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PREVENTING Denials

IMPROVE THE CLAIMS MANAGEMENT PROCESS:

A physician's roadmap to performance improvement must include best practices to reduce and reverse unpaid claims

BY DEBRA BEAULIEU-VOLK

You may be thinking you're doing everything possible to submit clean, accurate claims to payers—yet denials persist. And if it seems that every day insurers are sending back different types of denials, you're probably right.

"That's the way it is," says Elizabeth Woodcock, MBA, FAC-MPE, a healthcare consultant and author with Woodcock & Associates. "No matter how hard you try to make everything perfect, denials still happen. But you have to recognize that the insurance companies have an economic incentive to deny claims, so you're never going to get it down to zero."

That's the bad news. The good news, however, is that with a strong parallel strategy of denial prevention and follow-up, you can significantly reduce your denial rate and ensure that almost all denied claims get paid.

FOLLOW UP PROMPTLY

To maximize reimbursements, review all denials within 72 hours and act on them within seven days, Woodcock says. Gone are the days billing staff can simply reprint a denied claim and send it back to the payer with a rubber stamp that says "appeal,"

she adds. "Insurance companies would laugh at you."

But by correcting claims, such as by adding requested information, and sending them back to payers quickly, Woodcock says that at least 80% of them eventually will get paid.

OPEN YOUR TREASURE CHEST

The key to long-term revenue-cycle improvement, however, is learning from and correcting recurrent mistakes. Your most valuable resource in this quest is the denial report, Woodcock says.

It can be tempting simply to correct denied claims and send

them back, but failing to analyze the reasons claims are rejected in the first place only perpetuates the problem. “Denials are your treasure chest for performance improvement,” Woodcock says. “This is your guide to really make a difference.”

For example, by reviewing your explanations of benefits you might learn that you’ve been submitting procedure codes that are inconsistent with diagnosis codes, indicating that you need to work on coding. Or you may find a pattern of missing or inaccurate demographic information, indicating possible problems with your front-desk registration procedures.

DIVIDE AND CONQUER

But to really put this information to work, you need to organize it. For Brett Wares, MHA, FACMPE, chief operating officer at Tenet Florida Physician Services, the first phase of that process is dividing denials into those the practice understands and those it does not.

“There are denials for reasons that are specified by insurance companies that we can understand, such as maybe we didn’t get the middle initial or get the patient registration right. Those are denials we know how to handle,” he says.

Denials in this group then go through another (but not the last) round of sorting so they are addressed by the correct department: front office; billing office; or clinical staff, including physicians, notes Wares.

“But there’s a whole other category of denials for reasons that we may not understand or appreciate. It may be a denial for bundling of services in a surgical procedure that is payer-specific and not supported by Medicare rules,” he says. “Those types of denials we like to be able to build them back into our contracting efforts, but it’s exceedingly difficult to call those

out and have them addressed specifically in our contract.”

Another complicating factor in this process is lack of consistency in the terminology payers use to describe their reasons for denial. “So getting them translated, cross-referenced, and put into actionable information for those three sections is very difficult and manual,” he says.

“DON’T TRY TO FIX DEMOGRAPHICS, CODING, AND SO FORTH IN A MONTH. FOCUS ON YOUR BIGGEST IMPACT POINT FIRST.”

Owen Dahl, MBA, FACHE, consultant

This process is cumbersome for large systems like Tenet and small practices alike, but is too important to overlook, says Woodcock. “Even though it’s frustrating, we’re in a battle, and this battle is fought every single day. If we give up, we’re going to give up money as well.”

SET PRIORITIES

Addressing denials is far less daunting, however, if you prioritize well. “Don’t try to fix demographics, coding, and so forth in a month,” says Owen Dahl, MBA, FACHE, principal of Owen Dahl Consulting in The Woodlands, Texas. “Focus on your biggest impact point first.” Once the first item is resolved, move down to the next-biggest problem.

“It’s hard to chase more than one rabbit at a time,” agrees Wares. Where to begin, he adds, is a matter of preference. “You either pick the high-dollar, high effort or the low-dollar, low effort.” Either way, he says

prioritization is extremely helpful for a practice of any size.

RALLY (DON’T PUNISH) YOUR TEAM

Another common mistake is for a practice manager to attempt to come up with the solutions to identified problems alone, says Dahl.

“Talk and brainstorm with your staff and identify what the real source of the problem is,” he says. This approach not only eases the burden on managers, it also enhances buy-in among employees to follow through with the solutions they helped create.

Keep in mind, too, that firing an employee who may be responsible for a discovered mistake may not be a productive move. “Eighty-five percent of the time an employee is involved in an error, a system causes the error, not the employee,” Dahl says.

And such systems aren’t necessarily IT-related, but may have to do with inadequate training, poor tools, or too many tasks being assigned to employees, which winds up compromising their performance.

“Look at this as a teachable or fixable moment,” Dahl says. “Don’t make the mistake of perpetuating the problem by firing one person and hiring a new one.”

OPTIMIZE TECHNOLOGY

In addition to leveraging your team’s insights and expertise, take advantage of claims-scrubbing systems that help you catch errors before you submit them.

“The clearinghouse world has gotten much better and more sophisticated, so there are tools now available that practices may not be fully aware of or taking advantage of,” Dahl says.

Some basic versions of these tools may be bundled into general practice management software that practices already use, he says, adding the caveat that practices might need to spend

some time to understand the technology and how it works.

“People need to look at both what’s in their practice management system package and what’s in their claims management package from the clearinghouse, and then the compatibility of the two,” he says. “Do I fix a claim in the scrubber or the PMS and how do I make sure that data is being recorded properly?”

Furthermore, practices should determine whether their PMS allows them to build in their own edits on top of the basic pre-loaded rules, Woodcock says.

“You might say it’s kind of a pain to put in all those edits, all those rules. But remember, if I can prevent five, six, 15, or 25 errors from happening by building the rule each and every time, it’s definitely going to be worth the 30 to 45 minutes I spend researching and inputting that rule.”

FIND A SUPPORT SYSTEM

Despite the influx of technology into claims processing in recent years, interpersonal relationships with payers still matter, says Dahl.

“Payers are getting more sophisticated and doing more things electronically just like we are, but there’s still no substitute for the fact that I’ve known Mary from insurance company X for all these years and she always tries her best to help me. How you communicate with Mary could change to email, instant messaging, or texting, but I still recommend you contact Mary verbally on occasion just to say ‘hi.’”

Woodcock agrees, noting that such relationships may help give your practice a voice at the payer if you find that a claims-scrubbing rule built into the insurer’s system isn’t accurate.

“So that relationship may recognize that they’re working for a company just like us, and sometimes humans make mistakes

in what they input and we need humans to correct them,” she says.

Unfortunately, when Wares experienced just such a problem with a payer incorrectly denying claims, he was unable to reach payer employees empowered to resolve the error.

“Even if they agree with and are sympathetic to your problem, people can’t always affect systemic changes in insurance algorithms,” he says.

As a result his practice ultimately had to undertake a formal dispute process involving the state medical society and department of insurance, which took 18 months to complete. Because the denials were found to violate the group’s contract as well as department of insurance

rules, Wares was successful in obtaining a settlement from the payer that included penalties and interest.

