SELECTING A BILLING SERVICE, MORE THAN JUST PRICE

PART 2

BY PATRICIA KROKEN, FACMPE, CRA

The first article in this series discussed the importance of matching a billing service to the size and configuration of the practice, along with the importance of ensuring a qualified coding effort. While it is important to obtain a competitive rate for billing services, there are a number of other important considerations.

Technology has become a differentiating factor in performance and profitability, for both the internal billing department as well as the billing service. Just as picture archiving and communications systems (PACS), radiology information systems (RIS), and voice-activated dictation have improved radiologist productivity, there have been dramatic improvements on the practice-management system front.

What do we look for with improved technology? The following represent some of the key developments that have resulted in improved revenue for radiology practices:

- **Daily charge verification.** Radiologists have long suspected a certain number of charges are "dropped" between the hospital and the billing office. This is true. Newer systems electronically match demographic information with radiology reports, then provide an exceptions list for follow-up. Radiology volumes make this virtually impossible to do manually.
- **Extensive claims editing (scrubbing).** The ability to improve clean claims quality means more claims are paid by insurance companies on the first pass and today's claims editing software offers a sophisticated level of review, including missing/incorrect information, eligibility, and coding accuracy. Many systems use a third-party editing software and it is worth digging into this aspect of the process for detailed information.
- **Document management.** The use of document-scanning technology has reduced the cost of claims follow-up and improved productivity. In addition, optical character recognition (OCR) can post information directly into the system, again improving individual employee productivity and reducing overall staffing.
- **Real-time productivity and worklist management.** Newer systems enable managers to view daily production on a real-time basis. One of the keys to predictable cash flow lies in the consistent posting of charges on a daily basis and top performing companies monitor activity aggressively to ensure even workflow. Worklists can also be used to assign follow-up activity on insurance claims with no activity for a designated period of time or for denied claims.
- **Automated/facilitated coding.** Technology has drastically improved productivity, as well as enhancing the accuracy of radiology coders. In some cases, natural language processing (NLP) automatically codes most procedures and allows for an efficient process of verification. In others, the radiology report and demographic information are displayed side-by-side and coded directly into the billing system. Both approaches have proven invaluable at unclogging coding bottlenecks and enabling coders to focus on more complex procedures requiring decisions from a person who can weigh various contributing factors.

The key to successful radiology billing/collections lies in the ability to effectively handle large volumes of information, mainstream the processes of clean claims submis-

sion, and then focus on the "exceptions" requiring human intervention – every single day. It is critical then to spend time assessing the billing company's investment in technology, including the following:

1. **What is the current billing software and when was it originally installed?** In some cases, if the system has been continually upgraded, the system may have continued to refine its functionality. On the other hand, a platform more than 10 years old is likely to be a legacy system and may not offer the benefits of latest developments. The details of each platform's capabilities and limitations can be difficult for the non-technology manager to determine, however.
2. **What version is in use?** It is worth the homework to find out the latest version number for a particular system and then compare that to the version in use. If the vendor has worked hard to keep pace with new developments but the billing company is lagging several versions behind in updates the client is the one apt to suffer.
3. **When did the last upgrade occur?** This is almost a trick question. Most vendors will offer regularly scheduled upgrades and occasionally introduce a major new development. The latter can represent a potentially disruptive move and disruption quickly equates to decreased cash flow. If the billing company has been through a major upgrade and has since stabilized, that is a better situation that one upgrading in recent weeks and still struggling to adapt.
4. **Does the company plan a major upgrade or conversion within the next few years?** Again, just as computer conversions represent an unstable time for an in-house effort, they can also be very problematic for the billing company. It doesn't mean "no go" but if all other factors between two companies are equal, it would be better not to go through a conversion.

Technology and Management Reporting

Timely and flexible management reporting supports data-driven decision-making and moves to real-time actions, rather than the traditional "management in the rear-view mirror" limitations of retrospective reporting. In addition, the more recent addition of "dashboard reporting" allows for a snapshot of claims status at various stages within the system, again enabling more accurate cash-flow projections.

