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Picking the right process: Deciding the best way to submit claims

Getting a claim paid can be a maddening experience. Making it smoother takes the right technology, but also requires monitoring how your practice works with its claims processor and health plans.

By John McCormack, *amednews* correspondent. Feb. 18, 2008.

Jim Burgon, billing manager at Utah Valley Radiology, acknowledges that processing medical claims electronically is somewhat of a dream come true, but it's no nirvana -- at least, not yet.

"Electronic processing makes a world of difference. I can't imagine doing all of this by paper," says Burgon. Then he points out that his 30-physician, Orem, Utah-based practice has had to tweak its electronic claims processing a few times since submitting its first electronic bill seven years ago.

Certainly, the issue of whether to process claims electronically or by paper favors the former. A study by America's Health Insurance Plans, a trade association in Washington, D.C., shows that 75% of claims were submitted electronically in 2006, up from just 24% in 1995. Overall, about 85% of all physician practices process claims electronically, according to estimates from industry experts.

Both health plans and physicians like the relative ease and lower expense of electronic claims. The Centers for Medicare & Medicaid Services reports that the health care industry saved more than \$25 million as physicians and hospitals submitted only 80 million paper claims in 2006, compared with 114 million in 2005.

With electronic claims processing now the norm, the goal for Utah Valley and other practices across the country is no longer merely the adoption of electronic methods but the optimization of such efforts.

The need for better -- not just more -- electronic claims processing is becoming a hot-button issue. Faced with dwindling reimbursements, medical groups no longer can muddle along with less-than-optimal claims processing solutions.

"The bottom line is that physicians need to do what they can to reduce the cost of collection," says Frank Marshall, COO of MedSynergies Inc., an Irving, Texas-based revenue cycle management consulting company.

Certainly, there is room for improvement as the cost of collection in health care approaches 20% of what is actually collected, while the cost of collection in other industries is typically less than 1%, according to research from MedSynergies.

While not all of that cost difference is due to claims processing -- the difficulty of collecting from plans and patients, and arguments back and forth with plans over coverage play a very big part -- a better system can cut administrative costs.

Getting the right claims processing system is more than just picking the right practice management system. It's also about overcoming the various curveballs thrown their way -- such as complying with emerging standards, or health plans that have systems that don't jibe with yours.

Doctors can examine their electronic practices and find ways to make a good thing even better.

Frustrations be gone

Topping the list of current electronic claims processing frustrations is the fact that physicians have been struggling to keep up with a deluge of rules and regulations that have trickled down because of HIPAA, experts say. In recent years, CMS has instituted a number of HIPAA standards, including electronic health care transactions and code sets, privacy, security and the national employer identifier.

Although the intent of HIPAA administrative simplification is to improve electronic health care transactions, physicians often stumble with the initial implementation of such standards.

Most recently, physician practices have been struggling to comply with the National Provider Identifier standard. Implementation of the NPI will eliminate the need for physicians to use different identification numbers to identify themselves when conducting transactions with multiple health plans. Many Medicare, Medicaid and private health insurance companies, and all health care clearinghouses, were expected to accept and use NPIs in standard transactions by May 24, 2007. Small health plans have until this May 23. After those compliance dates, health care providers may use only their NPIs to identify themselves in standard transactions.

But physicians are struggling to get the NPI in place. CMS has indicated that a significant percentage of Medicare claims it receives still does not include the NPI, according to the Medical Group Management Assn. Starting March 1, CMS will start to reject claims that do not include the NPI in the primary provider fields.

While the intent of such standardization is to increase electronic claims processing efficiency, medical billing professionals find that compliance with requirements is troublesome.

"HIPAA was supposed to make things easier. But at least in the short run, it has made things more difficult," says Sharon Hollander, president of STAT Medical Consulting, a medical billing services company based in Los Angeles.

While complying with standardization puts a kink in physicians' electronic processing efforts, medical practices are experiencing other frustrations as well. The fact that electronic claims processing does not necessarily eliminate paper is one sticking point.

"Electronic claims actually generate a lot of paper," Hollander says. "Payers will send you a paper claims acknowledgement that says they have accepted your claim -- and then your claim is paid with a paper check. Or they might ask [that] you send all kinds of supporting paper documentation."

But the problem should dissipate as most payers are expected to migrate toward electronic remittance advice and funds transfers by the end of the year, says Patrick Kennedy, president of PJ Consulting, Rockville, Md.

Taking control

Although a certain amount of frustration is inherent in the electronic claims processing milieu, in many instances physicians can take matters into their own hands.