“The department of insurance of the state I was in, particularly their health insurance division, was instrumental in helping us get the attention of payers and getting them to change the way they denied or paid claims,” he says.

For situations that require less extreme efforts, professional organizations such as the Medical Group Management Association and state medical societies can often help practices get in touch with other offices tackling the same challenges, Wares says. “The important thing to remember is that you’re not alone.” ■

COMMON REASONS FOR CLAIM DENIALS

Duplicate claims

A duplicate claim was submitted when a practice hasn’t received reimbursement.

Typos

Errors or typos were made while collecting pertinent information from the patient or during the data entry process for a claim.

Deductible

The service won’t be reimbursed because the patient hasn’t yet met their insurance plan’s deductible.

Health plan benefits exceeded

The patient has exceeded his or her health plan’s benefit for the provided service.

Insufficient information

The claim is deficient in certain information. It may be missing a prior authorization or the effective period of time within which the service must be provided for reimbursement to occur.

Problem with modifiers

The claim form is missing a modifier or modifiers, or the modifier(s) are invalid for the procedure code.

Site of service problem

An inconsistent site of service is marked on the claim form, such as

an inpatient procedure billed in an outpatient setting.

Coding mix up

There is a coding or data error with mismatched totals or codes that are mutually exclusive.

Outdated codes

The claim includes outdated current procedural terminology codes, or it lists deleted or truncated diagnosis codes.

Service not covered

A particular service isn’t covered under the health plan’s benefits.

Lack of medical necessity

The health plan could deny a claim if it appears that a service was not medically necessary, or if there is a mismatch between the actual diagnosis and the service performed.

Out of network

When the physician isn’t an in-network provider for the patient, the payer may reimburse a lesser amount if the patient has out-of-network benefits.

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PAYER NEGOTIATING TIPS

FOR SMALL PRACTICES

Negotiating with payers is one of the necessary evils that independent physician practices must endure. Here's some advice to healthcare providers about negotiation.

BY MELISSA LUCARELLI, MD



Negotiating with payers is one of the necessary evils that independent physician practices must endure.

Despite the useful information these sources offer, many doctors in solo and small practices continue to believe that they have no power when it comes to negotiating, and that they must accept whatever terms the payer offers. I disagree. Regardless of your practice size, you can get a fair—or at least livable—con-

tract from even the largest payers, as long as you are prepared and go into the negotiation with the right attitude. I know, because I've done it.

I've owned and directed a solo family practice in the rural town of Randolph, Wisconsin since 2001. With the assistance of two other providers—a nurse practitioner and physician assistant—my clinic cares for a panel of about 6,000 patients. Just over half of our patients are covered by commercial insurers, and their reimbursements account for approximately 80% of our net collections. Apart from medical seminars and journal ar-

ticles, I have no formal training in business or contracting. Nevertheless, our practice has managed to stay financially viable.

Earlier this year I negotiated a new contract for my practice with one of the five largest national health insurance payers. It was the third time I'd negotiated with that payer, and this was by far the most successful. Our new contract reimburses us about 10% more than our previous one, largely because of a higher Medicare multiplier for preventive health services, which account for the highest volume of services we provide. In addition, this contract

includes a feature that neither of my previous contracts with this payer had, an “accelerator”—an annual cost-of-living raise.

What made this contract negotiation different? Like any other skill, negotiation gets better with practice, and I have learned some valuable lessons over time. Here are the basic strategies I use when approaching a payer negotiation:

Do your homework

Before I notified the payer that I wanted to renegotiate, I gathered meaningful data, including how much they were paying us as a percentage of our charges and how that compared to our other commercial payers.

Many of you probably have been told by a payer that the reimbursement increase you’ve requested is out of line, that “nobody gets that amount”—whatever it is. I looked at our charges and reimbursements and discovered that this payer was actually our lowest contracted payer, and I calculated by what percentage they were the lowest. Sharing this data with them gave me powerful ammunition, and the confidence to call their bluff.

Tell them what makes your practice special

To a giant commercial insurer, your small practice is just one of many they contract with. They are not going to know what makes you special—and why they should pay you more—unless you show them.

I told this payer about their sponsored quality initiatives in which we participate. I emphasized the specific recognitions we had received for quality care from their organization and the fact that we are the only family practice in a 15-mile radius that is an in-network provider for their product.

In addition, I took what may have been perceived as negotiating weaknesses—our size and location—and tried to turn them into advantages. I pointed out that small, rural practices like mine are important to employers outside of major metropolitan

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areas, and these employers often have strong loyalty to their community and local physician practices. Treating my clinic well creates a favorable impression among those employers and increases business for the payer.

Don’t be afraid to ask for what you need, or want

In my experience, most physicians are willing just to “go with the flow.” They want their professional relationships to be simple and non-confrontational. So when a payer presents them with a contract and tells them nothing in it is negotiable, they sign. This is a big mistake.

I recall a talk from a contract lawyer during the practice management part of my residency. He said there’s no such thing as a non-negotiable contract. You can always do an addendum or rider. It never hurts to ask. The worst they can say is no.

Incidentally, the same advice goes for any language that’s vague or that you don’t understand. A negotiating tactic many insurance network representatives use is to try to dazzle you with fancy terminology and legal-sounding language. Usually it’s just a lot of meaningless obfuscation. Ask the person you’re negotiating with to explain it and to give you specific examples of how that clause might be applied. If you are concerned that the language might be interpreted to your detriment or that it doesn’t really apply to you, ask them to take it out.

Be open to trade-offs and know when it is good enough

A payer may not be able to negotiate some items due to corporate policy or regulatory restrictions, but they might be able to make a change in another part of the contract that will make up for it. A negotiated agreement is seldom going to end up exactly the way you want it to. The trick is to know when it’s good enough, and how much the time spent in additional negotiation is worth to you.

Have a backup plan

Negotiating major payer contracts can be very anxiety-provoking. At times, I have felt that if I lost a contract my entire practice could fail. But there is nearly always an alternative, and if you haven’t discovered what it is, then you shouldn’t be negotiating yet.

When I bought my practice, a large regional HMO represented

40% of my business. I quickly realized I had to diversify the practice because if I lost that contract, I wouldn't have been able to keep the lights on. By contrast, when I renegotiated this year with the commercial payer I knew I could walk away if absolutely necessary. I was bargaining from a stronger position.

NEGOTIATION DOESN'T HAVE TO BE A BATTLE. THE IDEA IS TO FIGURE OUT WHAT YOU REALLY WANT AND HOW YOU CAN DEMONSTRATE THAT IT'S FAIR AND REASONABLE AND DATA-DRIVEN.

Approach negotiations as a collaboration

A book I recommend highly is "Getting to Yes: Negotiating Agreement Without Giving In" by Roger Fisher and William Ury. It helped me a great deal with contract negotiations. The authors introduced me to the concept that negotiation doesn't have to be a battle. The idea is to figure out what you really want and how you can demonstrate that it's fair and reasonable and data-driven.

The book also talks about having a BATNA—a best alternative to a negotiated agreement. Taking the BATNA doesn't mean you're cutting and running; it means this particular negotiation isn't going to be successful. You have to think creatively and ask yourself, "What can I do to get what I need without this particular negotiation?" Sometimes dropping the contract will turn out to be the best business decision.

