Physician engagement powers performance in medical billing/revenue enhancement

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We are all in business to generate the highest possible revenue for the work we do. Medical practices are no exception, whether independent or network-owned.

With this in mind, here some common problems most practices encounter that limit attainment of maximum revenue and optimal cash flow:

1. Patient/Subscriber insurance coverage information is not verified or updated.

2. The patient's insurance policy does not include benefits for the services provided.

3. There is no daily audit process to reconcile the daily schedule (office, hospital, nursing homes, OR, etc.) against the encounters completed for each date of service, thereby billable services often are missed.

4. The CPT and/or ICD codes are missing, incorrect or not eligible for insurance reimbursement.

5. Daily encounters are not submitted to the billing department within 24 hours of the service being provided.

6. Billing tasks, such are charge entry, payment posting, claim submission and patient statement generation, are not performed daily.

7. Timely and well-supported preparation of insurance appeals for denials and lower-than-expected reimbursements.

From this list, the two that are highlighted center upon a lack of physician engagement in the billing process, and that is the one factor that is completely within the physician's control.

How and why are physicians not typically engaged in billing matters?

Physicians' time is naturally and appropriately most often focused on treating patients. Therefore, physicians often will not allocate time or effort to learning how to code procedures or diagnoses. Some physicians are disillusioned by the bureaucracy, largely created by the insurance industry, or they simply don't like the technology (or lack of automation) involved with coding. The tendency of many physicians is to delegate coding tasks to staff.

With regard to the slow turnaround time to submit encounter forms or electronically approve visits for billing, again, physicians simply do not focus their energy on what is perceived to be a nuisance or an administrative duty.

What is the long-term and short-term impact on practices where physicians are not engaged?

In the short run, accurate and robust coding, combined with prompt turnaround time between service date and claim submission, result in:

- Higher reimbursement from insurers. One internal medicine practice realized a collection ratio increase of 10 points after only three months, after implementing what he learned in a half-day CPT coding and documentation seminar.
- Faster cash flow. This same practice realized an 11-day reduction in A/R Days in the same time period.

In the long run, corrected coding ensures compliance, mitigates the likelihood of insurer audits, and allows the practice to enjoy the highest reimbursement available and allowed.

What is the importance of proper coding?

Medical coding is the language of medical billing and reimbursement. Coding translates information from the medical record into a series of numeric or alpha-numeric codes which presumably represent an accurate description of what was performed and why it was performed. These codes are then attached to a fee and billed to patient or insurance carrier via the paper or electronic claim. Upon receipt of the codes, an insurance carrier identifies services performed, the medical justification of the services, and then determines payment or denial. Keeping this in mind, one can easily

understand why proper coding, consistent with prevalent conventions and guidelines, and supported by documentation in the medical record, is of paramount importance in determining the level or reimbursement physicians receive.

What is the role of the physician in the coding process?

Coding can be performed by a physician or a coder. If performed by the physician, the coder becomes an auditor who verifies that documentation in the medical record supports the codes selected by the physician. If a coder has the responsibility of assigning codes, the coder references and sources the physicians' documentation and codes accordingly. Either way, the physician plays an extremely prominent role in the selection of the correct and best code.

Physicians may want to consider their legal responsibility for the codes submitted. Physicians who choose to do their own coding often do so because only they know what they did and why they did it and, therefore, operate on the premise that only the physician can appropriately document and code.

What is the upside of a practice where coding is handled well?

It is understandable that all physicians may not want to perform their own coding. Regardless of one's personal feelings on this issue, it's indisputable that physician involvement in the coding process has a significant upside as revenue cycle management becomes more refined in terms of time and accuracy, and more complex.

Obviously, this impacts the livelihood of all physicians, and the financial well-being of all medical practices.

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