

EFFECTIVE RADIOLOGY CHARGE RECONCILIATION ENSURES LOWEST RISK OF LOST REVENUE

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PHYSICIAN BILLING — PRACTICE MANAGEMENT

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Most radiology practices readily admit that charge reconciliation is an important process to perform in order to prevent lost charges for services provided. Many practices may not be aware that even small miss rate percentages of charges can result in large amounts of revenue loss. If implemented and maintained, charge reconciliation allows radiology practices to improve weaknesses in the process of routing charges from the hospital system to the practice's billing system and in turn reduce risks in lost revenue. Many self managed radiology practices and third-party billing vendors claim 100 percent charge reconciliation, but there are many aspects to consider before this claim can be made accurately. Undergoing rigorous review of patient logs and source documents is necessary for the front-end of the process, while data entry, auditing and reporting are necessary steps in closing the loop on the back-end to ensure the charge reconciliation system is running effectively. To assure 100 percent charge reconciliation, radiology groups must consider automation, Current Procedural Technology (CPT) level auditing, the source of the logs and quality assurance as pieces fitting into a charge reconciliation system that will reduce risks.

CHARGE CAPTURE VERSUS CHARGE RECONCILIATION

In order to explore charge reconciliation, it is prudent to begin with a definition and a contrast to charge capture. Charge capture is simply the act of capturing the charges that are sent to the billing office from the various facilities and inputting these into the billing system. Charge reconciliation is the act of reconciling from a solid facility source log to the billing system to assure all procedures that were performed at the facility were truly entered into the billing system. The reconciliation process is not completed until a second charge reconciliation is performed assuring any missing charges that have been requested have in fact been received and entered into the billing system.

AUTOMATION

Due to its laborious nature, many practices and billing companies do not conduct a full reconciliation but instead conduct occasional spot audits. However, an effectively designed automated process to efficiently identify missing charges frees up labor to focus only on the exceptions. This is why the recommended methodology behind the charge reconciliation process incorporates automation. In an automated process a biller will usually obtain electronic logs from independent sources like the hospital's radiology or IT department, and an automated program will scrub or compare that daily log against what was entered in the billing system.

The most important facet of automation to keep in mind is it allows the biller to only work the exceptions and errors, meaning if 95 percent of the procedures were matched accurately in the reconciliation report, then the biller knows to only work on the remaining 5 percent, which is more effective. A sound automation system will ultimately allow for a biller to work just the exceptions or errors later in the reconciliation process, which in turn removes the human error factor, creates tremendous time savings, and provides greater efficiency in the revenue cycle.

DRILLING DOWN TO THE LOWEST COMMON DENOMINATOR WITH CURRENT PROCEDURAL TECHNOLOGY

It is important that the charge reconciliation process accounts for all billable services performed by radiology providers to the highest degree of specificity based on the source data available. Charge reconciliation tends to gravitate to three levels of specificity: 1) patient, 2) modality plus (+), or 3) CPT.

Specification to the patient level is only based on the patient and date of service. In radiology this method should only be used if this is the most specific level of detail available as this method has the potential for high miss rates. For example, if a patient walks into a radiology practice on a Monday and has two x-rays and an MRI (three procedures total), and the biller only verifies that the patient billed in the billing system matched on that Monday, then the biller has only verified down to the lowest common denominator (the patient) and the practice runs the risk of missing two of the other radiology exams that day. Assuming the above information is gathered to include patient and date of service, then adding the modality with body part or contrast specification would strengthen the charge reconciliation process.

The most accurate approach, and the one with the highest level of specificity, is to perform charge capture to the CPT level. This approach requires identification of each unique hospital billing code, whether it is CPT or some other internal hospital code set. If the hospital utilizes its own code set, each of these unique codes is then cross referenced and linked to the practice's CPT

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codes billed in order to perform charge reconciliation to the CPT level. The following diagram summarizes the three specificities above and highlights any risks associated.

