

Welcome to the Step by Step: Initiating and/or Enhancing Billable Services Module 2: The Medical Billing Process.

# RR Health Strategies

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# Learning Objectives

- To describe medical billing & revenue cycle management fundamentals
- To examine operational workflow
- To explore staffing your billing office

# Medical Billing and Revenue Cycle Fundamentals

## Definitions

- **Medical Billing** is “the process of submitting and following up on claims with health insurance and other companies in order to receive payment for services rendered by a healthcare provider. Medical billing translates a healthcare service into a billing claim. The responsibility of the medical biller in a healthcare facility is to follow the claim to ensure that the practice receives [reimbursement](#) for the work the providers perform.” (AAPC)
- **Revenue Cycle Management** is “all administrative and clinical functions that contribute to the capture, management and collection of patient service revenue.” (HFMA)



- Efficient medical billing processes optimize returns and shorten the revenue cycle process.



- Revenue Cycle Management is more than the billing of claims. The process begins at patient registration and the accurate collection of patient data

## Start of a Claim

- **Patient Registration:** Pre-registration and accurate information are key initial requirements in optimizing the healthcare revenue cycle management process. During this step, employees create a patient account that details demographics and insurance coverages by phone, patient portal, or registration forms mailed to the practice/clinic
- **Insurance Eligibility:** To help ensure a practice/clinic's revenue cycle success, it is recommended to verify patient's insurance eligibility each time an appointment is made
- **Patient Appointment:** Appropriate documentation and effective charge capture procedures allow for faster payment of services



- Having specific policies and procedures for patient registration, insurance and benefit verification, charge capture, and claims processing is an essential step to maintaining practice viability.
- Investigate and incorporate automated and software-aided insurance eligibility verification into current practice/clinic work flows.
- The tracking of patient visits is essential for charge reconciliation (e.g., no shows)

## Claim Submission

- **Charge Entry:** If the charge entry process is not completed in an accurate, timely manner, reimbursement may be impacted. With electronic billing, some practice management (PM) software may have a front-end edit capability that will confirm required data elements and validate coding edits
- **Coding:** The practice/clinic must determine who will be responsible for coding/verifying the assignment of Current Procedural Terminology (CPT)-4 procedure codes, Internal Classification of Diseases (ICD)-10 diagnosis codes and modifiers
- **Claim Submission:** In contrast to paper claims, clearinghouses are frequently utilized to electronically transmit claims to third-party payers. Reports are generated to alert the practice/clinic if the claims were rejected by the payers



- The charge entry process is where claims are actually created.
- Appropriate coding will assist in proper reimbursement.
- Coding is also critical for demographic assessments and studies of disease prevalence, treatment outcomes and accountability-based reimbursement systems (e.g., HEIDIS, MACRA)
- Electronic claims submission vs. manual claims submission
  - Reduce the amount of time and resources physician practices devote to manual administrative functions—time that can be better spent with patients or focused on other practice efficiencies
  - Pre-audit claim fields automatically for potential errors prior to submission.



# Claims Management

- **Payment Posting:** Whenever possible, electronic remittance should be set-up with payers, as opposed to manual payment posting. The electronic remittance process allows staff members to review and work from an “exception report.” Including payer contract details and fee schedules into the software, will allow for more accurate payment posting
- **Denial Management:** Best practices recommendations include tracking and trending denials at the time of payment posting. Denials should be tracked by payer, denial type, and provider
- **Appeals:** Appealing a denied claim does not guarantee that it will be overturned. However, failing to follow the formal process and associated submission timeline, will guarantee non-payment

## Accounts Receivable (A/R) Management

- **A/R Follow-up:** Most insurance carriers are required to pay or deny the claim within 30 days of receipt. Claim follow-up should begin as quickly as 7-10 days following claim submission
- **Patient Collections:** The practice/clinic should establish a policy and associated timeframe for transfer of responsible party from insurance to patient (e.g., 30 or 45 days after the claim is initially submitted). For all patient collection accounts, a timeframe in which the account will be reviewed internally before the account is written off and/or transferred to an external collection agency should also be established
- **Patient Statements:** Due to the large volume of carriers with higher deductibles, coinsurance, and copays, and services considered non-covered, more and more patients have outstanding balances with the practice/clinic. Patient statements should be issued on a regular basis to better manage the patient balances

# Analytics

**Reporting:** Generate claim submission and payment data in real-time to allow for better monitoring and control. The report data should include the provider name, CPT code, payer, facility, and referral information.

