

Playing the Claims Game

Confusing language, inconsistent enforcement of payment laws, and constantly changing coding requirements have physicians tearing their hair out.

Take steps to minimize the hassles and maximize your payments.

BY SUSAN MEYERS



ILLUSTRATION BY KEN ORVIDAS

WHEN TOM STEELE, MD, AN internist in McMinnville, Oregon, completed medical school and residency training in 1999, he held some very idealistic and altruistic expectations about practicing medicine and helping improve the quality of life for others. However, like many physicians starting private practice, he wasn't quite ready for the reality that would

follow. Before setting up practice with two veteran physicians in the area, he began the credentialing process, then began seeing patients and billing for his services. That's when the headaches began. He found no insurers would process claims until the credentialing process was complete. The claims were going out, but most were coming back rejected or not coming back at all.

It took nine months before he was credentialed by the main insurance company in the area, during which time he received no payment for his services. "It took a full year before I was getting paid enough just to cover my overhead," says Steele. In his first year of practice, Steele provided more than \$10,000 in free care to patients from these insurers. Even after he received credentialing by the necessary insurance carriers, the claim hassles continued. Some were paid, some were partially paid or down coded, and others were not paid at all with insurers saying the claims were lost or simply rejected. After billing, tracking down unpaid claims and refiling them, Steele figures it cost him an average of \$30 to \$50 to bill and follow each claim through the insurance system. "I was working the first three days of each week just to cover my overhead," he says.

It's not a new story to Jim Rohack, a cardiologist in Temple, Texas, and the chair of the American Medical Association (AMA) Board of Trustees. "These are the things physicians are not educated about in medical school or residency training programs but can make or break a successful practice," he says. It's also an issue that has received the attention of the nation's lawmakers the last few years.

Prompt payment legislation has been passed in 49 states and the District of Columbia as of August 2004 with the goal of stemming payer abuses and giving physicians an avenue for redress. Only South

Carolina has no legislation to date. Most prompt payment laws require payment of claims within 30 to 45 days, however deadlines vary from 15 days to 60 days. Payment past the deadline can result in penalties levied against the insurance carrier. While physicians are seeing improvements, the effectiveness of the laws varies from state to state. "Prompt payment laws are only as effective as to how clearly they are written and how well they are enforced," says Rohack. "Enforcement is now the weak link. States that have passed the strongest laws with regulations related to fairness, transparency, and openness have seen the greatest improvements."

The prompt pay movement

The movement toward prompt payment legislation began in the late 1990s, spearheaded by the AMA at both the state and national level. Since 1998, state medical societies—in conjunction with the AMA—have surveyed 25,000 physicians nationwide. The results reveal a plethora of problems related to billing and collection, including partial pay-

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ment of bills, lost bills, requests for resubmission, payment denial without reason, and requests for additional supporting information.

Billing hassles put a tremendous burden on a physician's ability to practice medicine, says Rohack, who calls the problem an access issue. "Physicians are in the business of providing high quality care," he says. "If they're not getting paid fairly and promptly, they can't provide these services and they may end up having to close their doors."

That's exactly the predicament Steele found himself in. After just two years in private practice, Steele chose to close down the shop and began working for the local hospital emergency department, where he had a guaranteed salary and was freed of many of the billing and insurance headaches he had to deal with in private practice. "I was working 26 to 28 days a month, seeing patients at my clinic during the day and moonlighting at two to three different hospitals during evenings and weekends and still I was only making \$11 to \$13 an hour," he says.

Steele's idealistic view of medicine was shattered. "I thought that if I just practiced good medicine, patients would come and I would be able to make enough money to support my family," he says. "I had to be willing to make a greater economic sacrifice than I was willing to make."

How effective are they?

A survey developed by the AMA's Private Sector Advocacy area and implemented by state and local medical societies questioned 25,000 physicians nationwide. The findings suggest that prompt payment laws

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John Baltz, the chief administrative officer with Internal Medicine Associates in Omaha, Nebraska, estimates that 20 percent of his business office staff time is dedicated to appealing denied claims. "It boils down to a game. ... We might have to bill or contact a carrier up to 10 times for the same procedure before we're successful in getting it paid."

have had some beneficial effect.

Physicians report that most health plans reduced the average of 90 to 120 days they once took to pay a claim. However, the survey found that most plans still fall outside the 15- to 45-day deadline required under state prompt payment laws. Why? Physicians and insurance plans don't see eye to eye regarding what constitutes a "clean" claim—the second half of the prompt payment debate. Even with fines and restitution over the last five years totaling an estimated \$50 million, according to AMA, insurers continue to hide behind the "clean claim" provision and other loopholes of the law and deny or partially pay claims it says are not filled out correctly. The fact is, what constitutes a clean claim varies from one insurance carrier to the next and it's up to the physician or his billing staff to know these subtle differences.

