How Billing Can Turn Hardship into Prosperity

Poor billing management can result in the loss of financial opportunities, or even financial distress.

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Practice Management Pearls is a regular feature that focuses on practice management issues presented by successful DPMs or practice management experts who are members of the American Academy of Podiatric Practice Management. The AAPPM has a forty-plus year history of providing its member podiatrists with practice management education and resources they need to practice efficiently and profitably, through personal mentoring and sharing of knowledge. To contact AAPPM call 978-686-6185, e-mail aappmexecdir@aol.com or visit www.aappm.com

Many medical practice owners are running their billing operations in isolation from their medical activities. Many times, the practice consists of two departments that do not communicate at all; this type of disconnection usually results in the loss of financial opportunities, or even financial distress.

The minute that a podiatrist opens up a medical practice, this individual also becomes a business owner and an entrepreneur. As an entrepreneur, every aspect of the business matters; this includes the billing department, which provides relevant information allowing practice owners to make wise decisions regarding the direction of their practice. Similar to the heart that pumps blood throughout our bodies, as the blood flow is vital, so is the flow of funds crucial for the survival of your practice. Your billing department works as the "heart" and is responsible for funding your business, and for that reason, there is no medical practice without a billing department (in-house or outsourced).

To better clarify how this connection works, let's review the number of new patients. How many new patients do you see monthly? Do you have a marketing budget? Do you need one? The office visit's procedure code billed for new patients will tell you. One new patient has the potential to generate $1,200 or more within the first year. For example, initial visit CPT 99203 with an average reimbursement of $110, routine foot care (CPT 11721 and CPT 11055) every 60 days (6 visits) with an average total payment of $672, and one pair of orthotics dispensed at $400. Being conservative, this new patient just generated a revenue of $1,200.00.

Now let's calculate this potential revenue with your total new patients seen in a month. For example, if you see 10 new patients per month, it means the potential of increasing the revenue into $144,000.00 per year. Any well-planned marketing campaign can bring a lot more than 10 new patients per month, but let's be conservative here. Would you invest $3,000 in a marketing campaign that can generate a revenue of $144,000.00? ***Tip: Run monthly reports of your New Patients' procedure code billed and understand your volume.*** Is your practice growing by bringing in a high volume of new patients? Maybe your volume is low, taking you in a direction toward revising your marketing campaign, or you are turning away new patients for lack of schedule availability, and it may be time to consider bringing an associate into your practice.

It is equally important to understand your patient retention numbers. Are your patients returning to the practice? How many patients does the practice see monthly? What percentage are new patients versus established ones? If you have a low rate of patient retention, it may require a review of office policies and customer service guidelines. It is also essential that patients understand the office's collection policies for payment of co-pays, co-insurance, and deductibles, its return policy for specific devices/products, policies for a late payment or no-show, and collection agency fees, among others. If patients are well informed about billing policy, this will mitigate their frustration and lack of compliance. If patients understand how the medical office operates, they will be more likely to cooperate and keep returning. ***Tip: Review the volume of returning patients based on established patients' office visit billing procedure codes. Also, make sure your office (front desk and billing) is aware of and applies the office's written policies.***

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Regarding the revenue, how do you

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measure how good or bad it is? The billing department can provide data that allows you to measure this. For example, from the total revenue collected within a month, what is the percentage of payments received from patients compared to that from insurance carriers? The ratio of income from patient payments can vary from 5% to 40% of the total revenue. A disconnected practice usually has a low portion of patient collections. One of the reasons for this revenue loss is the failure to collecting or discuss co-pays or past due balances when scheduling or checking in patients at the time of visit, while the billing office at the same time keeps attempting to obtain the share of responsibility from returning patients. The patients thus see the inconsistency and disregard statements received in the mail.

Billing Software

The fact is that some medical offices have no access to their billing software, and the practice manager and owner have no idea of how well or poorly the system is functioning. Live access to the billing software should never be an option; it is a must. It is essential that the medical office has the last updated information when interacting with patients, reminding patients about an open balance, ensuring a required pre-authorization is retrieved to prevent future denials, and updating inactive insurance IDs. If you are not requesting the patient's fiscal responsibility while interacting with him or her, what makes you believe this patient will respond to the second or third statement? I can ensure you if your front desk is not attempting to collect payment from open balances, chances are this patient will also ignore future statements. ***Tip: Always verify patient open balances before checking-in and remind patients to come prepared for payment.***

Many physicians are in business for many years having established workflow and policies, and it is essential to remember that as the healthcare industry has been changing and significantly increasing patients' share of responsibilities, the medical practices must also change and adapt their policies to allow them to remain in business as owners and to continually prosper. *"Doing the same thing over-and-over again and expecting different results"* is what Albert Einstein called the Theory of Insanity.

Among many healthcare changes, it is essential to highlight the increased HMO plans, as it also increased the pre-authorization requirements. From the perspective of the billing department, the frequency of denial of claims related to no pre-authorization on file has been increased significantly. For that reason, it is essential to have the front desk fully understand the need for pre-authorization and its ramifications if absent, which is also a significant reason for lost revenue. In the past, insurance carriers would issue retro-authorizations, which is non-existent today. Some (very limited) insurance carriers do issue retro-authorizations

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within 24/48 hours after the medical care is rendered, but that should not be expected. If a patient's plan requires pre-authorization, and it is missing, you may not be allowed to bill the patient as per your agreement with the insurance carrier, leading to revenue loss. About 90% of HMOs require pre-authorization. ***Tip: keep track of denials for missing pre-authorization.*** Invest in staff training, increasing their understanding of the information provided within an insurance ID and the importance of eligibility/benefits verification before the physician sees the patient.

A loss of revenue cannot be blamed only on the front desk and the billing department. Doctors also have their share of responsibility. Another primary cause of insurance denial of payment is when medical visits are submitted to the insurance carriers and lack supporting coding (adequate diagnosis matching procedures). The physician's unfamiliarity with insurance guidelines, while informing patients that insurance will cover a service whose insurance terms for reimbursement the doctor is unaware of, can lead to claim denials or patient responsibility, creating patient frustration and dismissal from the practice, and loss of revenue. For that reason, doctors must become familiar with at least its top 5 insurance carriers' guidelines for the top 10 services provided. Having a cheat sheet can be very useful. ***Tip: Doctors must become familiar with the insurance guidelines as requirements and supporting diagnosis, and it will mitigate medical necessity denials.***

Have the billing department edit medical claims before releasing them to the insurance carriers by linking CPTs, ICDs, and required modifiers, ensuring coding compliance as per CCI editing (National Correct Coding Initiative) combined with insurance guidelines. The use of claim scrubber's software may help this compliance (check the compatibility with your billing software).

Become intimate with your practice by routinely retrieving and using your billing data, which enables you to make a smart and accurate business decision that will work for the success of your medical practice. If you belong to a divided medical practice, you should merge both departments in one single system, with only one goal, regardless of whether your billing is in-house or outsourced. The success of your medical practice is the ultimate goal! **PM**

Mrs. Saenger is co-founder of ParaDocsMRC.com. For the past 18 years, she has been developing and implementing strategic business plans, policies, and procedures. The past 16 years of her career have been dedicated to the podiatry industry, providing medical billing, and effectively contributing to the growth of various medical practices. Gisele is the co-founder of ParaDocs Medical Revenue Center and is a speaker and a fellow member of the American Academy of Podiatric Practice Medicine (AAPPM).