Don't make it personal; it's just business (or should be)

I'm not friends with the provider network person I negotiated with, but our relationship was cordial and business-like. Negotiating shouldn't be emotional, but removing emotion from the process takes practice.

When I was in medical school, a professor told me that if a patient causes you to feel anger or anxiety, that patient is either manipulating you or is mentally ill. Similarly, if someone you're negotiating with causes you to feel those sorts of emotions, you need to step back and ask yourself, "Why is this personal? This person is only trying to get their goals met and make money for their employer, so why am I upset about this?"

As a corollary to this point, it's a good idea to avoid burning your bridges by saying or doing something that's personally offensive to the person you're negotiating with. You never know when you may cross paths with that person again, either in a contract negotiation or in some other capacity. For example, a former commercial insurance representative is now my clinic's contact at our Medicare regional extension center. It's amazing how much more cordial our conversations are now.

Keep a sense of humor

The ability to laugh or make a joke can be important in defusing a tense negotiating situation and maybe even help forge a bond with your negotiating counterpart. I know that if I'm not in the mood to laugh, I should probably reschedule the meeting.

Having a sense of humor also helps you to maintain your perspective about negotiating a contract. As physicians, sometimes we are faced with life or death situations, and a contract isn't

one of those times. It's just business, and sometimes you have to remind yourself about that.

HAVING A SENSE OF HUMOR ALSO HELPS YOU TO MAINTAIN YOUR PERSPECTIVE ABOUT NEGOTIATING A CONTRACT. AS PHYSICIANS, SOMETIMES WE ARE FACED WITH LIFE OR DEATH SITUATIONS, AND A CONTRACT ISN'T ONE OF THOSE TIMES. IT'S JUST BUSINESS, AND SOMETIMES YOU HAVE TO REMIND YOURSELF ABOUT THAT.

It's also OK to celebrate and be a little proud of yourself when you are done negotiating and able to walk away with a new contract that you're happy with. Any physician should be able to manage patient care, but you are also managing a business. That is part of our identity as independent physicians and one of the reasons that our services are still valuable and relevant. ■



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Accounts Receivable: Strategies for Better Management

Maintaining healthy accounts receivable (AR) is essential to strong financial performance, but it's easy for practices to feel overwhelmed or become complacent when it comes to keeping this piece of the revenue cycle on track.

BY DEBRA BEAULIEU-VOLK

The aging of your AR is crucial to watch because the older bills get, the harder and more costly they become to collect, says Laurie Morgan, MBA, a senior consultant with California-based Capko & Morgan. “When your AR slips and you have a very large backlog or balance, it can seem like you’ll never be able to tackle it,” she says.

What’s more, this challenge has been compounded in recent years by the rise in patient financial responsibility for medical care. While high-deductible plans have existed for some time, they’ve become even more widespread as more and more products available through new health insurance exchanges offer low premiums in exchange for high deductibles or coinsurance.

The multitude of new plans available to patients can in itself result in complexity and confusion for practices. Throw in the fact that many affected patients are unfamiliar with how health insurance works in the first place, and AR can suffer dearly.

ANALYZE YOUR AR IN DETAIL

The first step in improving your AR is to analyze your starting point. But just as the proportion of patient-paid AR has evolved, so too should the way you run reports. “It’s important to break down the patient AR from the insurance AR to be able to understand what’s driving each of them. You can’t just look at it as one massive AR,” says Morgan.

So if you note that your patient AR is mounting quickly, for example, that could suggest deficiencies in your front-desk processes or the way employees communicate to patients about your financial policy. Declining performance on the insurance side could also indicate front-

desk errors, or point to a larger issue related to a third-party or centralized billing function.

PRIORITIZE INSURANCE VERIFICATION

A starting point for addressing many of these issues is your process for verifying patients’ insurance coverage and eligibility. “Making sure we’re checking insurance eligibility well in advance of that patient presenting to the clinic is a strong indicator of AR,” says Stephanie Davis, director of revenue cycle management for Halley Consulting Group in Ohio.

“MAKING SURE WE’RE CHECKING INSURANCE ELIGIBILITY WELL IN ADVANCE OF THAT PATIENT PRESENTING TO THE CLINIC IS A STRONG INDICATOR OF AR.”

Stephanie Davis, consultant

Most systems that practices use to check eligibility—including payer websites, software built into practice management systems or third-party products—can now provide medical office employees with detailed information that can help with AR. This data includes, for example, not just whether the patient has coverage, but how much of the deductible has been used up and even if the policy is in danger of suspension due to nonpayment of premiums. Ideally, practice employees communicate (and potentially translate) this information to patients before they come to the office for an appointment.

“If patient insurance eligibility is not being verified or we’re not

connecting with the patient prior to them presenting to the office, it creates a massive amount of work on the back end to try and resolve open AR or open claims,” Davis says.

Tina Smith, CPC, CPC-H, administrator of Steamboat Medical Group in Colorado, adds that practices often make the mistake of not maintaining sufficient staff to adequately verify benefits and educate patients. “The value of that function gets minimized and physicians have a difficult time seeing the bigger picture,” she says. “But what you’re collecting as a result of doing that [upfront] work will more than pay for the additional staff member it takes to do that.”

COLLABORATE WITH OUTSIDE BILLERS

Of course, the revenue cycle extends far beyond the front desk—even if a practice uses a third-party billing company. “Practice managers are often really busy and anxious to offload some things to not worry about,” Morgan says. “So the temptation is there to start thinking as though billing is someone else’s job.”

But even when most of the billing legwork is outsourced, practice managers have to work in concert with billers to make sure all parties are getting the information they need and performance is meeting expectations. Success in this area depends on maintaining a strong relationship with your billing company, according to Smith. Because her office is in a rural area, she enjoys the benefit of using a local billing company whose employees pick up the practice’s charge slips and drop off reports in person.

When face-to-face interaction with billers isn’t an option, it becomes even more important for an individual in the practice who understands billing rules to

communicate with the company routinely. When possible, the same billing company employees should work with a given practice consistently, she adds, so the company becomes familiar with your office's charges and contracts.

FOCUS ON CODING

In almost any primary care practice, there is opportunity for physicians to improve documentation and coding. When physicians see patients in multiple settings, such as nursing homes or hospitals, it's especially important for practices to have systems in place to capture all of the services physicians are providing across these settings, says Davis.

"You would be amazed at the amount of billable services that are not captured by physician practices just because we don't have processes implemented that will allow physicians to enter that charge capture," she adds.

Even if physicians are using a superbill, they need to make sure not only that they are capturing all charges, but also know which of them they can and can't charge separately, Smith says.

"It's a challenge because it's not physicians' area of expertise. They want to be seeing patients, not learning all the coding rules and regulations. But at the end of the day it's the physician who is responsible. If there's evidence of fraudulent billing, it's not going to come back to the billing company. It's going to come back to the physician," she says.

Accurate coding also speeds up the billing cycle, which increases the likelihood of patients paying their balances, Morgan points out. Any delay in the time it takes a bill to get through the clearinghouse and then to the health plan for payment also stalls the practice's bill to the patient.

The more time that elapses between when the patient is seen and when he or she receives a bill, the greater the chances the

patient will have forgotten about the bill, will consume staff time questioning the bill, or simply not pay it. "So you lose money not just on the operating expense of dealing with the problem, but you may not get paid at all," Morgan says. "Even in the best case it creates a negative experience for the patient, which is a result you don't want."