"Tracking down denied claims is a huge burden and expense," says Erik Swensson, MD, a general and vascular surgeon in McMinnville, Oregon, who has been playing the "billing game" since he set up private practice in 1998. In the process, he has come close to shutting his office down on several occasions and has lost three partners as a result of hassles with billing and cash flow. His problems with insurance carriers led him to play a leading role in the passage of a prompt pay law in Oregon.

The claims game

"There is a constant battle with cash flow," Swensson says. He estimates that a small physician office requires two

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HOW TO BETTER MANAGE YOUR CLAIMS



No matter what you do, claims filing and chasing down payment for your services is likely to remain one of the least desirable parts of practicing medicine. You can, however, grease the wheels and increase your chance of filing that all-important "clean claim" from the get-go.

Become familiar with prompt pay state regulations.

Regulations regarding what define a "clean claim," as well as payment deadlines, vary from state to state. Prompt pay rules also may vary among payers. For example, Medicare and Medicaid managed care plans are subject to different rules, while self-insured ERISA plans may be exempt. The appeals process may also include deadlines. Find out if your state has a formal complaint process and report those carriers that repeatedly pay outside the deadline.

Carefully review payer contracts.

Payer contracts will vary considerably from definitions of a clean claim to conversion factors—the rate or percentage of a service the company agrees to pay for a service rendered. Also check for pre-certification requirements, claim adjudication policies and procedures, as well as coding guidelines. Have legal counsel review contracts before signing or renewing them and don't automatically accept amendments. Remember, you don't have to sign bad

contracts. And evaluate continued participation with insurers that have unreasonable denial rates.

Stay informed of coding requirements and changes.

Learn the business end of your practice. No matter how good your office staff is, you are ultimately responsible for the decisions they make. Make sure your office staff is also formally trained in office management and claims processing. If possible, hire certified coders. Take coding courses yourself to ensure you use the appropriate codes to reduce denial rates and become familiar with the CPT code book, which is updated annually. Using the wrong billing code will result in an automatic claim denial. Small offices might also consider hiring a billing service to process claims.

Identify each carrier's provider liaison.

Most insurance carriers have a provider relations office that can help answer your questions and explain rules and regulations. Also, always document discussions with payers, recording the date, name of the representative, and

the issues discussed or resolved. You may need this information later if your state has a formal grievance process.

Request written explanation.

Request explanation for all claim delays, partial payments, and denials, and maintain a follow-up log on all claims delayed beyond state-law specifications.

Report violations.

File complaints with the state insurance commissioner for claims delayed beyond state-required time frames. However, know that many commissioners will only accept claims from consumers. You may have to go through your local medical association to be heard.

Employ technology.

Use billing software systems that track claims and payments and can incorporate insurance carriers' contracted rates. If you don't know how much you're supposed to get paid for a service and you aren't tracking which claims aren't getting paid, prompt payment laws aren't going to be of much help. A denials tracking report can help you determine why your claims are being denied. Some

providers are using systems that automatically generate letters one day past the deadline—and sending them to both the payer and the state. John Baltz, the chief administrative officer for a 17-member multi-specialty group in Omaha, Nebraska, recommends the use of "claims scrubbers" software, which performs a variety of cross-checks before a claim is filed to ensure the claim includes the proper diagnosis, codes, and modifiers as well as the proper documentation specific to that insurance carrier. Baltz expects a recent implementation of a claim scrubber to reduce denials by at least 50 percent.

Use resources.

The AMA has developed a variety of resource kits to assist physicians in the prompt payment and processing of claims. These kits include detailed steps to prevent abusive payment tactics as well as the Claims Management Resource Kit which has step-by-step guidelines on how to prepare a claim, how to follow it through the claim filing process, how to appeal it and track it through the claims denial process, and how to select billing software vendors. Visit www.ama-assn.org/go/psa ■

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full-time office people per doctor to sift through the billing process. "That's a huge drain on the entire health-care system," he says. "Solo practice is now a rarity because physicians can't survive the game of claims and malpractice."

Swensson refers to a March 2003 survey of physicians by researchers at the University of Albany in New York that found that only three percent of residency and fellowship graduates planned to seek solo practice upon graduation.

John Baltz, the chief administrative officer with Internal Medicine Associates, a 17-member multi-specialist group in Omaha, Nebraska, estimates that 20 percent of his business office staff time is dedicated to appealing denied claims, which average about 16 percent of all claims his office submits. "It boils down to a game," he says, "and the insurance carriers are the judge and the jury. If the insurance company denies a claim, it is our responsibility to find out why. Then we have to resubmit additional documentation in paper format. This alone doubles the cost of manpower to prepare the documentation. In some cases, we might have to bill or contact a carrier up to 10 times for the same procedure before we're successful in getting it paid."

Swensson has managed to survive through creativity and ingenuity. As a solo physician, he requires a staff of four to keep the office

running and cash flow coming in. This includes a receptionist, a medical assistant, a medical coder and a biller. To afford his office staff, Swensson worked out an arrangement with the local medical center in which he "rents out" the billing services of his office staff to other physicians. "I wouldn't be able to afford it on my own," he says.

