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Seven-step plan aims to increase payments from insurers

Hospitalist groups: Take these steps maximize revenue

Is your hospitalist group looking for new sources of revenue? You might want to start by looking at an old source -- payment for the work you are already doing.

Many hospitalist groups are not maximizing their revenue potential, according to consultant **Martin Buser**, MPH, FACHE, a partner in Hospitalist Management Resources LLC, based in Del Mar, CA. Missed opportunities range from delays in securing Medicare credentials to prices set below what the market will pay for patient encounters that are never reported to the practice's billing office.

Though much discussed, coding is just one part of a much larger puzzle that Buser urges groups to work through. "If they leave a lot of money on the table, they're throwing it away," he says.

The following seven-step plan for optimizing revenue is based on Buser's experience in consulting with dozens of hospitalist groups.

1. Expedite applications for credentials from payers

This is step one for a reason. You can't submit a bill until your physicians obtain their provider numbers from Medicare and your state's version of Medicaid. Eight out of 10 hospitalist practices dally on the paperwork or are careless in filling out forms, according to Buser. As a result cash may not flow for six months -- or even longer -- while the program waits for approval.

Typically, each new physician has to complete an extensive information packet. Grumbling is okay. Leaving blanks is not. The application will be rejected, and the clock starts all over again when it is resubmitted. If all goes well, approval can take 60 days for a

Medicare application, says Buser, longer for Medicaid. In California, he estimates, 120 to 180 days for MediCal.

Two of the biggest problems are missing social security and driver's license numbers, according to **Kathy McGuirk**, CPC, vice president of San-Diego-based HRA Medical Management, Inc., a billing company that specializes in emergency medicine, trauma, and hospitalist groups. "They don't want to give it up," she says of physicians who routinely leave out this information for fear it will be stolen.

Be persistent when dealing with dodgers, McGuirk urges; there's no point in filing an application without these numbers.

Advises Buser, "Do it right the first time. There are no shortcuts. Everything has to be filled out."

2. Set your fees strategically.

Many programs use a rule of thumb for setting their fees -- for example, two times what Medicare approves for a particular code. As a result, Buser says they might be charging less than what private insurers would pay to groups that charge more for their services. If a practice bills \$120, for example, no private insurer is going to offer to pay \$140, even though it would and does when invoices are submitted for higher amounts.

The problem, of course, is that commercial payers generally do not publish a rate schedule. Information is available, however. Buser advises his clients to set fees based on the annual *Physicians Fee and Coding Guide* published by Mag Mutual Healthcare Solutions Inc. in Duluth, GA (www.coderscentral.com). The book gives a high-low range on every CPT code. It also presents regional adjustments, and practices can decide

how aggressive they want to be in setting rates.

In addition, HRA president and CEO **Anthony S. Vacchi, Jr.**, CHBME, suggests you analyze each carrier's prior payments and the contractual allowances generated to be sure you have optimized your fees across the spectrum of insurance carriers. Instead of bemoaning the dollars you are writing off to contractual allowances, he advises you should become alarmed when carriers are paying your full fees.

"If you have a contractual allowance for every charge for every carrier, no matter how small, you have optimized the revenue," Vacchi says.

3. Audit your charting and coding

This is one of the hardest areas for physicians, according to Buser. Medical schools don't teach it, the rules are constantly changing, and accurate coding depends on accurate charting.

Drawing attention to another standard resource, Buser proposes reviewing distribution of evaluation and management codes in your group's claims against national distributions in the *E/M Bell Curve Data Book*, which comes with a software template. Published by PartB News in Rockville, MD, the book uses national data from the Centers for Medicare and Medicaid.

The data on rounding is of particular interest to hospitalists, according to Buser. Rounding falls under three evaluation and management codes -- 99231, 99232, and 99233 -- ranging from low to high intensity with the latter commanding higher fees. Plotting your claims on a graph should produce a bell curve, the shape of which can vary according to the severity of cases in your hospital.

If your curve shows a disproportionate number of low-intensity cases, Buser suggests you may be under coding. An unrealistic number of high-intensity cases could be a red flag that you are at risk of challenges for over coding.

"Most new doctors just out of school tend to under code. They're afraid to make a mistake. Senior doctors over code," says Buser. "I am not saying what's right or wrong. Audit to see if they are charting the right code. The point is not what you did, but what you charted that you did."

Hospitalist groups often fail to make sure their physicians are familiar with charting and coding guidelines, adds coding and billing expert **Cindy Catterson**, owner of ProFee Billing Specialists Inc. in Napa, CA, a consulting company serving small hospitalist practices. As a result, she says physicians will write three pages of chart notes that fail to document all the elements required for payment under the code billed.