ENGAGE PATIENTS

Instead, it's crucial to engage patients early in setting expectations so that a bill or request for pay-

IT'S CRUCIAL TO ENGAGE PATIENTS EARLY IN SETTING EXPECTATIONS SO THAT A BILL OR REQUEST FOR PAYMENT WILL NOT COME AS A SURPRISE.

ment will not come as a surprise.

This step doesn't stop with providing patients with your payment policy or reminding them of their balances. It also means giving patients easy ways to connect with the practice and pay their bills, says Davis.

"Patients are very technologically savvy, and the more you can give them access to communication tools, such as an online portal, and convenient methods of payment, it makes it easier for the patient to be engaged in that process," Davis says.

BEWARE OF CONSOLIDATION CAVEATS

Patient engagement and accessibility are particularly important when a practice is going through a transition such as a merger or hospital buyout, notes Morgan.

Of particular concern, switching to a hospital billing system often results in billing delays, leading to the problems men-

tioned previously that can sour a patient's relationship with the practice. "So anything you can do in the clinic to communicate what's going on, such as changes happening, updates to infrastructure, potential billing delays, or a new person to talk to with questions can head off problems," Morgan says.

Also, while being owned by a hospital or health system can be a plus when it comes to negotiating contracts, adopting hospital-centric policies is not always advantageous from a billing perspective, according to Davis. "We recommend you try to get the best of both worlds, whereby you allow the practice to continue to do their charge capture and other revenue cycle functions that are going to drive that performance," Davis says.

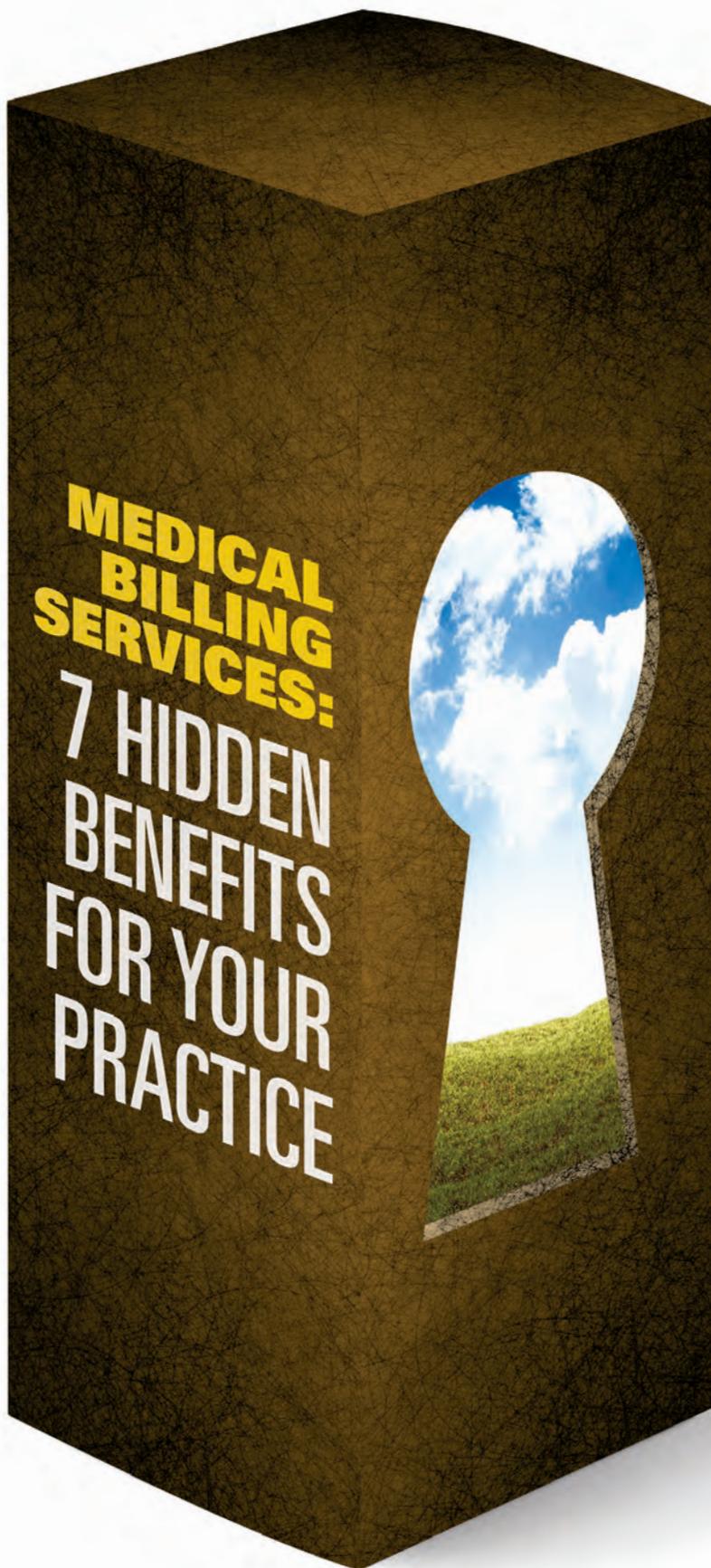
FOLLOW THE GOLDEN RULE

Regardless of your practice structure, Davis recommends following a credo of, "Whoever enters the data owns the data."

An example of this philosophy at work would be when a claim comes back denied because of an incorrect subscriber ID. Rather than taking the seemingly quickest route of fixing the error at the back-office level and resubmitting, Davis suggests routing the claim back to the employee who made the mistake so he or she can see what happened and not perpetuate the cycle.

"Our front-desk personnel are typically people who strive to do their best. And where we see the breakdown is when we don't provide that feedback loop and we don't allow them to understand the results of their actions," Davis says. "Engaging employees in the solution is the ultimate training." ■

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Most practices are aware of how medical billing services and revenue cycle management can reduce costs and increase collections with benefits such as electronic eligibility verification, included EHR and practice management (PM) software, financial reporting, and faster accounts receivable turnaround.

But how else can medical billing services benefit a practice? Here are some unknown benefits you can expect to see.

DECREASE PRACTICE OVERHEAD

Avoid hiring additional employees to handle your billing services. Fewer employees can streamline a practice's operational and financial processes. Keep costs down and headaches minimal.

"Typical support staff is 37.16% of total practice costs," according to the Medical Group Management Association's [2014 Cost Survey](#). The size of the billing staff is usually determined by the number of claims the practice submits and according to AMA board member, [Barbara McAneny, MD](#), "physicians divert as much as 14% of their gross revenue to insure accurate and sure payments for their services." Any savings in support staff and billing costs will go straight to the bottom line.

INCREASE PRACTICE EFFICIENCY

Without the stress of managing your practice's billing, your staff can focus on other areas and improve workflows.

EHR solutions not only give you the power of faster note taking, but allows you to stay organized throughout the day while efficiently managing administrative and financial tasks. Utilizing the tools provided by the medical billing service

company and your EHR can also drastically improve your internal communication because data can easily be shared. Staying organized and optimizing processes can even reduce test duplication and decrease errors.