At a minimum, the following should be expected of management reports:

1. **Radiology Business Management Association (RBMA) standard definitions and formulas.** The use of RBMA criteria has allowed for improved comparison of performance to industry key indicators, moves data analysis to a standardized platform, and reduces the temptation to manipulate data with proprietary calculations.
2. **Standard management reports.** Practice leadership should have a set of standard reports to clearly illustrate activity and trends. This means the reports should summarize and format data clearly – not provide inches of line-item detail that is meaningless in terms of management decision-making. At a minimum, standard reports should include – but not be limited to – the following:
    a. Accounts receivable aging by payor (insurance companies and private-pay patients)
    b. Charges, adjustments, and collections (including trends)
    c. Reports by site (procedure volumes and dollars)
    d. Payor-mix analysis
    e. Credit balances
    f. Adjustments by payor
    g. Referring physician activity (volume and dollars)
    h. Reports by modality
    i. Write-offs/bad debt activity
    j. Detailed reports for A/R follow-up
    k. Activity by radiologist
    l. Denials
3. **Custom reporting flexibility.** The practice should also be able to request custom reports to slice and dice data based on varying criteria. This is especially important as payors implement new payment rules, market fluctuations occur, or new services are offered (or marketed).

Staffing and Experience

In many cases, the people involved in presenting the qualifications of the billing company are not involved in its operations (and probably won't be seen again after the transition phase). Therefore, it is important to verify which top management people will remain involved on an ongoing basis and to meet the practice's account manager if possible.

Most of the high-performing radiology billing companies ensure top management remains involved after the sales pitch – and many of these people are former radiology managers with operational problem-solving experience. The group should feel comfortable with the expertise of the management team, including an estimation of the more intangible chemistry of their interactions. In other words, there should be a premium placed on the authenticity and authority of responses, rather than the feeling of "telling us what we want to hear."

In addition to a strong management team, the group should seek staffing from a core group of experienced supervisors and front-line staff. The billing company may have to add new employees to take on your business but it is less desirable to hear an entirely new crew must be added. It is also fair to ask about turnover rates, since the more reputable companies are able to maintain better stability in staffing, assess employee competence/accuracy, and provide better levels of training. High levels of turnover are often indications of inadequate training and poor performance.

Operational Overview

"Production" tasks include such areas as data acquisition, charge entry, coding, claims editing/submission, and payment posting. The use of efficient technology has removed geographic barriers so it is not unusual for these functional areas to be centrally located and the group's information can easily travel across state lines– or across the country.

On the other hand, claims follow-up, including problem resolution, is more often a local phenomenon and it will be important to determine how the billing company proposes to handle this aspect of the process. Who and how many people would be assigned to staff locally? (Please note: local staffing is likely to be a variable of group size and may not be necessary for the smaller or less complex radiology practice. However, the group with multiple hospitals and/or imaging centers or a high level of payor complexity may require a local presence. This will also represent a cost variable).

Electronic-claims submission has become an industry standard, but there is often significant variance in the depth of utilization. Ideally, claims submission will be electronic unless supporting documentation must be sent on paper due to payor guidelines. (More payors are beginning to accept secondary electronic claims, including attachments). In addition, claims should be sent on a daily basis and while that seems like a given, it is not always the case.

The billing cycle and follow-up procedures for private-pay patients should also be delineated, including whether the billing company accepts a range of credit-card payment options as well as payment plans. There can be a wide variance in the level of follow-up for private-pay patients so criteria for turning an account over to the collection agency should also be discussed.

The group should also determine whether any processes are outsourced, whether nationally or overseas. Outsourcing in itself has become more common, but it is essential in these cases to ensure appropriate data-security elements are in place. For example, a HIPAA violation regarding data-security breaches will be the ultimate responsibility of the practice but may not be covered by foreign laws. This is another area where technology has advanced to a level capable of supporting strong data security, but it is not to be taken for granted.

Denials Management

Denials management should be more than a sales slogan. The billing company should be able to outline its mechanism for identifying denial trends and working with the practice to implement corrective measures. So far, most people talk about their denials-management programs but are less successful illustrating the types of reports and feedback processes used.

The group should also ask for examples of how the company worked with one or more of its radiology groups to reduce denials. This will most commonly occur in terms of coding and/or medical necessity, which not only represent compliance risks but opportunities to improve revenue by improving the quality of documentation.

Compliance

The radiology practice is held to a "know or should have known" standard in terms of the appropriateness of the billing company's policies and procedures. Therefore it is recommended the billing company function with formal compliance plans to ensure operations within regulatory guidelines for billing and HIPAA. The Health and Human Services Office of the Inspector General developed guidelines for third-party billing companies and they should serve as the baseline expectation.