If hospitalists don't have time to read the

guidelines or are confused, Catterson says the practice should enlist a certified coder to help identify their missing essentials. Often coders will provide a printed "cheat sheet" or hand-held software that physicians can consult on their own, according to Catterson.

Many physicians complain that coders are "too black and white," she acknowledges, but following the guidelines is vital not only to securing payment, but also to protecting the practice in the event of an audit. "Coders aren't making rules," Catterson says. "They are telling physicians what the rules are."

Buser also recommends that you have your billing company do chart audits and monitor your coding. He suggests you require the billing company to present periodic coding seminars at which it reviews trends with the hospitalists in your group, so they can adjustments, if necessary.

4. Capture all encounters.

A hospitalist is walking down the corridor when a subspecialist calls him into a patient's room for a consultation. The patient is not on the hospitalist's schedule, but he performs the service.

Will he be paid for it? "If he doesn't put it in the chart, and he doesn't tell the billing company, nothing happens," warns Vacchi.

Indeed, doing one without the other -- entering notes on a patient's chart but failing to tell the bill office, or alerting the billing office without charting the encounter -- has the same outcome: no payment. "The hospitalist will go on his way, and there goes \$150 right there," says Buser, reporting that in his experience hospitalists do not record 10% to 15% of cases.

"It can account for a huge amount, \$65,000 to \$85,000 across the whole practice that they didn't bill for," he says, describing missed encounters as "a key area that causes lost revenue for most practices."

Practices should implement some form of patient tracking data software that is easy for

Evaluating your hospitalist program collection rate

When you look at your collections overall, you see that commercial payers are remitting 75% of what you bill for your services. Should you congratulate yourself on a high collection rate or complain about being short-changed?

"We like to see between 45% and 60%," says consultant **Roger A. Heroux**, MHA, PhD, CHE, a partner in Hospitalist Management Resources LLC in Colorado Springs, CO. "If the percentage gets too low, the billing company may not be doing a good job. If it's too high, you may not be aggressive enough in pricing."

physicians to use, according to Buser. A growing number of products are available, including hand-held versions that can be carried during rounds. Whichever you use, it should have a way to communicate information to the billing office on a daily basis.

"We have learned that this one step can increase a hospitalist's practice revenue by 10% to 15%, he says, adding, "If you can bill daily encounters, that can improve cash flow."

5. Make your charge sheet physician friendly.

Whether your charge sheet is electronic or pre-printed, it should be user-friendly for a busy hospitalist on the go. You don't want physicians struggling to find illogically placed or absent codes -- or overlooking codes that they should be using.

Each practice needs to develop its own charge sheets, according to Vacchi. The process takes time, requiring give and take between the physicians and whoever is doing the billing. You need to be sure to include all commonly used codes, and that the physicians can find them.

"If they can't find what they need, the charge sheet is revised," he says. "It's a work in progress."

Buser also recommends putting some guidelines on the back of the form or in the software to help physicians resolve questions they may have in choosing what to check off.

6. Select a billing company by services provided

Some small hospitalist groups will try to do billing in house, or shop for a billing company that charges the lowest fees. Wrong, says Buser. Picking a billing company is one of the most important decisions a practice makes. Shortchanging yourself here could lead to a shortfall in collections.

"We worry less about the fees charged by the billing companies and are more concerned about their

collection results," he says with emphasis. "We want to see a company that gets patient payer authorization prior to billing, provides ICD-9 coding for the physicians, drops bills within five days of receipt from the practice, and electronically bills to the payers."

The company also should provide meaningful reports that the program director can use to manage the practice, according to Buser. Key documents would include (1) a trends report showing how each physician uses different codes, and (2) an "aging" report on how long your claims are sitting in accounts receivable at each payer.

In addition, you want regular meetings at which it updates your physicians on changes in coding rules (Medicare updates quarterly) and helps them improve their performance. Another crucial factor is compliance: Buser says the billing company should have a strong, up-to-date compliance program and be able to ensure your group has one, too.

7. Reward productivity with compensation

Many hospitalists are on straight salary and have no incentive to increase their charges through better charting and coding. Buser recommends retooling the compensation package to reward productivity.

"We helped one of our clients move from pure salary with no incentive to a compensation program based on salary plus productivity related to what its physicians were actually able to collect from patients," he says. "We saw a 15% jump in revenues from that moment on. You want to give people an incentive to do the right thing."

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