AVOID NEGOTIATING WITH PAYERS AND CREDENTIALING BODIES

If you are a new practice or adding a physician to your practice, you must go through a credentialing and enrollment process to connect with insurance companies. This process can be time-consuming and cause delays if you don't enroll properly. Medical billing service companies usually offer solutions to take care of this process for you. They have the contacts with insurance companies and can make sure you are enrolled properly and have the correct credentials.

The next step in this process is negotiating with payers to receive the best rates. For smaller practices, this can be a little overwhelming and feel like you're going up against Goliath when trying to negotiate with large insurance companies. Let a medical billing service company do the negotiating for you. They have the experience and can get the best rates for your practice. This service is normally free of charge, so be sure to take advantage of payer negotiation. You don't need the added headache.

COMPLETE TRANSPARENCY

Having your software and billing service under one roof and also connected to each other is a key benefit that is often forgotten when evaluating medical billing services as a solution.

Practices need to have complete transparency with their billing process in order to know where each charge is in the process and have the ability to track the charges all the way back to the practice.

If there are any denials, practices need to know what they are and how to correct them. A transparent process makes it easier for billers to confirm that all claims are processed in a timely manner. From there, practices can be sure that the insurance companies are processing the claims as soon as they receive them and are being paid the correct amount. A medical billing service makes this transparency possible.

THIRTY-SIX PERCENT OF PROVIDERS SAID THAT THEY WILL HAVE TO REDUCE THEIR CAPITAL SPEND (ACCORDING TO A PEER60 REPORT) AND 79% OF CHIEF FINANCIAL OFFICERS ARE LOOKING TO CUT TIES WITH RCM VENDORS THAT ARE NOT PRODUCING A RETURN ON INVESTMENT IN 2016, ACCORDING TO BLACK BOOK REPORT.

COLLABORATIVE ENGAGEMENT OF IT/TECHNOLOGY

Using a medical billing service company that also uses the same technology as the practice provides the added benefit of everyone being on the same page. Using a one-stop shop for both software and service makes setup and implementation a breeze by incorporating patient reminders, online bill pay, patient portals, and more. Medical billing service companies can provide all of these solutions and since they use them daily, they can help with any questions you may have along the way.

BEST PRACTICE TRAINING INCLUDED

One thing to remember about most medical billing service companies is that they have years of billing experience and know all the ins and outs of how to make your practice as efficient as possible. They typically provide training for basic practice operations and best practices for using your PM software. They are a great resource for any tips and training.

If additional in-depth training such as on-site visits is needed, most medical billing service companies have available options. Be sure to reach out to see what options they have and utilize them as much as possible. They are there to help you succeed and most practices are unaware of these additional services.

ACHIEVE POSITIVE ROI

Return on investment (ROI) is a best practice in any business, but as billing costs continue to increase, keeping costs down and revenue up has never been more important. When deciding whether or not to keep a software solution, evaluating the ROI is one of the key variables at which to look. Thirty-six percent of providers said that they will have to reduce their capital spend (according to a [peer60 report](#)) and 79% of chief financial officers are looking to cut ties with RCM vendors that are not producing a return on investment in 2016, according to [Black Book report](#). ■



Manik Chawla is a healthcare professional at [Medico](#), a healthcare management company providing revenue cycle management, medical coding, and compliance services to practices nationwide. Chawla has more than 11 years of healthcare experience at leadership positions in operations, transition and training, and business development. He can be contacted at manik@medicoinc.com.

High Deductibles:
**Why Physicians
Must Adjust
How They Practice**

BY SUSAN KREIMER



Accelerated by the Affordable Care Act, high-deductible health plans have emerged as a major trend in healthcare. Placing more financial responsibility on patients for medical services has a direct impact on physician practices. Operating successfully within this framework requires greater awareness of differences among insurance policies and discussions of treatment options that are sensitive to patients' out-of-pocket expenses.

"Doctors need to understand the landscape has changed. A doctor's primary concern used to be whether a patient had insurance. Now, it's the type of insurance," says Devon M. Herrick, PhD, a senior fellow at the National Center for Policy Analysis in Dallas, a nonprofit organization that promotes private alternatives to government regulation.

"Patients are more cost-conscious now. That means patients will question their physicians about costs for procedures," he adds. "Patients will also ask uncomfortable questions like: 'Doctor, do I really need that MRI?' 'What's that going to cost?' 'Can that test wait?'"

The best way to approach billing issues in a physician office is to be proactive with patients by clearly detailing costs and options. "Otherwise, a disgruntled patient who believes they were treated unfairly—and gouged by a rich physician—may be less likely to pay their bill," Herrick says.

HOW COSTS AFFECT PATIENT CHOICES

Studies have shown that consumers exercise greater caution in spending when health plans require them to share more of the costs, according to The Rand Corporation, a research organization that has conducted the largest independent study of high-deductible health plans.

High-deductible coverage "really does reduce people's healthcare costs and use. About two-thirds of the reduction is in number of episodes of care, and about one-third of the reduction is in the cost per episode," says Amelia M. Haviland, PhD, an adjunct senior statistician with Rand and an associate professor of statistics and health policy at Carnegie Mellon University in Pittsburgh.

HIGH-Deductible Coverage "Really Does Reduce People's Healthcare Costs and Use. About Two-Thirds of the Reduction is in Number of Episodes of Care, and About One-Third of the Reduction is in the Cost per Episode. Detrimental Impact on Patients' Health Over Time."

Amelia M. Haviland, PhD,
healthcare economist

"There may be some good news in terms of bending the cost curve, but there are also some concerns—that it might have a detrimental impact on patients' health over time," Haviland adds, citing an already apparent decline in cancer screenings, child immunizations and recommended tests for diabetics. "The concern on a physician's side is that patients will be less compliant, or in particular, that they will not come for appointments; they'll reduce their interactions with their doctors."

For many patients, the decision to avoid appointments stems from not knowing that their deductible doesn't apply to annual wellness visits, certain cancer screenings, and other preventive services. Physician offices may consider countering this misunderstanding by sending explanatory postcards, emails, or letters, Haviland says.

High-deductible health plans "certainly are continuing to gain traction in the employer-sponsored insurance world and are the dominant plan type on the individual and small group markets on the exchanges. On the employer-sponsored market, they've overtaken HMOs," she adds. "It's more and more likely that doctors will have patients who are in these plans."

'A NEW SCENARIO'

In many cases, high-deductible health plans are paired with tax-free individual health savings accounts (HSAs) or employer-sponsored health reimbursement arrangements (HRAs). When a high-deductible plan accompanies one of these options or some other type of tax-free savings account, the result is described as a "consumer-directed health plan."

In 2014, 48% of companies offered a consumer-directed health plan, up from 39% in 2013, according to Mercer benefits consulting firm's national survey of employers. Enrollment in these plans increased to 23% of covered employees in 2014 from 18% the previous year. Average in-network deductibles were \$2,500 for an individual worker or \$5,000 for a family plan.

"It's a new scenario for a lot of patients and physicians," says Katherine Hempstead, PhD, director of health insurance coverage at The Robert Wood Johnson Foundation. The change has created "a little bit of a learning situation for everyone."

At first, many consumers didn't fully grasp their financial responsibilities under the high-deductible plans they had selected. Consumers who tend to be lured to lower monthly premiums often are the ones who will encounter the most difficulties paying their deductibles, Hempstead says.