Matching Criteria	Ranking	Risk Area	Example	Result
Specificity #1 Patient and DOS	Adequate	Risk of not identifying multiple procedures done on same day	Patient has 2 exams; CT and MRI. Biller only “matches” patient and does not check that both studies were billed	Lost revenue
Specificity #2 Patient + DOS + modality/body part	Better	Risk of not identifying higher code	CT with and w/o contrast is worth more than just CT with contrast; or 2 view was ordered and 3 view was done	Lost revenue
Specificity #3 Patient + DOS + CPT	Best Practice	Minimal to no risk	CPT transactional comparison = no risk	No lost revenue

KNOW WHERE THE SOURCE LIES

The source of the procedure or audit log is a key factor in the charge reconciliation process. A procedure log should ideally be based on what was performed as opposed to what was ordered, in an effort to avoid false positives. A false positive is defined as a charge that was presumed to be missing from the billing system that is ultimately discovered to have been in the billing system from the beginning. For various reasons and particularly in an outpatient setting, the radiologist may confirm an exam with the primary care physician, and the order may be changed for clinical reasons. A CT head scan with contrast may be ordered, but instead it may be done as a CT head scan with and without contrast. If the log is based off of the order entry system, the procedure will show up on the log as a CT head scan with contrast and when the biller enters it correctly as a with and without it would show up as an error on the reconciliation report. Someone would then need to verify what was ordered versus what was performed. However if the log is based off of what was performed rather than what is ordered, this would not show up as an exception, and time could better be utilized tracking down the actual missing charges.

Another important aspect is to have the log produced from a source outside of the transcription system. The physician dictates procedures, which are usually transcribed by the hospital. If there was a hole in the dictation or transcription process, a biller could be comparing from a faulty log. Getting a log from a third-party source assures a greater commitment to finding out what procedure was done outside of what was dictated.

CLEAN CROSS WALKING HELPS AVOID FALSE POSITIVES

The hospital IT department or the radiology department typically provides a biller with electronic logs that have different

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identifiers in terms of codes and procedures it bills for. Typically this includes the following information: description of the procedure being performed, the patient's name, accession number, date of service, modality and perhaps an internal code. In a hospital setting, an internal code of 2310 might be equivalent to an MRI with contrast, whereas in a biller's CPT setting, the same procedure would be coded as a 74650. These internal hospital codes are initially cross walked to the CPT billing code by the billing specialist and are cross walked on an ongoing basis by the automated system. Often times, a biller will make rules for the codes. For example, a hospital may have two internal codes that point to one CPT code, or the hospital may have an internal code that a biller would not bill for. Since this would not be considered a missing charge, it would be excluded from the billing entry process altogether, meaning there would be no appearance of these codes on the exception report.

If the hospital makes changes to or deletes codes then it will increase the number of exceptions a biller is receiving on a month-to-month basis from the automated charge reconciliation exception report. These are simply false positives that can be avoided by updating the cross walk from the hospital code to the CPT code. The desired goal is to implement a thorough coding process with consistency; often a time-consuming, but needed process of charge reconciliation to assure meaningful and accurate reconciliation that creates as few errors as possible from the start.

TIMING IS EVERYTHING

In order to avoid chasing down missing procedures that are simply delayed, rather than truly missing, a time gap between the date of service and the charge reconciliation process must be included. A typical time gap between date of service and the charge reconciliation process is 45 days. There is a delicate balance between too short of a time gap (which causes false positives) and too long of a time gap (which can cause timely filing issues). For example, if the lag time for the charge capture process is set to 60 days, the missing CPT code or claim must be identified, requested from the hospital, and received and billed in time to meet a possible 90-day timely filing deadline. Typically, 45 days is acceptable due to the hectic schedules of radiologists, the process of obtaining records or addendums, or a need to redo a transcription in order for correct submittal.

QUALITY IS NEVER AN ACCIDENT

Martin Van Buren once said of quality, "It is easier to do a job right than to explain why you didn't." If a quality assurance system shows error rates from the initial exception report that are anything north of 2 percent to 3 percent, then it is important to understand why those errors are occurring. It may be they are systemic errors in the process, meaning a log may not be accurate, or the hospital has added a new code that should be cross walked to a CPT code. Finding the errors in the data and setting up an effective quality assurance scrub from the beginning saves the practice both time and money.

