves as financial advocates for their patients. By using automation in the insurance verification process, they are able to conduct a full and complete roadmap of patient financial responsibility and payer approvals. This knowledge helps assure that the post-service period does not produce unpleasant surprises that upset patients and, inevitably, erode the relationship between the patient and the provider. Patients whose coverage or benefits cannot be confirmed in advance appreciate knowing of a demographic or other error that they can correct before obtaining the service. Patients also benefit by recognizing the extent of their financial responsibility before the service is provided.
- Collecting due balances. A critical pre-service strategy is to collect due balances. Too often, medical practices relegate the pursuit of past-due balances to the normal collections process that takes place after a service has been provided. High performing practices give appointment scheduling staff access to patient account data in the practice management system. This allows practice employees to spot outstanding

balances when appointments are first scheduled. An alternate process used by many practices is to review the schedule of upcoming appointments to identify the patients with past balances. This also can identify patients who may have not yet followed through on sending the payment when requested during the scheduling call. Using a report of due balances for scheduled patients, a member of the practice staff can call these scheduled patients a few days prior to the date of service to establish payment expectations for the balance due.

- Using other pre-appointment contact opportunities. During the pre-appointment telephone calls, high performing practices also ask patients with past-due amounts if they would make a credit card payment on their account over the telephone. By explaining that this advance payment helps reduce the amount of paperwork – and time – needed on the day of service, medical practices find that many patients are willing to bring their past-due accounts up to date.

Time-of-service payments. A multitude of strategies can improve time-of-service collections which, in turn, creates a net savings of staff and other practice resources. Examples of these approaches include:

- Collecting more at the time of service. To assure full collection of the patient's financial responsibility, high performing practices rely on a multi-payer portal with an estimator for patient financial responsibility to assist with collections as patients exit the practice. Because beneficiary cost-sharing – copayments, coinsurance and deductibles – varies by plan, not just payer, attempting to maintain currency with these many variables on a manual basis is a near impossibility. Attempting to reference a spreadsheet of allowables by CPT® code for these many payers would certainly slow patient flow to a crawl. An automated patient financial estimator allows the practice to confidently and accurately collect patient financial responsibility at the time of service. If the service to be performed is pre-determined, using this automation during the registration process helps patients make informed decisions around their treatment options. The automation of financial responsibility estimates also can assist when patients refuse to or cannot pay in full for services they have received. It allows the practice to print out a statement and initiate the collection process at check-out, instead of waiting 30 days – or more – to mail a paper invoice. The Medical Group Management Association (MGMA) found that 30 percent of patients walk out the door without paying any amount at the time of service.⁴ In contrast, high-performing medical practices seek timely and accurate collections before the patient leaves.

⁴ 2010: MGMA Practice Perspectives on Payment – 2009, <http://www.mgma.com/patientpayments/>, Median data reported.

- Using remote deposit. A remote deposit service allows the practice to accept – and process – patients’ checks electronically at the time of service. Remote deposit technology speeds the entry of collected amounts into the practice’s bank account. It can save substantial labor costs by greatly reducing the need for staff to make deposit runs to the bank. In addition, remote deposit vastly reduces the costs of accepting checks drawn on accounts with insufficient funds, and provides a strong defense against internal check fraud.
- Using credit card reconciliation. The MGMA recently reported that 10 percent of a practice’s revenue stream is from high-deductible health plans (HDHPs).⁵ Many payers offering HDHPs do not yet offer an “instant” resolution process. Lacking such a process, there can be delays of days or weeks before the practice can collect funds from the patient’s HDHP for services rendered. As credit cards are swiped for payment of services at the practice, technology can automate credit card funding reconciliation, which helps reduce HDHP-related delays because the practice can authorize the payment much sooner. This technology also makes advanced payment processing – the ability to hold the card for later payment – secure. Medical practices find that this technology, available through a multi-payer portal, helps settle more accounts than the traditional monthly mailing of billing statements. The ability to “hold” credit card payments helps medical practices establish and administer payment plans more effectively. This swipe-and-hold process also provides the necessary infrastructure for practices serving patients with HDHPs. Used with the patient’s permission, this technology can greatly reduce staff time spent to administer HDHPs, which is a growing cost to most practices. Medical practices also find that offering advanced payment processing to patients whose outstanding balances are not known at the time of service helps settle accounts more effectively and completely than mailing billing statements. The ability to “hold” credit card payments also helps medical practices establish and administer payment plans more effectively.