**Key Performance Indicator (KPI) Reports:**

- Accounts Receivable Aging by Carrier or Patient
- CPT/Volume Billed and Paid by Carrier
- Collections by Carrier
- Collections by CPT Code
- Patient Volume by Month
- System Financial Summary



- Physicians and practice administrators need to be astute in comparing and analyzing data and should ask for assistance from experienced professionals if there is difficulty in interpreting any practice/clinic financial reports
- Reports aid in determining areas that need the most focus, especially regarding revenue, productivity and efficiency
- Establish a broad spectrum of KPIs for long-term success (e.g., gross collection percentage – total charges/total collections informs a practice of what it collects relative to each dollar charged)

# Sample Year to Date (YTD) Productivity Report

Your Facility Name

% of your revenue comes from procedures

Report on Date: 7/24/2017

CPT	Sum of Payment	%
10021	\$ 379.95	0.02%
10060	\$ 2,342.79	0.14%
10061	\$ 773.76	0.05%
10120	\$ 4,401.31	0.27%
10140	\$ 250.70	0.02%
11000	\$ 220.80	0.01%
11730	\$ 74.58	0.00%
11740	\$ 141.82	0.01%
11760	\$ 177.84	0.01%
12001	\$ 30,720.55	1.89%
12002	\$ 17,419.64	1.07%
12004	\$ 1,954.40	0.12%
12005	\$ 982.53	0.06%



- Productivity reports can expose opportunities for facilitating dialogue among the stakeholders in the practice, serve as a catalyst for changes in the operation such as maximizing revenue through changes in the fee schedule or hours of operation

# Sample Year to Date (YTD) A/R Totals Report

ACCOUNTS RECEIVABLE AGING  
Wednesday November 8, 2017

Date Filter(s):  
Active patient index in use

Search for bills in range : 01/01/2017 -> 06/30/2017  
Search for bills older than: 0 days

## Totals

Column	Total	Current	Over 30	Over 60	Over 90
Billed	2768131.28	0.00	0.00	0.00	2768131.28
Outstanding	1668320.26	0.00	0.00	0.00	1668320.26
Patient Owes	61989.37	0.00	0.00	0.00	61989.37
Payer Owes	1606330.89	0.00	0.00	0.00	1606330.89
Unbilled					
Patient Owes	220535.41				
Payer Owes	106222.56				
Combined					
Outstanding	2075078.23				
Patient Owes	202524.70				
Payer Owes	1792553.45				



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- Each A/R report may be formatted differently
- The 0-30 day bucket for both patient and insurance should be the highest totals. This category represents the most recent claims submitted.
  - The next highest will be the 31-60 day totals. Typically most of the claims due will fall in the 0-60 day period.
  - The monies in the 61-90 day bucket should drop off dramatically, especially with insurance balances.
  - The 91-120 day bucket amount should drop as claims are worked, patients are billed, carrier follow-up is performed and collection efforts are made.
  - Generating this report monthly, will demonstrate your progress in each area.

# Sample System Financial Summary Report

Your Facility Name

System Financial Summary 2016 and 2017 Report on Date: 7/24/2017

Months	Patient #	DOS #	Procedure #	Charge \$	Ins Receipt \$	Guar Receipt \$	Adjustments \$	Total Payments \$	Balance \$	Avg Charge Per Visit \$	Avg Payment Per Visit \$
Jan-16	269	288	310	\$ 241,992	\$ 30,690	\$ 7,620	\$ 154,323	\$ 38,309	\$ 49,360	\$ 840	\$ 133
Feb-16	157	171	207	\$ 153,554	\$ 20,203	\$ 4,485	\$ 105,538	\$ 24,688	\$ 23,328	\$ 898	\$ 144
Mar-16	194	221	271	\$ 211,042	\$ 32,140	\$ 6,445	\$ 119,023	\$ 38,585	\$ 53,435	\$ 955	\$ 175
Apr-16	347	367	416	\$ 321,249	\$ 52,098	\$ 6,356	\$ 204,981	\$ 58,454	\$ 57,815	\$ 875	\$ 159



PRIMARY CARE  
DEVELOPMENT  
CORPORATION

- The Financial summary provides high level data of the total charges, adjustment and payment for a specified period of time.
- Provides a quick overview of the practice/clinic's financial status.