How bad is the problem? Swensson says that in 1986, he received payment for 98 percent of what he billed. Today, even after haggling with the insurance companies, he is paid for approximately 60 percent of what he bills. The way Swensson sees it, "everybody needs to play under the same rules, but insurance companies claim they are private companies and they can have their own rules."

Inconsistencies in the system

And that's where the crux of the problem lies. The Centers for Medicare and Medicaid have established specific codes and modifiers which physicians are required to use when documenting services rendered. Private insurance companies are not required to use these same codes and/or modifiers and many do not. Therefore, a physician must be familiar with the coding system used by each insurance carrier. These codes and definitions can change at any time without notice. "I deal with 40 dif-

ferent insurance companies," says Swensson. "There's no way I can keep up with all of their rules and changes."

Claims can be rejected for any number of reasons. Some of the most common include: incorrect codes for the procedure submitted, incorrect modifiers, lack of proper information, the procedure not being considered a medical necessity or not warranting additional medical expertise. Depending on the insurance carrier, the reason for rejection may or may not be included in the explanation of benefits (EOB) sent to the physician. It's up to the physician or her staff to track the claim down, contact the carrier, and find the reason for rejection. Of course, then it must be resubmitted, often with additional supporting documentation. "We can spend as long as six months or more trying to get payment for a bill," says Swensson. Two years after leaving private practice, Steele says he still has \$10,000 in outstanding claims.

In addition to documentation headaches, there are inconsistencies in what insurance companies will pay for. "Sometimes [a company] will pay for a procedure and sometimes they won't pay [for the identical procedure]," says Baltz. "It's up to us to find out why. If we don't ask the right question in the right way, we're not given the right answer."

Two sides of the coin

Mohit Ghose, the director of public affairs with America's Health Insurance Plans in Washington, DC, which represents 1,300 insurers and health plans nationwide, says the payment process is problematic for both sides. "The laws are extremely tight," he says. "Ninety-five percent of laws require plans to pay in a 35- to 45-day timeframe from the day the patient receives the service. However, there is no prompt filing component. If we don't receive the claim until day 20, we still have to work within that same time frame."

Swensson disputes this fact, claiming that in most states, the time requirement begins when the insurance company records it has received the claim. In fact, most state laws say the clock starts ticking upon mailing/e-mailing or receipt of the claim.

Ghose also disputes the claims denial rate physicians report. "In 1997, the ultimate denial rate for preauthorized claims was 1.4 percent," he says. However, these were for hospital claims, an apples and oranges comparison with denial rates for physician offices tending to run higher, according to Swensson, who says hospitals carry more clout because of their higher dollar claims. Multiple attempts to get denial rates for outpatient physi-

cian visits were unsuccessful.

"The insurance industry has a two-fold responsibility," says Ghose. "We have to ensure physicians are being paid for their services at the proper rate in a timely fashion. Secondly, from the employer perspective, insurance companies have to ensure they are paying only claims that fall within that contract, and that has been an abuse in the past."

"We're not here to hold onto money," he says. "We have to strike a balance between paying correctly for the right services, for the right contract, and to prevent fraud."

There are scattered efforts to make improvements in the system. The Council for Affordable Quality Healthcare, (CAQH), a not-for-profit alliance of the major health plans and networks, was created in 1999 by a coalition of health-plan CEOs to reduce administrative barriers to claims processing. It has developed a universal credentialing data source program that eliminates the need for doctors to complete multiple credentialing forms.

Electronic claims processing

Electronic claims processing, which many offices now use, is intended to improve the claims filing process, but it's already receiving mixed reviews. New HIPAA guidelines originally required all physician offices and third party

payers to have electronic claims processing in place by October, 2003. However, that deadline has been forgiven and all offices are now expected to at least have a plan in place to institute electronic claims processing.

"There are still pockets of the country that are not using standardized formats, but once providers and third-party claims administrators are all on the same page, things should get much better," says Ghose. "For instance, if a claim isn't clean, it can be sent back to the provider within 72 hours."

However, some providers who are using electronic claims processing say the system has its own set of problems. For starters, insurance carriers may use two to three different billing software clearinghouses that sometimes don't speak the same language. That can result in lost or rejected claims. Secondly, insurance carriers bill the health-care provider a transaction fee for use of the clearinghouse, further reducing the physician's payment for the service being billed.

"Electronic claims have not necessarily had an impact on the claims process," says Rohack. "The only difference is that now we get rejected claims faster." Many states, especially those that differentiate between electronic and manual claims processing, require payment within 15 to 20 days for

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claims submitted electronically.

In the end, change is coming slowly, Rohack says. The AMA and state medical associations are slowly making changes to the system, and “insurers are beginning to recognize that physicians play a very important role in providing high quality medical care,” he says. However, he cautions physicians to stand up for quality care by communicating to patients their dissatisfaction with particular insurance plans. “Eventually these insurers will begin to lose customers.” ■

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