BILLING OVERHEAD AND EXPECTATIONS in a Hostile Environment

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Radiology billing has never been easy, largely due to the high volume and number of codes involved in a hospital-based practice. As a result, radiology was an early adopter of technology and filing electronic claims was routine even 25 years ago. But something interesting has been happening over the past couple of years; it promises to be the trend for the future, and frankly, it isn't good. Our business environment, which has always been challenged by doing more with less, seems to have reached an unprecedented level of hostility and the fallout is pretty serious.

Whether your organization functions with an in-house billing department or outsources to a billing company, there is a shared stress in terms of managing overhead and therefore, profitability. The goal is to maximize physician revenue, and every year the radiologists don't see a decline in revenue, we win as managers. Those physicians who have maintained income in recent years have done so largely by improving their productivity through the use of technology, and the average reads per physician have increased dramatically over the past decade. Once that happens, the focal point turns to reducing overhead, whether that means improving billing technology and reducing staff, or renegotiating billing company fees. While there is still far too much antiquated software in use and too many outdated "mom and pop" billing companies (and therefore some rich opportunities for cost reduction), there is a disturbing trend among those who have led the pack, made the upgrades, reduced costs, and now find themselves in the center of the spotlight.

Setting expectations

There are baseline costs associated with billing and the largest line item always ties to people. A common characteristic of top-performing billing offices lies in low turnover and experienced staff with the tools they need to function optimally. This includes utilizing Radiology Certified Coders (RCCs). The days of hiring inexperienced people right out of high school at minimum wage and "developing our own" is over (or should be).

Technology has improved processes and results in the following areas, although the list is not all-inclusive:

- Improved and verified charge capture (yes, we were missing charges and only the number varied).
- Improved clean claims submission, so more claims are paid on the first pass.
- Less phone time as reps can do more work online (but they still need to be on the phone too).
- Improved efficiency in filing secondary claims, appeals and follow-up submissions—so staff members no longer need to get up from their workstations to "work" a claim.
- Increased automation, with technology supporting coding, claims submission, and tracking.
- Enhanced productivity monitoring and measurement.
- Offshoring certain processes became easy and cost-effective.

Technology has greatly improved per-person productivity and reduced the number of people it takes to do the job, therefore positively impacting the cost of doing business. Sounds good so far. We have successfully done more with less and that's a good thing.

On the other hand, administrative demands are increasing with the implementation of ever-expanding regulations. Compliance programs and modality accreditation evolved from being something the market leaders offered as "value-added" to an increasingly complex, mandatory burden with ballooning documentation and management requirements. Patient privacy and information security issues are expanding at both the state and federal levels, with regulations seeming to pop up overnight like mushrooms. (Usually you find out about a new deadline soon after you missed it.) And even more exciting is the fact major healthcare regulations can crop up in totally unrelated legislation.

Not only do we feel like part of a large herd ready to spook, stampede, and kill us at any given minute, there is no apparent upside (other than "improving" imaging quality and making patients feel more secure—right). We cheerfully bear the additional cost in face of the alternative—being put out of business, fined excessively, or doing prison time.

There is a cost associated with compliance, accreditation, prior authorization, documentation, and reporting. For a while it was relatively easy to absorb because the evolution and expansion was slow and gradual. We griped but we could cover it by trimming here and consolidating there.

At the same time, we're getting paid less whether through outright fee reductions, combining codes, changing utilization calculations, or paying stepped down rates for multiple procedures. And more responsibility for payment is being shifted to the patient in the form of high-deductible insurance plans.

A disturbing trend

We were giddy for about 15 minutes with our new-found efficiencies and cost savings. Then some interesting things began to happen, especially in regard to billing companies (although in-house operations face similar cost/value challenges). Billing fees seemed to go into free-fall as a couple of companies touted their level of automation, advanced technology, and reduced costs. Radiologists, who have always been interested in a better deal, began to take the bait and the market shuddered to the core. The promise was too good to be true: You could have quality and pay almost nothing. It was a lie (or at least an exaggeration) but it was such an attractive proposition!

The market shift was clearly evident and the pressure was on for the full-service, more expensive billing companies. They could reduce fees and learn to live with scanty profit margins or watch their businesses quickly erode. Game on!

What does it mean operationally? Let's say 80 percent of claims go through and are paid by the insurance companies without any problems. That means operational overhead (largely human capital) is linked to the 20 percent requiring additional follow-up. Maximized technology can drive the 80 percent more quickly and lowers the cost of working the 20 percent—but the game then becomes one of prioritization. Do you invest human capital in the areas offering the greatest return (for example, following up on commercial insurance claims) or in the inefficient areas of workers compensation, Medicaid, motor vehicle accidents, and self-pay? It's all a matter of choices and making the numbers work—and in numerous real life cases, the results are in.