# Operational Workflow

# Operational Workflow

Workflow and productivity are essential for any practice/clinic's success.

A well developed and streamlined workflow will improve employee productivity.

The **Billing Workflow** is one portion of a practice/clinic's overall operational workflow whose effectiveness must stand alone and also work collaboratively and seamlessly with the other Departmental workflows (e.g., front desk, outpatient blood draws, patient check out, etc.).



- A better defined regular process will allow for a more efficient team.
- To streamline work processes and improve workflow, assess **all** workflows, looking for opportunities for improvement in each area.



# Medical Billing Workflow



- There are many steps involved in the medical billing process.
- Each step is an integral part of the process and must be performed properly in order for the entire cycle to run smoothly.

## Front Desk Operational Workflow

Front Desk operations will have a direct impact on the overall success of your practice/clinic's medical billing. Policies and procedures and well-trained staff in the following key areas are imperative:

- Appointment scheduling
- Patient Demographic Entry
- Insurance Verification
- Point of service Patient Collections



- Front desk is a key and pivotal role in the success of the practice/clinic.
- Set goals. For example, patients are to be treated the way you like to be treated; always interact with a person.
- Set a goal for patient communication to occur within the first sixty (60) seconds of a phone call or in-person interaction at the front desk.

## Front Desk Operational Workflow

The front desk is the first line of communication that a patient has with a practice, and sets the tone for the patient encounter. These important staff members are responsible for:

- Incoming telephone calls, including appointment scheduling and other patient related concerns
- Performing the initial “pre-registration” including, patient demographics, reason for visit, and insurance verification
- Greeting patients and obtaining all pertinent information for demographic data entry
- Outgoing telephone calls including appointment confirmation and missed appointment phone calls and documentation
- Collecting payments from patients (copay, coinsurance, deductible, past due balances)
- Communicating with the clinical staff when patients arrive



- Testing your phone system as a user. This is the easiest way to better understand the patient experience.
- Assess the equipment and its functionality.
- Front office staff must be trained and be able to operate each piece of equipment efficiently (e.g., credit card machine, fax, copier, ID scanners, label printers and multi-line phone systems)

## Patient Accounts Receivable

Over the past several years, the insurance industry has shifted additional financial responsibility to the patient in the form of:

- High deductibles (in and out of network)
- Higher copays
- Copay plus coinsurance
- Catastrophic coverage only plans
- High copays and co-insurance levels
- Non-covered services which were previously covered
- Plan limitations on certain covered services

***The front desk and billing staff must be educated and trained on a regular basis. They must also be provided the appropriate tools and policies and procedures to best handle patient collections.***



- A/R backlog and balances have increased dramatically due to the rise in patient financial responsibility for medical care.
- Many patients are unfamiliar with how their health insurance works or recent changes in their coverage,
- Prioritize insurance verification.