Low-income enrollees in high-deductible plans were more likely to forgo emergency care due to unaffordable out-of-pocket expenses, according to a study of small employers in Massachusetts. Researchers reviewed emergency department visits and hospitalizations over two years among high-deductible plan members. Those of low socioeconomic status incurred 25% to 30% declines in high-severity visits over both years. Hospitalizations decreased by 23% in the first year but increased in the second year.

"Initial reductions in high-severity ED visits might have increased the need for subsequent hospitalizations," the authors wrote in the August 2013 issue of *Health Affairs*. "Policy makers and employers should consider proactive strategies to educate high-deductible plan members about their benefit structures or identify members at higher risk of avoiding needed care. They should also consider implementing means-based deductibles."

When insurance policies come up for renewal, it will be interesting to see if consumers who initially opted for high-deductible plans make different decisions for the future, Hempstead says. Meanwhile, providers will find it necessary to become more efficient in their practices and transparent about their pricing, as consumers demand more value for their healthcare dollars.

ADVANCING PRICE TRANSPARENCY

In particular, the trend toward high deductibles "will certainly

push price transparency for services or tests that physicians may order.

"A patient may ask, 'Where is the least expensive place to get an MRI?'" says Mark S. Williams, MD, MBA, president of the Southern Medical Association and chief physician executive for Tenet Healthcare and

"INITIAL REDUCTIONS IN HIGH-SEVERITY ED VISITS MIGHT HAVE INCREASED THE NEED FOR SUBSEQUENT HOSPITALIZATIONS. POLICY MAKERS AND EMPLOYERS SHOULD CONSIDER PROACTIVE STRATEGIES TO EDUCATE HIGH-Deductible PLAN MEMBERS ABOUT THEIR BENEFIT STRUCTURES OR IDENTIFY MEMBERS AT HIGHER RISK OF AVOIDING NEEDED CARE. THEY SHOULD ALSO CONSIDER IMPLEMENTING MEANS-BASED DEDUCTIBLES."

Health Affairs, August 2013

Brookwood Medical Center in Birmingham, Alabama. Practices that have compared rates and quality among local imaging and laboratory facilities would be more prepared to answer such questions.

Some physicians may experience a decline in the use of their services, while others gain a competitive advantage.

"Physician offices may be further challenged in collecting reimbursement for their services, as the patient will be paying more out of pocket," Williams says. One way to continue serving patients while reducing their out-of-pocket costs would be to delegate less-complex visits to a nurse practitioner or a physician assistant.

"Physicians who are best informed about these trends and changes will do very well," says Williams. Conversely, "those physicians who may not take the time or make the effort to learn about these things are at risk. That high-deductible concept is not going to go away."

Among employer-sponsored health plans, deductibles for employees have edged steadily upward. In 2014, 80% of all covered employees had a general annual deductible averaging \$1,217, according to the annual Kaiser Family Foundation/HRET survey of more than 2,000 small and large employers. The average deductible has increased 47% from \$826 in 2009.

Also in 2014, 41% of covered employees had a minimum annual deductible of \$1,000, and 18% had deductibles of at least \$2,000. Those at small companies (three to 199 employees) were even more likely to encounter large deductibles.

Wanda D. Filer, MD, MBA, FAFAP, president-elect of the American Academy of Family Physicians (AAFP), says pricing information isn't readily available in all healthcare markets, especially in competitive areas. She manages about 90% of patients' health concerns in her primary care practice in York, Pennsylvania, without referrals to specialists. "My role is to offer them the best services that I can," Filer says, while acknowledging that she tries "not to incur any more costs than I need to."

However, there are times when patients require procedures that fall outside the scope of her expertise. For example, she says, a male patient recently presented with problems that required consulting with a urologist but the patient couldn't afford the out-of-pockets fees.

While Filer's clinic—Family First Health—is a federally-qualified health center, she also sees numerous patients with private insurance. “They're a little more attuned to what time of year it is and where they are with their deductibles,” she observes. Many patients are unaware that preventive office visits and services would be covered regardless of whether they have met the annual deductible.

There are also alternatives to traditional fee-for-service insurance billing. In a direct primary care (DPC) model, physicians typically charge patients a monthly, quarterly or annual fee that covers all or most primary care services, including laboratory tests, care coordination and comprehensive care management. This fee doesn't cover some services, so practices often advise patients to acquire a high-deductible plan for emergencies, according to the AAFP.

Direct primary care is not the same as concierge medicine. “I hear this confusion a lot,” Filer says. “DPC practices operate at a lower monthly fee in order to open more services and access to those who have previously been excluded financially.”

SETTING THE RIGHT EXPECTATIONS

Physician practices walk a fine line between providing good clinical care that meets patients' needs and limiting the burden associated with spiraling costs.

It's important for staff members to know what a plan covers

as well as a patient's financial limitations, says Laura Palmer, FACMPE, director of professional development at the Medical Group Management Association in Englewood, Colorado.

At the outset, it helps to “set the right expectations with patients and staff.” Palmer recommends having open and honest conversations about costs well before a collections problem arises and the financial aspect compounds the stress for a patient undergoing treatment.

“THE AMA IS A STRONG ADVOCATE FOR BRINGING TRANSPARENCY, SIMPLICITY, AND CONSISTENCY TO THE MEDICAL CLAIMS SYSTEM. WE ARE URGING A STREAMLINED APPROACH THAT ALLOWS MEDICAL CLAIMS TO BE SUBMITTED AND SETTLED IN REAL TIME AT THE PATIENT'S POINT OF CARE.”

Robert M. Wah, MD

A provider may ask, for example, if a patient on a high-deductible plan would encounter a financial hardship in paying for prescription medications. Sometimes a provider may be able to offer free samples and help a patient apply for a low-cost or subsidized prescription drug program, Palmer says.

'CONSTANT EVALUATION'

Physician practices also can avoid losing revenue by learning how to collect payments from patients at the time of service, says Robert M. Wah, MD, president of the

American Medical Association (AMA) and a reproductive endocrinologist in McLean, Virginia.

They can turn to the AMA's website for point-of-care pricing resources that encourage increased electronic transactions and payment transparency. Webinars and toolkits explain how to use practice management software to provide point-of-care pricing, and how to measure a practice's success at collecting payments at the time of service. There is also a sample template letter with contract language.

“The AMA is a strong advocate for bringing transparency, simplicity, and consistency to the medical claims system. We are urging a streamlined approach that allows medical claims to be submitted and settled in real time at the patient's point of care,” Wah says. “This will cut unnecessary administrative costs in the medical office, while helping patients to know their total out-of-pocket costs prior to treatment and help give them more control over their healthcare dollars.”

It is not uncommon for physician practices to face shortfalls in cash flow at the beginning of the year unless the practice has established a methodical approach to collecting deductible payments at appointments, says James Smith, MBA, FACHE, a senior vice president in the New York office of The Camden Group, a healthcare consulting firm.

“Given the rapid increase in share and the impacts on cash flow, practices must constantly be evaluating receivables and committing resources to their collection, as well as assuring adequate lines of credit and other financial instruments are available to help mitigate short-term cash shortfalls,” Smith says. ■

Susan Kreimer is an Illinois-based freelance healthcare writer and editor. She can be contacted at medec@advanstar.com.