1. Private pay/self-pay is the single largest void, but the most expensive and least efficient area in which to get results. Unfortunately, a billing company cannot make the numbers work when paid on a percentage basis and the problem has only gotten worse. The alternative? Send the accounts to the collection agency more quickly and fail to find those patients who in fact are covered by insurance (until after the filing limit is missed). And the trend increases just as the number of patients with large deductibles falls into this bucket.
2. The next casualty varies by practice but the theme is common. One or more inefficient payor classes won't be worked. It might be Medicaid in one group, the VA

in another, and motor vehicle accidents in all. Reimbursement is typically lower, the process to file more complex, and it's easier to let charges set in the accounts receivable and work them when there is time. Or write them off when filing limits are exceeded.

3. Finally, secondary claims are ignored unless they are automatic crossovers. And secondary appeals also sit in the A/R forever. (While secondary balances are smaller, they are also not discounted.) Secondary insurance is also a growing class of business and in the aggregate, can represent "real money."

It's very simple, really. Pay less and get less. Physicians are noticing something is wrong, they suspect the billing company is slacking off and they want something done about it! Did they go with a lower cost option or demand a fee reduction? There's a good chance that happened.

What's even more disturbing is that a look under the hood can reveal some scary things. For example, while it has become a fairly common practice to offshore certain functional areas, it has also become evident that some companies merely maintain a shell presence in the U.S. and offshore virtually the entire core of their businesses. If you want to talk to someone on staff directly involved in the day-to-day management of your account, you could be out of luck. Does this mean a largely offshore group can't do a good job? No, but they should be honest about how they are conducting business and many are not. Instead they too often drop both the pricing and performance standards in the market, placing the high-quality, value-added firms in an untenable position.

Where does that leave us?

There is a balance between cost and value, with little room for inefficient processes and sloppy measurement. And costs (along with business risks) are increasing as regulations proliferate. At the same time, advanced technology has moved to an essential core role.

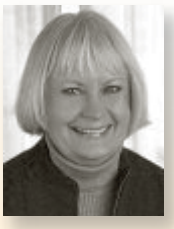
It's an issue of value, let alone value-added. Value-added, however, has a tendency to increase revenue and hopefully reduce risk. What are you looking for with value-added? A few things come to mind, but the list is not comprehensive. You should feel confident of the following at a minimum:

1. An ongoing commitment to investing in technology, process improvement, and employee skill development, which includes certifying coders in radiology.
2. Development of a solid infrastructure, with depth of experience among managers, supervisors, and staff. This is often evident in lower turnover rates and prompt resolution of problems. (There will always be problems.)
3. The ability to follow up on the less efficient payor classes—and a willingness to discuss how to improve patient pay processes.
4. A commitment to compliance, monitoring, and documentation. You should be able to ask for a copy of the compliance plan and receive it quickly—for both billing processes and the Health Insurance Portability and Accountability Act (HIPAA). Physicians should also receive periodic updates regarding regulatory activity.
5. A high level of communication that goes beyond monthly management reports. For example, each year hundreds of millions of dollars are lost due to suboptimal physician dictation patterns. There should be ongoing feedback regarding problematic codes, denials, and dictation issues—as well as changes in coding/dictation requirements.
6. You should also periodically meet other key people assigned to your account. Some of the worst billing companies have outstanding marketing departments (or verbally adept managers) supported by lousy operations and you may never know if you only see the same select people year after year.

I am convinced the most critical conversation between practice leadership and the billing company (or internal department) needs to focus on the area of private pay/self-pay. This includes payment of patient deductibles or co-pays after insurance because the obvious trend is toward higher and higher deductible plans. Chances are this is the weakest area in the operation and frankly, it needs to be totally re-examined in our entire industry. For too long the prevailing attitude was "we can't afford to follow up on that portion of our business." Technology has lowered the cost of the mainstream work and we no longer have the luxury of not working patient responsibility.

The universal problem is the cost of following up on patient accounts. There is an acceptable middle ground here that can make it work for both parties. It may involve a different fee arrangement for that portion of the business, a different staffing model, and in some cases, totally re-tooling processes. It may also involve a test phase that is subject to modification. The company (or companies) that figure out this puzzle first will be successful in the long run, but it won't happen without an honest business discussion and a willingness to work together.

The price of "cheap" can in fact be exorbitant. We are living in difficult times.



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