# Staffing Your Billing Office

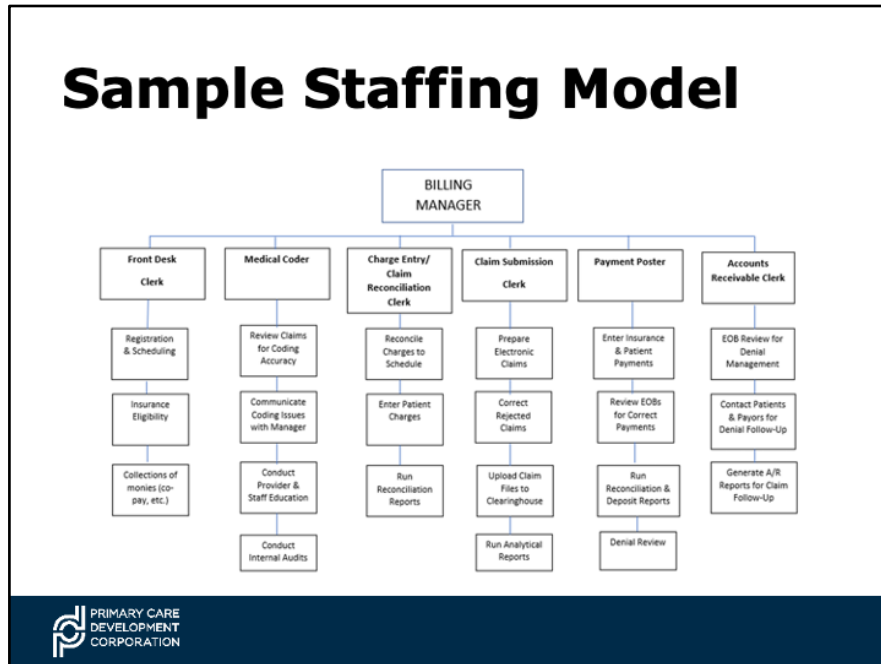
## Staffing Model

- The appropriate staffing model for a Billing Department is determined by the number of Full Time Equivalent (FTE) billing Providers (MD, NPP, etc.)
- Medical Group Management Association (MGMA) provides national staffing data to help determine the appropriate staffing model based on specialty
- MGMA's 2015 Executive Summary Report (based on 2014 data), indicates approximately **2.7 FTE** support staff as the average staffing required per Provider (*includes front office **and** business operations support staff for Multi-specialty with Primary and Specialty Care Practices*)



-The best performing practices/clinics tend to have more staff available to assist with the various tasks.

# Sample Staffing Model



- Staffing models are not one size fits all.
- Resources will dictate the staffing model.
- Staffing levels will vary based on various factors - size of practice, specialty and services provided.

## Key Billing Staff Roles

- Billing Manager
- Medical Coder
- Charge Entry/Claim Reconciliation Clerk
- Claim Submission Clerk
- Payment Poster
- Accounts Receivable Clerk

*It is important to note that although the Front Desk Clerk may not be considered part of the Billing Office's Table of Organization, this role plays a key part in the overall Billing Workflow.*



- A billing staff is the intermediary of the operations and accounting departments of a practice/clinic.



## Billing Manager

This position will have overall responsibility of ensuring the financial health of the practice/clinic.

Key Responsibilities include:

- Maintain an extensive knowledge of the PM and EMR system
- Ability to design, implement and enforce billing policies and procedures, as well as streamline effective billing processes
- Create detailed job descriptions for all billing positions
- Create easy to use grids of managed care billing requirements for front desk and other team members
- Analyze key billing and financial reports
- Motivate, train, coach and provide clear guidance to team members to perform their billing tasks properly and efficiently
- Set goals and objectives for the team members
- Conduct staff meetings where identified issues and concerns are discussed and reviewed
- Ensure staff is trained on all Compliance Programs, including HIPAA
- Provide cross-training for staff members



- Understanding the medical billing process requires specific knowledge coding and collection processes.
- The billing manager must understand the entire accounts receivable process, as well as personnel management.

# Billing Manager

## Skills Required:

Extensive knowledge and skills in many areas of healthcare is required for the success of this position, including:

- Understanding of all aspects of medical insurance billing
- CPT/ICD-10 coding knowledge
- Working knowledge of insurance carrier regulations
- EMR/PM system knowledge
- Excellent communication skills
- Multi-tasking ability
- Detail-oriented
- Analytical abilities and problem solving skills
- Reporting proficiency



- The billing manager will not likely be involved in transcribing and coding patient services. However, he/she must have a strong understanding of the service being rendered by the practice/clinic and the associated codes.
- Some smaller practices/clinics may have only one medical billing representative to manage all accounts receivable.

# Medical Coder

## Key Responsibilities include:

- Review the provider coding for accuracy and compliance with insurance and regulatory guidelines
- Communicate with providers and administration regarding coding issues identified
- Collaborate with the billing department to ensure all bills are submitted in a timely manner
- Assist with insurance denials as it relates to coding issues
- Conduct internal audits and coding reviews to ensure all documentation is accurate and meets with CPT and carrier guidelines
- Maintain knowledge of the coding industry and associated changes
- Conduct provider and staff education
- Provide statistical data for analysis and research by other departments



- Practices/clinics should must submit accurate coding in order to receive proper reimbursement.
- Provider education and training can reinforce accurate coding of services.
- The practice/clinic should always have internal/external coding reviews to validate documentation and coding.