There are, however, pitfalls where the identification and entering of missing radiology studies is concerned. Suppose for example the biller accurately identifies a missing procedure and goes through the process of personally requesting the missing dictation from the hospital, but no one verifies whether or not the dictated report was ultimately obtained and actually billed. Due to this scenario, a second reconciliation must occur to assure all the exceptions have been tracked down and entered into the billing system. The bottom line: it is the doing it that matters. A biller can identify errors and request what is missing, but what is most important is to make sure that what is missing has been verified and entered, which is the true quality assurance piece of the charge reconciliation process. Quality assurance means the process is verified, error rates are looked at, and there is an understanding of why error percentages may have increased so as to compare data and improve. Is it a change in interfacing? Has the hospital changed codes? A monthly error rate analysis is often a part of a thorough quality assurance program, but going beyond finding the errors is the most important quality-related facet of charge reconciliation as it assures optimized revenue.

REPORTING REQUIRES SCRUTINY FOR REMEDIES

The analysis of data and reporting of error rates aligns closely with standard quality assurance practices. Reporting on the practice's charge capture data and error rates is dependent on the scrutiny of three sources of information: 1) "what was billed" log (i.e. the radiology group billing system), 2) exception report trends, and 3) source logs. For example, if errors on inpatient ultrasounds are a pattern that are identified as a revenue gap or hole within the exception process, then a biller can go back to the radiology practice and highlight the service and showcase the data in its analysis. This, in turn, allows the radiology practice and the biller to benchmark all ends of the process and make improvements to problem areas.

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THE THIRD-PARTY ADVANTAGE

With a third-party billing company such as Medical Management Professionals, Inc. (MMP), a practice can be assured that 1) people with the necessary skill sets are assigned to individual segments of charge reconciliation, and 2) advanced automated processes have been put in place. A synergy of people and technology is often the key to assuring 100 percent charge reconciliation is met. For example, one person with CPT and ICD-9 knowledge may only be in charge of working the exception reports. Once a missing report is identified, it can be obtained from the hospital quickly. Third-party billing companies have the ability to efficiently demand and obtain reports once missing exams are detected as they typically have individuals dedicated to this function. Ideally, a report comes back to the person in charge of the manual reconciliation to enter into the billing system. In conjunction with people who have specific roles, it is also important to remember that automation of the process is critical because the human error factor is reduced. Daily logs can be compared and thoroughly scrubbed for accuracy with automation. If a practice's charge reconciliation system is run in-house, it would be wise to make sure there is little room for misinterpretation or mistakes and allow for more time efficiency to work the exceptions.

LOST REVENUE IS RISKY BUSINESS

The ultimate goal of a charge reconciliation program is to lower or eliminate risks on lost charges. The dollar impact of a 1 percent to 2 percent miss rate could result in a significant amount of lost revenue annually for a practice.

Just to drive home the importance of this process, a typical loss rate is about 3 percent, a practice's average collections per procedure and annual volume can be plugged into the following hypothetical scenarios to determine its estimated revenue loss.

A	B	C	(A x B x C)
Annual Volume	Loss Rate %	Collections Per Procedure	Estimate Revenue Loss
50,000	3%	\$42.45	\$63,675
100,000	3%	\$42.45	\$127,350
200,000	3%	\$42.45	\$254,700
500,000	3%	\$42.45	\$636,750

Doing the math might be an exercise in futility if a practice is unsure what it is missing, so assuring the right charge reconciliation pieces are in place is the key to reducing even the smallest risks.

Andrew Casselberry serves as a vice president of operations for the West region of Medical Management Professionals, Inc. (MMP) and is based in Tulsa, Okla. He has 17 years of healthcare experience specializing in all aspects of billing and revenue cycle management including managed care contracting, third-party reimbursement, denial management and process improvement. Mr. Casselberry obtained his bachelor's degree in business management from Gettysburg College, and earned his master's of business administration degree from Loyola College in Baltimore, Md.

About MMP

Medical Management Professionals, Inc. (MMP) was founded in 1993 and is a leading provider of billing and practice management services to radiology groups and imaging centers. It currently serves more than 150 radiology practices with more than 1,600 radiologists combined. MMP's flexible solutions range from billing-only services to full-practice management services.

For additional information please call **1.877.541.9690** or email radiology@cbizmmp.com

