Effectiveness versus Efficiency in Billing

Is Your CBO a Krispy Kreme?

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Faced with increasing billing complexity, initiatives such as National Provider Identifier (NPI) and Patient Quality Reporting Initiative (PQRI), and the voluminous documentation demands for a “clean claim”, medical providers are experiencing a growing need for additional accounts receivable management staff. The economics of a medical practice do not allow for increasing non-clinical staff. However, with average annual reductions of 8 to 10 percent in the provider allowables, a medical practice must find ways to optimize the efficiency and effectiveness of its non-clinical staff.

Efficiency is defined as the highest level of production per unit of labor. In a medical provider’s office, many terms for efficiency are used. Collection ratios are the most common but do not address the cost of collection or fee schedule variability and can be manipulated in many obscure ways. Overhead ratios are also common but do not utilize the impact of what should be collected and are not comparable across various practices. Here are a few metrics to consider:

- **Medical collections per full time equivalent employee (FTE).**
  An FTE is defined simply as hours paid each week divided by forty. For example, “$2 million in practice collections for every one accounts receivable management FTE.”

- **CPT codes worked per FTE.**
  This analysis provides the medical practice with a strong measure of throughput or labor utilization. For example, a Central Billing Office (CBO) works an average of fifty CPTs per FTE per day. This metric does not measure how effectively or accurately these codes are processed but provides some evidence of staffing levels for backlogged accounts receivable and current volumes.

- **Billing revenue per FTE.**
  An outsourcing metric that applies to internal departments as well. Assume that you have outsourced your revenue cycle functions to a third party for a fee. Calculate that fee divided by the total number of FTEs in your revenue cycle operation to arrive at dollars per FTE. For example, your practice generates $1 million in annual collections and you assume that you can outsource your billing for 10 percent of collections or $100,000 annually. If you have two FTEs, then your billing revenue to FTE would be $50,000. This metric ranges from $50,000 per FTE to a high performing number of $75,000. Very efficient and effective operations can reach above $100,000 per FTE in this category. *Now, consider how CPT code denial rates would impact this number.*

Regardless of the CBO operating metrics you use, you cannot have efficiency without effectiveness. Efficient people working very poorly will erode these metrics over time.

Effectiveness is defined as touching a CPT code at the appropriate time with the appropriate action. These actions might include appeal, transfer to alternative payer, transfer to patient, adjust the balance due, etc. The appropriate time is a critical definition. The appropriate time is defined as the point in the process where there is a necessity to take action. Many claim status applications within a practice management system tend to create duplication of effort that can be counter-productive to the ultimate goal of increased collections with less cost.

Have you ever been requested to rebill claims that you know will not be paid regardless of the action? This is a typical request and underscores the incorrect strategy of working claims versus getting claims paid correctly and on time.
Your CBO as a Krispy Kreme Store?
A typical claim has an action cycle of thirty to forty five days between each action. Picture a claim as a doughnut. You must mix the dough, let it rise, cook it, ice it and let it cool prior to consuming. If you do not give each stage the appropriate time, the end product will not be acceptable. Likewise, a claim has similar characteristics. There is verification of benefits, charge entry, billing, reconciliation, payment posting, etc. Each step has a definitive time allowance where additional action will be counterproductive. For example, calling a payer on a claim that is ten days old from the date of service and date of insurance receipt will generate no additional information that can be used to get that claim paid even though we can state that we “worked” the claim.

It is expected that a claim should be paid, denied or have no response 45 days from the date of service (DOS), assuming that the date of billing receipt (DOBR) is within two days of DOS. A claim should only be worked within that first 45-day window if you receive a response from the payer and post it into the practice management system. An Explanation of Benefits imaging system is very helpful here. If there is no payer response, then those claims should only be worked at 45 days from the DOS. Until this time limit is hit, any action will generally delay the payment of claims. This also assumes the payment posting function of correspondence occurs, is reconciled and is current. After 45 days from the DOS, all claims should have some actions to accelerate payment. After a claim action has occurred, that claim should rest for an additional 30 days until the claim is paid, denied or receives no response. Too many times, the current account queuing systems within practice management systems are not set up to follow these time frames and generate numerous opportunities to “overwork” or disturb the payment of a claim.

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Summary and Thoughts to Consider
What does this mean? Many CBOs operate under the traditional yet erroneous strategy of working all the claims. Simply working claims is the wrong approach. Getting claims paid correctly and on time is where a CBO should be focused. While one would like a CBO operation to feel like a clean and pleasantly aromatic bakery with the regular yet soft whirring and clicking of machines in the background, most CBOs are hectic, stress-filled, high turnover and undesirable environments for accounts receivable processing. You can achieve efficiency and effectiveness using the right process metrics to optimize the CBO operation. However, you cannot achieve efficiency without effectiveness. They are the flour and water to make your CBO a nice, warm, sugary doughnut.
Ten key considerations for your CBO

1. What is your employee turnover rate? Greater than 20%?

2. Do you promote internally, turning solid receivables management staff into ineffective managers? Do you use your best staff to train and reduce overall productivity?

3. Do you bill claims more than an average of three times? Do you see any claims with statement cycles in excess of five or ten?

4. Does your group tend to run on old A/R projects every 90 days?

5. Have you used automatic rebill on a regular basis?

6. Do you always need additional billing people?

7. How many days are you behind in your payment posting?

8. Do you close your month on a consistent basis (i.e. second business day of the month)?

9. Have you lost high producers? Do your high producers work weekends or display evidence of burnout?

10. Do you know if you are filing secondary insurance or relying upon crossovers?

The answers to these questions will provide you with indications of both the efficiency and effectiveness of your CBO.
John R. Thomas  
President and Chief Executive Officer

John Thomas has been with MedSynergies since its inception in 1996, when he began as senior vice president and managing director of development. While at MedSynergies, Mr. Thomas has held positions such as senior vice president and chief financial officer, and has been a member of the board of directors since 1999.

Prior to joining MedSynergies, Mr. Thomas was the vice president of the newly formed HealthCare Finance Group for Bank One. He was also the assistant vice president for Texas Commerce Bank, where he focused on hospitals, emerging healthcare markets, core finance and revenue.

Mr. Thomas is a national speaker on topics such as revenue cycle management, billing and collections processes and capitalization, raising funds, bank debt, turnaround and high/low debt revenue.

Mr. Thomas received his Master of Business Administration, with honors, from the University of Texas Graduate School of Business. While at the University of Texas, he focused on finance and management and was selected as the Sword Scholar and received the Dean’s Academic Award. Mr. Thomas received his Bachelor of Arts from the University of Arkansas.

About MedSynergies, Inc.

Now serving 2,300 healthcare providers in 27 states, MedSynergies provides revenue cycle services and integrates leading software programs into the daily operations of healthcare organizations. Founded in 1996, MedSynergies serves physicians in hospitals, specialty medical groups, ambulatory surgical centers, rehabilitation centers, and independent practice associations (IPAs). Based in Irving, Texas, the company has regional offices across the United States. For more information on MedSynergies, please visit www.medsynergies.com.