GETTING PAID

A white line graph with orange circular markers at each data point, rising from the bottom left towards the top right. The background of the graph is a green-tinted image of a US dollar bill. Two black silhouettes are positioned on the graph: a man in a suit standing on the highest point, and a woman in a business suit standing on a lower point.

Strategies & Best Practices

Doctors and their staff members often find themselves chasing patients and insurance companies to get paid, and frequently are forced to write off bills that could and should be paid

BY COREN H. STERN, JD

The Affordable Care Act has resulted in higher levels of patient responsibility, yet many patients remain under-insured or without insurance, leaving physician practices to manage those encounters to ensure proper payment.

The following strategies can help physicians approach their workflow from the perspective of maximizing their reimbursements and ensuring they are able to collect all they've earned.

MAXIMIZING YOUR ACCOUNTS RECEIVABLE

In general, doctors rely on billing personnel or outside billing services to issue statements and to follow up with patients and insurance companies.

But billing services and personnel need direction from administrators or doctors as to the most efficient way to maximize the remuneration they receive for the care they provide. With this in mind, every physician should have intake forms that clearly assign medical benefits (though these aren't always honored).

These forms also should remind patients of their responsibility not only for unpaid portions of bills, but for any collection costs that might become necessary, including fees charged by collection agencies or attorneys.

Without this provision, physicians often end up paying up to half of their fee to a collection agency or a lawyer, when including this clause in their intake forms would have cost them nothing.

Providers also need standard billing practices that leave nothing to discretion. Doctors should send statements on a regular (perhaps monthly) basis, and have a strict policy as to how many statements are sent prior to referring an account for collection. (Three statements is a good number.)

The reason for this is three-fold. First, issuing quick and

consistent billing statements reminds patients of their obligation to pay. Second, fresh debts have a much higher repayment rate than aged ones.

Finally, statements must be sent consistently to preserve the right to sue. Most states provide that patients' failure to object to statements in a timely manner is grounds for later legal action.

WHEN TO USE A COLLECTION AGENCY

Collection agencies can provide pressure that billing personnel or services cannot. It is important, however, to ensure that medical practices use reputable collection agencies that comply with state and federal laws.

Furthermore, billing arrangements must be taken into consideration when selecting a collection agency. Many agencies charge a percentage of monies recovered, with some rates as high as 50%.

Other agencies, however, charge a flat fee, with rates as low as \$10 per account. The advantage to the percentage-of-fee basis is that it gives the collection agency a financial incentive to collect, and ensures that doctors won't pay anything if the agency is unsuccessful.

However, a percentage fee basis typically results in doctors paying much more when the collection agency is successful. Conversely, the flat fee arrangement generally costs less, but rewards an agency for bringing in accounts rather than actually working them. The downside to the flat fee arrangement is that physicians run the risk of paying for a service that does not guarantee, or in many cases, does not produce, results.

Additionally, collection agencies have no ability to compel patients to pay. They can call and write letters, but have no legal means to extract payment from patients unwilling to settle their accounts.

WHEN TO USE AN ATTORNEY

Attorneys can do what collection agencies cannot: file lawsuits against debtors, get legal judgments, and in certain cases, levies on assets and wage garnishes. Rather than waiting until a collection agency fails to produce results, sometimes it makes more sense to refer an account directly to an attorney.

In cases where patients deposit (and possibly spend) checks meant for their doctor, involving an attorney right away helps the doctor preserve his or her right to compel the patient to pay the money owed and reduces the risk that the patient will dissipate the funds.

Doctors need to consider fee arrangements when dealing with attorneys. Attorneys paid on an hourly basis have no economic stake in the debt. Moreover, paying an attorney on an hourly basis risks paying legal fees on debts that ultimately are not collectible.

However, while contingency fees may provide the attorney with an incentive to collect, and ensure that the doctor does not pay if no money is collected, physicians usually pay significantly more on accounts where money is recovered.

DON'T JUST WRITE IT OFF

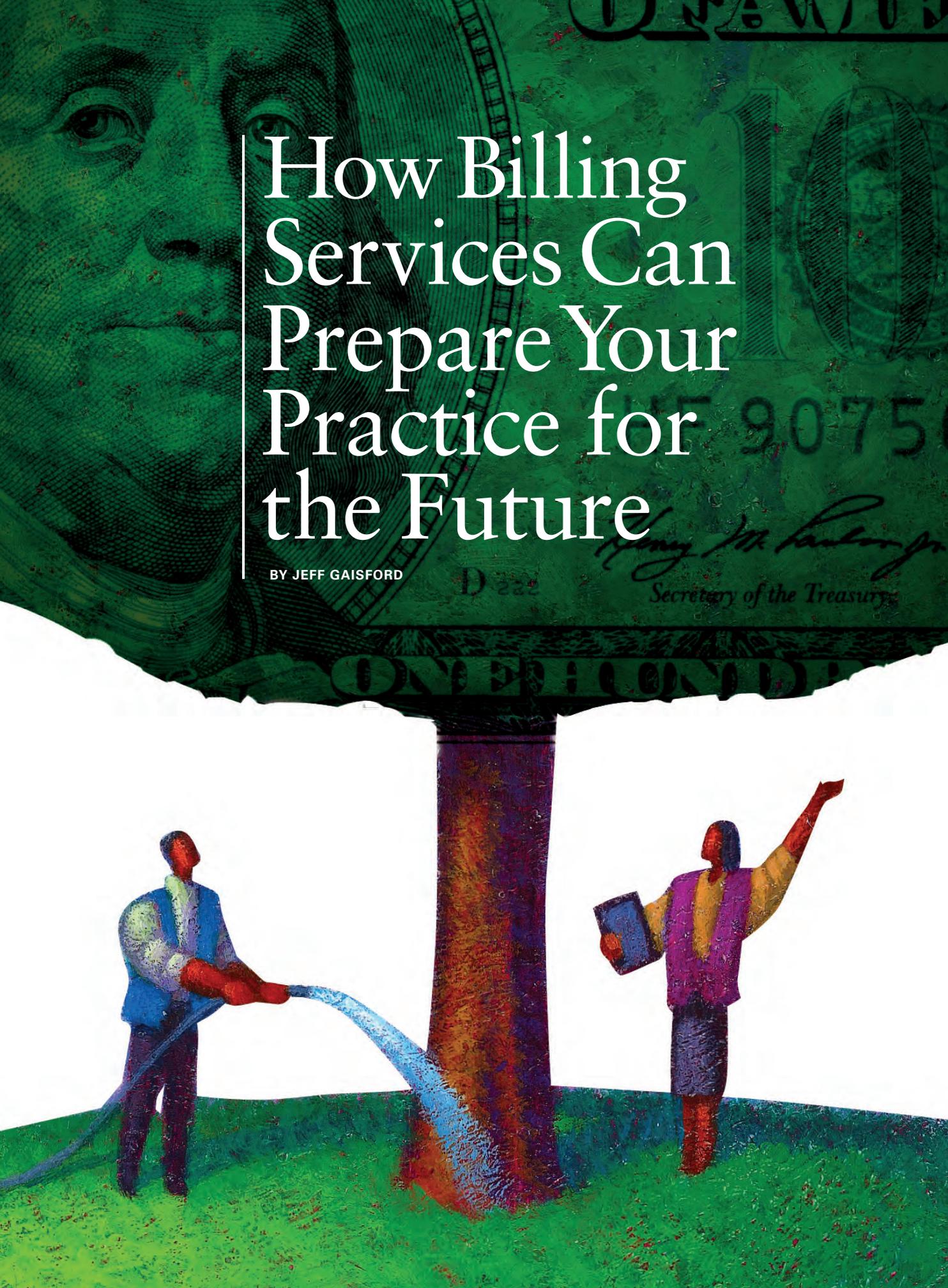
Doctors, like other professionals, have a right to be paid for their services. From internal billing personnel to collection agencies to attorneys, you have options, and if you manage your accounts properly, you can efficiently and (almost) painlessly bring in money that you thought would never materialize. ■