# Medical Coder

## Skills Required:

- Professional Certification (CPC)
- Excellent written and oral communication skills
- Ability to conduct educational and training sessions
- Exhibit strong knowledge of medical terminology, CPT and ICD-10
- Technical and computer skills
- Strong analytical skills
- Detail oriented
- Ability to work in a team environment



- Although not identical, medical billing clerk and medical coder positions are often combined due to the similarity and required expertise for these roles.

## Charge Entry/Claim Reconciliation Clerk

### Key Responsibilities include:

- Retrieve charge documentation from providers
- Reconcile charge documents to appointment schedules
- Follow-up on outstanding charges by Providers
- Accurately enter CPT and ICD-10 codes in PM software
- Reconcile all electronic charges to the appointment schedule to ensure all charts have been closed and billed
- Run reconciliation reports following charge entry to ensure all charges have been captured
- Work closely with Billing Manager



- The process requires attention to detail and accuracy of data entry.
- When charges are entered, the insurance and patient demographic information should have been entered accurately in the billing system.

## **Charge Entry/Claim Reconciliation Clerk**

### Skills Required:

- Understanding of medical billing guidelines and regulations
- Strong data entry skills
- Technical and computer skills
- Knowledge of CPT/ICD-10 coding
- Insurance knowledge
- Attention to detail
- Ability to work in a team environment



- Instituting an effective reconciliation process is important process that should not be overlooked.
- Missing charges (e.g., appointments that do not have charges posted, lost encounters, unclosed chart notes in EMR) has a large impact on the practice/clinic's overall financial performance.

# Claim Submission Clerk

## Key Responsibilities include:

- Responsible for creating electronic claim files in PM system to prepare for submission
- Review and correct any claim errors that the PM scrubber reports
- Upload the electronic claims file (837 file) to the clearinghouse
- Review and correct any claim errors identified in Clearinghouse reports
- Review all reports generated by the payers (277 file). Review and correct claims
- Generate analytic reports to review:
  - Claim denial types
  - Payer denial types
  - Rejection patterns
- Work closely with the Billing Manager to identify trends



- The Claim Submission Clerk works closely with commercial and government payers to ensure the practice/clinic receives the maximum reimbursement.
- Claims must be submitted accurately and timely.

# Claim Submission Clerk

## Skills Required:

- High level understanding of medical billing and the claim cycle
- Extensive knowledge of clearinghouse functions and reporting
- Technical and computer skills
- Knowledge of CPT/ICD-10 coding
- Attention to detail
- Excellent analytical skills
- Highly organized
- Ability to work in a team environment



- When billing problems arise, the Claim Submission Specialist will assist with rejections, appeals and corrections.



# Payment Posting Clerk

## Key Responsibilities include:

- Data entry of insurance and patient payments in PM system, including point of service collections (copay, coinsurance, deductible, outstanding balances)
- Review insurance Explanation of Benefits (EOBs) and post payments in PM system
- Ensure allowances, adjustments and write-offs are posted correctly
- Prepare documentation and recommendations for refunds
- Perform check payment reconciliations and complete deposit reports
- Post denials
- Investigate unidentified cash and resolve misdirected payments
- Generate reports



- The payment posting process affects many other functions of the medical office and can have a major impact on patient satisfaction, efficiency, and overall financial performance.

# Payment Posting Clerk

## Skills Required:

- Knowledge of medical billing and coding guidelines
- Excellent knowledge of insurance reimbursement guidelines
- Ability to analyze insurance reimbursement trends and report concerns to Management
- Generate payment reconciliation reports and receipts for reporting and banking purposes
- Technical and computer skills
- Highly organized



- A Payment Posting Clerk must be able to spot trends and issues hidden in the payment amounts and EOB comments.

## **Accounts Receivable (A/R) Clerk**

### Key Responsibilities include:

- Review insurance carrier EOBs, identify denials, and work claims accordingly
- Perform extensive account follow-up activities utilizing the PM system to investigate, analyze and resolve problematic and delinquent accounts with insurance carriers
- Review accounts receivable reports and notify management of potential issues and denial trends
- Receive and make calls to relevant parties, such as insurance company representative and patients
- Establish and maintain effective working relationships with carrier representatives
- Utilize relative resources and websites to retrieve pertinent information related to accounts receivable
- Generate A/R reports in PM system to allow for appropriate claim follow-up



- This position requires attention to detail, organization and the ability to work independently in determining the hierarchy of A/R account follow-up.