In addition, details should be requested regarding employee background checks, internal audits, training, and feedback in the event a suspected compliance incident has occurred. Another critical area involves levels of virus protection in place, security measures for protected health information (PHI), use and storage of system back-up media, and existence of a formal disaster-recovery plan.

A number of top companies maintain a system of both internal and external audits and in some cases, those with very low fees were found to conduct only the most cursory background checks (validating employment but not criminal background). As identity theft becomes increasingly prevalent, background checks should be prioritized.

And Finally…Fees

Billing company fees are still, for the most part, paid on a percentage of collected revenue. This is changing in certain parts of the country and is an ongoing regulatory concern so it would not be out of the question to see an increase in per-procedure code fees. In general, fees for professional component billing will be higher than those for imaging-center global fees and in practices with both sources of revenue, a blended rate may be developed.

Fees should be a reflection of value; that is, what is offered in terms of the key points discussed in this article. While technology has decreased baseline fees on a national basis, there will still be regional and/or market variability as well as the impact of the practice profile. The following should be expected to influence the final fees:

1. Level of Medicaid and/or private-pay business. Medicaid is notoriously difficult and less efficient to work with, so a group with a large proportion of Medicaid business or private-pay patients is likely to be quoted a higher fee.
2. Modality mix. Needless to say, a high level of MRI, CT, and interventional cases represent better revenue opportunities for both the group and the billing company on a per-case basis. On the other hand, a disproportionately large volume of plain film and emergency-department cases result in lower per-case revenue – and a higher fee percentage.
3. Payor requirements. Certain payors have a national reputation for being difficult to work with and there-

fore, increasing the intensity of claims follow-up and/or denials. This is why prospective billing companies will request payor-mix information as part of the proposal process. (On the other hand, they may also have a good record working with a payor that is currently underperforming for the group and that is also good for them to know in advance).

4. Number of locations and data-acquisition challenges. It is more efficient and less costly if billing information can be received electronically rather than on paper. Multiple hospital locations (if electronic) will require multiple interfaces – and interface development may be included in baseline fees. On the other hand, the greater the number of paper sites, the higher the fees! Again, this aspect also takes into consideration whether or not sites are billed for professional components only, involve global fees, or are itemized on a statement for outside reads.

A baseline fee can also be highly variable in terms of what is – or is not – included. Even when a breakdown is requested in a request for proposal, it can be difficult to decipher inclusions and exclusions so it is best to ask. For example, does the fee include:

- Postage (and postage increases)?
- Statements and/or collection letters?
- Shipping (for example, getting billing information to the billing company's centralized processing site)?
- Credentialing for insurance plans? Hospitals?
- Insurance contracting?
- Interfaces? All of them? New sites?
- Custom reporting?
- Credit-card fees?
- Coding?

If the baseline fee seems too low (compared to the competing companies), it should be questioned. In some cases, the "extras" when itemized can exceed a rate that at first appears too high – and value in terms of compliance plans, training, coding, and/or denials feedback and audits may not be taken into consideration. It is in the best interest of the practice for the billing company to be comprehensive in service levels and staff quality as well as profitable. Ideally, this is a one-time decision for the practice with an emphasis on value, experience, and a solid operational infrastructure rather than a compelling but empty sales pitch.

Final Comments

The environment for radiology will continue to be challenging for all parties involved and not all billing companies will survive. The days of the "mom-and-pop" company are over (although a number of them are still in business) and mediocre performance levels are costly. The final recommendation is to take time to do the homework, get all questions answered, develop a relationship with the company that feels like it will be a good business partner, and then check references – and not just the ones on the recommended list.

All radiology practices and billing companies will face challenges from time to time. The successful companies will have a pattern of prompt and effective problem resolution, strong levels of communication, and high management response levels. In the end, the emphasis needs to be on value – not just on price.

PATRICIA KROKEN, FACMPE, CRA, is a principal in Healthcare Resource Providers, a radiology business consulting firm. She is a regular contributor to industry publications and a frequent speaker on topics related to radiology practice management and HIPAA. *Patricia may be reached at Healthcare Resource Providers, LLC, PO Box 90190, Albuquerque, NM 87199; 505.856.6128; 505.797.1205 Fax; pkroken@comcast.net.*