Complete transcript of Contracting and Reimbursement

[00:00:03] The health care dynamic is rapidly changing. Understanding the basic fundamentals related to the Business of Medicine empowers practitioners to advance their skills in and knowledge of the business aspects of medicine. SMA's Business of Medicine Simplified program explores the essentials of everything from reimbursement and compensation models, insurance and risk management, to practice employment, and business finance.

[00:00:29] Welcome to the Southern Medical Association's Business of Medicine Simplified podcast. I'm Jennifer Price and today we are discussing contracting in reimbursement with Jeff Gorke. Jeff is a managing director in the management consulting group leading Stout's healthcare advisory and consulting area. He is also a contributing editor to Forbes.com. He joins us to offer some key tips designed to empower providers with the information they need to succeed in today's business of medicine environment. Thank you for joining us, Jeff.

[00:00:58] Thank you for having me again.

[00:01:00] CMS rejects nearly 26% of all claims and up to 10% are never resubmitted. This can result in lost revenue of up to 10% per physician. Realizing that all claims aren't submitted through CMS, in your experience, Jeff, what is the number one reason for claim rejections?

[00:01:18] That's a great question. Actually and I would go back to the premise that 10 percent of revenue can be lost per physician. It could be more than that. It could be less than that. It really depends on the physician, the specialty, and the revenue cycle processes and procedures that are in place in the practice. So oftentimes, especially in the private practice setting and I will tell you this happens in health systems with great frequency as well, there there are either not sound policies and procedures in place relative to the revenue cycle or people get a little bit lax and aren't held accountable to their component pieces; the roles that they play within the revenue cycle process. So for instance, eligibility not being checked for the patient, make sure they have insurance when they have insured. When they say they have insurance, There's little little steps along the way that can go a long way to improving the revenue cycle function. So it's eligibility. It's asking to see the insurance card and verifying the insurance instead of, "You still have insurance X", which is a sin in my book; Advance Beneficiary notices to let the patient know that they will be on the hook financially if Medicare is not going to pay; medical necessity; Medical Necessity forms for those procedures that the physician feels are medically necessary, and again that the patient would be on the hook; and for being really clear upfront with the patient with regard to what their financial obligation is for their service. And interestingly enough, I've heard horror stories about, alcohol horror stories, because this is a sort of a no-no, definitely no-no. But patients will come in though they'll pay X and the doctor will then just write off the difference instead of going after the patient to collect the remainder of the money. And technically that's a violation of the contract that the physician has with whatever the insurance company is. For instance, let's say it's BlueCross BlueShield for for want of another commercial payer. BlueCross BlueShield's contract is with the patient as well. And the patient's responsibility is whatever their financial obligation is under that contract, and if the doctor writes it off and the patient doesn't pay it, that creates a lot of problems for the patient relative to their,

well and for the physician, for that matter. Having said that, with high deductibles nowadays and out-of-pocket payments that are increasing annually, most of the financial piece is going to fall to the patients so they play a huge role in and what I would call the revenue cycle and being able to have that conversation with the patient and collect what is due upfront at the time of service.

[00:04:20] How can a provider improve on his or her percentage of claim rejections?

[00:04:25] Yeah. Again this is all part and parcel of the revenue cycle process. And when I speak to that, a lot of folks look at the revenue cycle as billing and collecting or even coding, billing, and collecting and it's, it's far more than that and involves many more parts, and so really taking the time to understand all of the pieces in the revenue cycle in a practice, for instance, as you say in a private practice, let's say it's three or four physicians. It's making sure that every one on the team, including the physicians, understand their role in collecting revenue, in revenue, obviously is the lifeblood of the business side of the medical practice and so that means making sure their policies and procedures in place that touch on every component of the finances all the way through the patient visit. So when the patient gets scheduled, we run eligibility before the patient gets in the door. We verify insurance, we collect the appropriate copay upfront, run the patient through the visit, the physician or PA or NP documents, we document a level-three office visit, we submit that to the insurance company, the patient leaves, and we follow-up later with a recheck or we bill for anything that ends up being outstanding. Then the other components on that from the kind of pure rev cycle billing and collecting side is, "Did we, did we send out a clean claim?" "Did we get back the money that was due the practice, right; our contractual agreement with." Again, we'll just say BlueCross BlueShield and what is our follow-up, and then the next piece of that is really, in my mind, you can't manage what you don't measure and I'm a big advocate of, even if it's a simple dashboard, but having having a measurement tool that monthly can be delivered to the physicians so that they can see the status of what's going on with the revenue cycle. And it can be very simple it could be, "What our data?", and we'll get into this obviously in June, but it'll be, "What are our days outstanding?", "What is the industry norm for us for days outstanding?", "What are we collecting what are our net collections?", "What are our gross collections"?, and then managing and monitoring those numbers to whatever the appropriate benchmark is so that if something gets sideways in the revenue cycle process you will see that something's broken and then you can dig down and fix it before it becomes terminal.

[00:07:12] When contacting with an insurance carrier, what is one thing to be aware of?

[00:07:17] The interesting thing that I found in 30 years in health care and having run private practices is and now on the consulting side, many practices don't even know where their contracts are. And so not knowing where your insurance contracts are, it's hard to know what your reimbursement rates are. And so now many healthcare providers have their allowables loaded into their practice management systems and that's good. Then the next question is, "Are those reimbursements being managed to our allowable amount?", and sometimes they are and aren't. And that again gets into a whole other revenue cycle process and and procedure follow-up. I would look at under, I would first understand my contracting leverage. The unfortunate part of the healthcare kind of revenue generation side of things, if you will, is that small physician practices generally don't have the leverage of big health systems or big private practices. So, so the negotiating piece from the insurance company side is really, "Do I need these physicians in

my network?" And if I don't, or I, or I do need them, but I, you know, I can go down the street and get another 10-doctor internal medicine practice. Understanding your bargaining leverage with the insurance companies. "Can they can you leverage where you are in your market, with your group size, to get better rates out of the insurance companies?". And the other piece of that is understanding your data. In health care historically, we've been really bad about managing and utilizing the data that we have, and the interesting thing is where we are in with the industry but health care is a business segment that doesn't really manage its data well. It's starting to, but there's been all this data out there that people have not taken advantage of. And so understanding what you are making per procedure code is essential and, again we'll get into this in June, and then being able to maybe give a little bit up on the contracting side for certain codes and get more out of other codes and understanding how to utilize that data to negotiate better. One of the things apropos of the contracts is contracts that are tied into Medicare reimbursements. If Medicare reimbursements happen to go down, that will automatically lower your reimbursements if you are tied into Medicare. And many contracts have evergreen provisions so they rollover year over year, and it would behoove any practice to have a good contract review process in place so that they know, you know, you review this annually you look at patient volumes and visits and and you start your negotiation process with the payers early instead of just getting a contract dropped in your lap that maybe doesn't suit the practice.

[00:10:49] Jeff, this has been very informative. Thank you again for joining us.

[00:10:53] And thank you very much. I look forward to seeing you in June in Birmingham.

[00:11:00] Jeff will dig deeper into these and numerous other Business of Medicine topics during the one-day Business of Medicine Simplified program, taking place during SMA's Southern Regional Assembly June 27-29 in Birmingham, Alabama. Visit SMA.org/assembly for more information and to register. I'm Jennifer Price with the Southern Medical Association. Thank you for listening today.