## **Accounts Receivable (A/R) Clerk**

### Skills Required:

- Excellent customer service skills
- Knowledge of payer websites
- Extensive knowledge of individual insurance carriers reimbursement guidelines
- Knowledge of CPT and ICD-10 coding
- Understanding of insurance benefit and eligibility guidelines
- Proficient in submitting written and online appeals to payers
- Excellent organizational skills
- Excellent communication skills
- Technical and computer skills
- Ability to work in a team environment



- The A/R Clerk has frequent verbal and face-to-face interactions with patients and insurance carrier representatives.
- Must have strong customer service skills.

## Staffing in a Smaller Office

- If the Practice/Clinic Manager is not personally performing the billing operations, he/she should be monitoring the KPI reports.
- The KPI reports generally include:
  - Productivity
  - Charges/Receipts/Adjustment Detail
  - Denials
  - Clearinghouse edits
- Practice Management and EMR systems should be utilized to their fullest extent and all office processes should be automated, wherever possible
- Ensure the proper staff is hired and adequately trained



- The quality of the staff is more important than the quantity of staff members available.
- A solo physician practice seeing an average of 30 patients per day (without any ancillary services), may have as few as three (3) staff members (e.g., manager, front desk, and MA) and maintain an effective and efficient work flow.

# Outsourcing Medical Billing

Many practices/clinics choose to outsource their billing to a professional medical billing company.

PROS	CONS
Reduction in billing errors	Patient satisfaction – dedicated staff to handle billing concerns
Reduction in practice expenses for staffing, benefits, etc.	No direct supervision of staff
Ensure billing compliance	Lack of control of the billing processes and procedures
Additional time to focus on patient care	HIPAA Privacy and Security concerns
Current knowledge of specialty specific billing and coding guidelines	Lack of communication regarding denial trends and other revenue impacting concerns
Detailed financial reporting on a scheduled basis	Hidden Fees and Variable costs



- A good outsourced medical billing service will provide feedback regarding:
  - Ways to increase productivity and profitability
  - Monitoring performance standards of staff, both in the office and the outsourced staff
- Ensure the outsourced billing service is performing all the duties as outlined in their contract.

# Case Study

## Watauga Medical Center

**Challenge:** The Watauga Medical Center in Boone, N.C. was facing an uphill battle in late 2007. With annual operating losses approaching \$3.5 million, the community hospital had only 50 days of cash on hand and accounts receivable were languishing at 77 days. Watauga executives knew their revenue cycle was the cause of their financial difficulties; however they weren't exactly sure how to correct it.

**Solution:** The center augmented their patient access process by implementing stringent preregistration processes, verifying insurances prior to appointments and proactively discussing with patients, what associated out of pocket costs would be along with payment options.

**Result:** Today, Watauga is a healthy institution, posting a \$5.5 million operating profit in 2009. Days of cash on hand have increased three-fold to 150. Days in accounts receivable have been cut nearly in half. As a result, Watauga's operating margin increased from -3.5 percent in 2008 to 5.4 percent in 2009.



Reference: Case Studies. (n.d.). Retrieved from <http://www.revenuecyclesolutions.com/communications/case-studies/>



## Session Highlights

- Medical Billing: Maximize collection and reduce time to payments with effective workflows and skilled staff.
- Revenue Cycle Management Processes
- Staff Models: Design cohesive front and back office billing functions
- Job descriptions and skill sets for efficient billing operations
- Determining the health of your Revenue Cycle through billing reports

## Session 2 Mini-Assignments

- Review your office policies and procedures. Create a list of deficient front desk and billing operational policies
- Compare your current front desk and billing department job descriptions to those outlined in the presentation. Create a list of missing job descriptions
- Review the required skills for the job descriptions and evaluate the skills to your current staff members
- Assess the training programs available to your staff for certification (e.g.; billing, coding, etc.) and ongoing continuing education
- Create an outline of a billing staffing model for your practice/clinic
- Review A/R and productivity reports for 2016 and 2017. Identify any significant trends