Here are just some of the ways experts recommend that medical practices move toward more effective electronic claims processing:

Choose the right claims processor. Typically, physicians send their claims to clearinghouses that, in turn, process the claims through a multitude of payers. The problem is that the market is flooded with clearinghouses -- and sometimes it's difficult to separate the good from the bad.

"A few years ago, there was a rash of quite a few claims clearinghouses that just couldn't keep up with the technology," Marshall says. As a result, these clearinghouses either went out of business or didn't provide optimal service to their providers.

"That's a big issue for [physicians]. When you have a claims filing deadline of 45 days and you send your claims to a clearinghouse and they can't handle them, you might never see that money again," Marshall says.

Indeed, as Radiology Associates began to process more claims electronically a few years ago, billing manager Burgon discovered that his claims clearinghouse just was not up to the task.

"We were sending over 500 claims at a time, and they just could not handle our volume," Burgon says. As a result, he investigated the clearinghouse market and switched to an Internet-based claims clearinghouse that offers the capability to handle large volumes -- and also provides better reporting services.

Don't settle for just any practice management system. Physicians need to make sure that their practice management systems have the right functionality to process claims efficiently, experts say.

When practice management system vendors can't keep up with emerging standards, for example, medical groups lose money. Hollander says her billing company recently started working with a large physician practice because the group's practice management system could not handle the new standards -- and therefore could not submit claims to its clearinghouse.

"They had all this money that was due to them, but they could not bill for it," Hollander says.

Medical groups also should request that their software vendors offer editing or claims-scrubbing features. These tools proactively edit the claims and check for missing, incomplete or wrong information before the claims are submitted in an effort to cut down on denials.

"As a doctor, you have to go to your vendor and tell them that you want a claim-editing function," Kennedy says. "Sure, you might have to pay money for it -- but it is worth it."

Azadeh Farahmand, CEO of GHN-Online, a Dallas-based revenue cycle management consultant, adds that doctors should consider the bigger picture when evaluating their practice management software.

"A lot of practices continue to use old practice management technology because it is cheap," she says. "That's a mistake, because with some of these systems, you could be losing money."

It's not just about what you have but how you use it. Although it's important to select and use the right processor and technologies, physicians need to concentrate on establishing effective processes as well.

"You could have great technology, but if you don't have an operational process that supports the technology, then you are not going to get anywhere," says Charles Garrity, regional manager with Beacon Partners, a Weymouth, Mass.-based health care consulting company.

For example, medical practices need to make sure that they have a front-end process in place that enables them to collect all of the information needed to produce a clean claim.

Cry uncle. Dan Bruhl, MD, contends that claims processing has become increasingly complicated -- and physician practices shouldn't try to handle all of the billing functions in-house.

"I have been in practice since the 1970s, and in that time the complexity of the billing process has steadily increased. And it is reasonable to assume the complexity and challenges will continue to increase in the future," Dr. Bruhl says. As such, he recommends that practices -- especially smaller ones -- consider outsourcing billing functions.

"The sophistication of processes, workflow and technology that a third-party provider can offer can really help a practice improve its billing functions," he says. His practice, Ophthalmology Associates, an 11-physician group in Fort Worth, Texas, has experienced significant reduction in accounts-receivable days by using a billing management company.

Push for real-time adjudication. Although electronic claims processing has made it possible in theory for physicians to receive payments in a more timely fashion, real-time adjudication, where physicians receive electronic remittance advice at the time of service, could improve the process even more.

With real-time adjudication in place, physicians will know what portion of a patient's bill will be paid by the payer at the time of service. Medical groups then can collect the patient portion at the point of care.

Some payers are offering real-time adjudication, though it has been limited. As patients take responsibility for a greater share of their health care costs, physicians should push more payers to offer real-time adjudication.

"Real-time processing has been used in other industries -- such as financial services -- for years. We need to move toward that goal in health care," Farahmand says.

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ADDITIONAL INFORMATION:

Guidelines for claims processing

The AMA has resources aimed at helping physicians with claims processing problems. Among the items available for members and nonmembers:

Prepare that claim: Taking an active approach to the management revenue cycle A guide that covers preparation, submission and collection of a claim. Topics covered include checking patients' insurance coverage, billing and codes procedures, and collections strategies (www.ama-assn.org/ama1/pub/upload/mm/368/prepare-that-claim.pdf).

Appeal that claim: Taking an active approach to the claims management process A guide that covers claims auditing and review, and how to prepare an appeal on a denied or downcoded claim (www.ama-assn.org/ama1/pub/upload/mm/368/appeal-that-claim.pdf).

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