⁵ *Ibid.*

Clean claims. It's important to keep up with coding changes. Today's complex coding system, combined with the web of payer reimbursement rules, makes it a challenge for medical practices to be paid in a timely and accurate manner. High performing practices assure clean claims before submitting them by:

- Recognizing all current payer policies. The technology of a multi-payer portal can help practices keep up with important insurer policy information by offering medical policies and clinical guidelines, formularies and precertification requirements.
- Using code editing assistance. While it is almost a "must" to have some staff trained in coding professional services, the daily volume of new charges may make it impossible to scrutinize each line item. Coding staff and providers alike can appreciate the assistance of a code editing system. Ideally, the system is integrated with the practice management system. An automated process can alert the clinician or coder of coding problems such as an inappropriate modifier or the need for one. These systems also can quickly spot when a diagnosis code is mismatched with a procedure code, a procedure code is not linked to a diagnosis code or other coding issues.
- Deploying automated "code scrubbing" technology. After charges are prepared, a second review can be applied to review data when claims are ready to be submitted. The second review of claims can spot errors and omissions that may result in a denial. Many practices rely on their claims clearinghouse to provide the service of a final "scrub" of the codes before releasing claims to payers; others employ staff with coding knowledge and certification in the business office; others use software that reviews – scrubs – claims to spot problems. Without this "scrub," the practice may not be alerted to a problem for many days, weeks or months, learning of the problem only when the claims come back denied. Thus, a mistake that could have been fixed in seconds ends up consuming a significant amount of the practice's account representative's time.
- Following up on coding efforts. High performing practices have a process that quickly re-circulates any problem claims to the provider responsible for quick correction. This re-routing can be done electronically or on paper, but the goal must be rapid correction to assure prompt submission.
- Making claims status inquiries. For employees working in a business office, verifying the receipt of the claim is often the initial step of the insurance follow-up process when a claim is denied or delayed. Automating claims status inquiries can free up valuable staff time by eliminating the hours spent on the telephone with a payer or toggling between websites over just one claim. A multi-payer portal offers extended functionality for this process by automating claims investigations – and even appeals. Denial management, thus, migrates from a purely manual process of preparing a letter, printing supporting

documents, and mailing these off to a payer. Electronic submission of appeals reduces the workload of the business office – and the time to get the payment re-adjudicated.

- Posting payments electronically. Posting payments not only consumes reams of paper, but a great deal of staff time. Posting isn't as easy as keying in a number. While keying in the payment is easy, it can only occur after the patient's account is located, the line item found, and the related transactions – adjustments, shifting of financial responsible party, etc. – are performed. Technology offers a solution in the form of electronic remittance to reduce these many time-consuming functions and the staff time required. Posting and accepting funds electronically helps increase the cash flow, which is the lifeblood of any business.

Post-service collections. Historically, practices create thousands of pieces of paper every week. While medical records are certainly a source of most of this paper, a significant portion of the volume comes in the form of patient statements. Not only does the traditional process of mailing patient statements consume reams of paper, but it also uses postage and staff time (or the expense of paying a vendor to provide that service). Solutions that high performing practices use to improve this portion of the revenue cycle include:

- Offering patients the ability to pay online. Online billing, a function offered by a multi-payer portal, allows more payment options to patients. The result is faster payments, more complete payments and fewer write-offs. Online statements reduce costs significantly and help streamline workflow. The online statement, with its accompanying messaging, can help combat the increasing collection costs due to higher patient financial responsibility.
- Allowing online payments. Another option that helps speed payments from patients is offering credit card payment through a secure online system. An automated online system allows payment data to flow quickly and accurately into the practice's ledger. It also can offer patients the ability to ask questions, as well as request appointments and prescriptions online. Because these requests come in electronic form, they can more easily be processed.
- Calling patients. Practices can't rely on statements alone – mailed or online – to effectively collect from patients. Telephone calls are an effective component of a collections strategy, but they are time-consuming and reaching patients (instead of voice mail) may take numerous attempts, which is expensive. High performing practices automate this process through a predictive dialer, which facilitates optimal use of staff resources by ensuring that operators are used for conversations, not just dialing.
- Monitoring payer contracts and loading the expected fee schedules. Searching for under- or overpayments will detect erroneous payments. The process of matching

monies received to reimbursement expected can be performed manually by random sampling or through an automated system.

- Sending accounts to collection. Sometimes the only alternative to a write-off is to send an account to a collections agency. High performing practices automate this part of the revenue cycle by sending accounts – and any payments later received – to the agency electronically.

With automation used to handle these many resource-intensive processes, business office employees can focus on collections, not pushing paper. Automation also helps administrative employees at the front office or those who manage the scheduling process to likewise focus their efforts on more productive tasks than managing paperwork. Automation can allow the administrative personnel – who often have the most face-to-face and telephone contact with patients – to devote more time and attention to tasks that support patient access, patient flow and physician productivity. Ultimately, a well-organized revenue cycle speeds the flow of cash into the practice. Automation of the various steps of the cycle cuts costs related to staffing while increasing the accuracy and volume of what they do.

About the Author

Elizabeth Woodcock, MBA, FACMPE, CPC, is a professional speaker, trainer and author specializing in medical practice management. Founder and principal of Atlanta-based Woodcock & Associates, Elizabeth has focused on medical practice operations and revenue cycle management for nearly 20 years. Combining innovation and analysis to teach practice operations, she has delivered presentations at regional and national conferences to more than 150,000 physicians and managers. In addition to her popular email newsletters, she has authored 10 best-selling practice management books, and published dozens of articles in national healthcare management journals. Elizabeth is a Fellow in the American College of Medical Practice Executives and a Certified Professional Coder. In addition to a Bachelor of Arts degree from Duke University, Elizabeth completed a Master of Business Administration in healthcare management from The Wharton School of Business of the University of Pennsylvania. Learn more about Elizabeth at www.elizabethwoodcock.com.