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How Billing Services Can Prepare Your Practice for the Future

BY JEFF GAISFORD



With all the changes in healthcare, it can be difficult for your medical practice to keep up on regulations, mandates, and other initiatives that will affect your bottom line. These changes include the transition from ICD-9 to ICD-10 codes, a shift from traditional fee-for-service models to value-based models, and updates to the Affordable Care Act.

Medical billing services can be your partner during the changes recently enacted and those ahead. Here's how.

EASIER AND SUCCESSFUL ICD-10 TRANSITION

After the move to ICD-10, "86 percent [of physicians] indicated ICD-10 having an impact on patient care," according to a recent [SERMO poll](#). By now you should have a good idea if your practice's transition went smoothly or not. If you're experiencing any issues or rejections, using a medical billing service can immediately solve some of your issues without the need to hire additional coders or make costly software upgrades. Even after the transition, 68% of providers said that ICD-10 conversion is an area that still needs to be addressed, according to peer60's [Healthcare Revenue Cycle Management: 2015](#) report.

PREPARE FOR VALUE-BASED REIMBURSEMENTS

Get back to doing what you care about and focus on patients rather than dealing with billing. According to a [press release](#) by the U.S. Department of Health & Human Services, we are starting to shift away from traditional fee-for-service (FFS) models to value-based models with more emphasis on patient performance. Now is the time

put the focus back on patients. Using tools and services that produce an integrated environment within your practice is shown to have greater patient engagement. One key patient experience benefit that comes from medical billing services is an easier bill paying process for the patient. Having systems in place to make paying a bill as painless as possible for the patient is a must when every dollar counts.

THE CONGRESSIONAL BUDGET OFFICE NOW PROJECTS MEDICARE ADVANTAGE ENROLLMENT WILL REACH 22 MILLION BENEFICIARIES BY 2020, MORE THAN DOUBLE THE NUMBER PROJECTED SHORTLY AFTER THE AFFORDABLE CARE ACT WAS ENACTED IN 2010, NOTES THE KAISER FAMILY FOUNDATION; CURRENTLY THAT ENROLLMENT IS AT MORE THAN 16 MILLION.

REACTIONS TO THE AFFORDABLE CARE ACT

The Affordable Care Act added a lot of new rules and regulations to processing medical billing claims, and with that, came confusion for billers. If your practice has in-house billing, these changes have added even more headaches. Using a medical billing service company, who is already prepared for these changes, can alleviate any confusions and more importantly, errors.

Another outcome of the Affordable Care Act has been a boom in

health insurance enrollment since it requires individuals to obtain coverage, as reported by [Medical Billing Advocates of America](#). This will increase the total number of claims being processed, resulting in a higher demand for billing staff. A medical billing service can help alleviate these added costs and human resource needs.

CONNECT REIMBURSEMENT TO QUALITY CARE

The move to value-based reimbursement that will occur over the next few years will cause issues in the beginning as practices start focusing on quality goals. As stated by [HealthCatalyst](#), "the switch to value-based reimbursement has turned the traditional model of healthcare reimbursement on its head."

Small to medium-size practices are less prepared for these goals and need the expertise provided by medical billing service vendors and accountable care organizations (ACOs), which handle both payment and care requirements, [Healthcare IT News](#). During this time, it is also important to make sure the quality care incentives are connected to the reimbursements and you are getting paid. Software and billing solutions are available from medical billing service companies to help with these incentives and as the importance of quality care continues to rise, these solutions will only become more necessary as time goes on. ■



Jeff Gaisford is a sales leader at [ChartLogic](#) with more than 10 years selling and leading

teams in complex technologies. Gaisford has educated and assisted medical professionals in the benefits of healthcare IT and billing services. He can be contacted jeffgaisford@chartlogic.com.

Medical Billing Services Bring EMR, PM & Revenue Management All Under One Roof

Practice Profile

Name: Advanced Orthopaedics & Sports Medicine

Location: Casa Grande, AZ

Specialty: Orthopaedics/Sports Medicine

Locations: 1

Physicians: 1

ChartLogic User Since 2011



Advanced Orthopaedics has been using [ChartLogic Electronic Medical Record](#) (EMR) for four years and [ChartLogic Medical Billing Services](#) for one year. Before ChartLogic, the practice was using another EMR and outsourcing their billing. Dr. Matanky and his staff like many features within ChartLogic such as customizable templates and Document Manager. "We like the specialty-specific templates. For example, we have a fracture template that we use, when patients call in we know exactly what questions to ask them" said Office Manager, Jennifer Gonzales.

Dr. Matanky accesses ChartLogic remotely when he is not in the office, which is quite often since he is in surgery three times a week. This is convenient for the doctor as well as his staff. If the staff needs a note done or needs the doctor to take a look at something, he can access ChartLogic on his laptop at home, on vacation or even at the hospital. A feature of [ChartLogic Practice Management](#) (PM) that the practice enjoys is the automatic eEligibility. "Before we would have to call the actual insurance company every time a patient would check in to see if the eligibility was up to date, and it was a pain and really slowed down front desk down, now it is a click of a button and takes two seconds."

"The billing with ChartLogic is definitely different from our last solution which had a lot of issues trying to get our claims out, I felt like we were doing most of the work for them. We love our claims now, it is way easier!"

*Jennifer Gonzales, Office Manager
Advanced Orthopaedics & Sports Medicine*

Billing Ease with ChartLogic

Using ChartLogic Billing is much easier than when the practice was outsourcing their billing because staff no longer has to double enter information in both programs. According to the office manager, "the billing with ChartLogic is definitely different from our last solution which had a lot of issues trying to get our claims out, I felt like we were doing most of the work for them." Jennifer shares that things are a lot easier for the practice now that everything is under one roof with ChartLogic EMR, PM and Billing, "we love our claims now, it is way easier!"

If patients have concerns or questions about their bill, they can contact ChartLogic Medical Billing Services directly instead of the practice. This prevents slowing down and distracting the front desk; they can spend more time with patients and answering phone calls. The practice utilizes advanced reporting within ChartLogic. "We report on claims and collections for patients that owe us money; we generate these every other week; we really like those reports." These reports have increased collections from where they were before using ChartLogic. Overall, efficiency, scheduling, claims/collection, and time management has improved since Advanced Orthopaedics & Sports Medicine made the switch to ChartLogic Billing and began managing everything under one roof for complete transparency.



SCHEDULE A LIVE DEMONSTRATION

Call us: 888.337.4441

Visit us online: [ChartLogic.com](#)