



Optimize Your Billing System: Making Your Changes

By Larry Houghton

Part Three of a three-part series

Focus on getting the biggest bang for the buck.

Make basic changes to improve your billing system and its use. That does not mean that you look only at simple changes. Just address the simplest first in your prioritization.

Look at the entire system with a critical eye and factor in systemic affects. How will one change impact other procedures or users? For example, a change to a dictionary, table or master file may have no impact on data entry but make a world of difference to staff who create and use reports.

In the previous segments of this billing system optimization trilogy, we discussed separating your tasks into *Things to Correct* and *Things to Automate*. Now let's go to the specifics of both.

The most apparent areas to correct relate to dictionaries, tables and master files. Regardless of terminology, these structures are critical to accurate data entry, as they store supporting information about each entry, such as diagnoses, procedures and financial classes. For our purposes we'll use the term dictionaries to encompass all three.

Organizational Structures

The first dictionaries to review are those that reflect your organization's structure. They could be named Group, Department, Division, Billing Area, Location, etc. Again, semantics aside, this set of dictionaries affects data entry and reporting and must be accurate.

Interview your data entry people. They can tell you what they are having problems entering, and, if you can come up with remedies, their supervisors will be glad to share regularly-seen data entry errors. Ask your organization's accounting staff what kinds of journal entries they are making to move money

from one group to another to correct inaccuracies. This feedback will pinpoint required changes.

Devote as much time as possible to the billing system's organizational structure. All detailed elements should flow through the hierarchically superior structure. If you employ a structure or configuration element, such as a coded functionality that works with dictionary fields to ensure accurate data entry of the hierarchy, review this element for outstanding issues.

Financial Class

Financial Class categorizes how and to whom you bill. Rash changes could have a negative impact on billing and categorization of business performed, as well as the contractual adjustments taken and bad debt realized. However, carefully thought-out modifications can result in easier maintenance and a reduction in configuration errors.

Billing and reporting will be improved greatly by being judicious in the way Financial Classes are added. Here are some rules of thumb.

- Each major payer, i.e., Medicare, Blue Shield and Medicaid, and each payer with whom you submit a significant number of claims should have its own Financial Class.
- Smaller managed care payers should be grouped together if there is a mechanism in your billing system for specifically defining each payer within the group; likewise for smaller non-managed care payers.

You must be able to define mailing addresses and other supporting information for each payer or product within a group. For example, Blue Shield in your state may have different addresses for its POS and PPS claims. You can group both products within the Blue Shield Financial Class, but you must be able to identify each address within that class.

If your organization has a secondary Financial Class for each primary, consider creating secondaries for high-volume payers only or categorizing your secondary Financial Classes. When it comes to Financial Classes, fewer choices minimize data entry errors, inaccurately billed services and the resulting delays in payment.

Procedure/Charge Codes

The advantage of dictionaries is that entries are stored indefinitely. So why do so many organizations opt to have the same thing in a dictionary multiple times?

The procedure codes dictionary is the one with which organizations take the most poetic license, sometimes with 10 to 15 entries for a single code. Review the procedure codes dictionary in code order. Separate the Centers for Medicare and Medicaid Services (CMS) approved codes from the custom codes (sometimes referred to as *pseudo codes*). If the custom codes outnumber the CMS codes, find out why.

The majority of your procedure codes should be CMS-approved; however, there are instances when custom codes are necessary:

- Fees are part of the procedure code dictionary and different fees are required in different situations.
- Non-CMS procedures or groups of procedures are defined within the organization and are not included on an insurance claim.
- There is a need to use entry codes instead of the CPT codes during data entry.

Take care with entry codes. It is understandable that some providers receive different codes on their source documents. Work to see if CPT codes can be sent instead of custom codes. Sometimes the fix is as simple as changing codes on a preprinted document.

All CMS codes are five digits; you are inviting problems if you use the same convention for custom codes. Also, do not think that, just because you are an anesthesia billing company, you will never use codes outside of the normal range for anesthesia billing. As your organization grows you could at some point share your system with a billing organization that does go outside of your current range.

Data Entry Modifications

Other areas ripe for optimization are data entry screens and/or questionnaires, where modifications

can speed up manual data entry while minimizing errors. Check with the vendor to see what options are available for changing your organization's data entry screens.

Overall you want your data entry to flow in a logical manner. For example, you could have your data entry screens flow in parallel to your encounter forms, which should be uniform enterprise-wide.

Multiple Points of Entry

If your billing system has multiple points from which users can enter the same information, you want to make each data entry point as similar as possible. If you have a charge suspense system scrubbing charges prior to filing with its own entry point, make sure its entry information is identical to entries entered directly into the system.

Defaulting and Field Flow

In some cases, users enter the same information for all charges that have been batched together for entry. If your system allows for it, have information default in the fields whenever possible. For example, if a user batches encounter forms by department, you want a default to the department when the department field comes up in the flow. Most billing systems have the ability to handle multiple default scenarios.

Field flow is also important. A simple change to the field flow can dramatically improve user performance. Your screens should follow a logical flow as users go from field to field.

Automation

Every organization wants to minimize its manual data entry and processing, and most newer billing systems include tools that allow some functional automation. These tools typically require minimal programming expertise; however, anyone using these tools must have a good handle on the way the billing system works.

There are also a number of industry standard tools to help automate your billing system. Applications such as Digital Command Language scripting and other off-the-shelf utilities allow automation of multi-tiered tasks, and some terminal emulators provide powerful scripting features for non-programmers.

Programmable routines can be as simple as providing a default to a field in a data entry screen or as complex as a program that allows non-programmers to schedule jobs and tasks to run at predetermined times.

Interfaces

Creating interfaces can automate a major part of your data entry process. Incoming and outgoing interfaces enhance efficiency by transporting more information at one time than any number of full time employees could.

The format of an interface (HL7, ANSI X12, print images, delimited text files) will differ depending upon the type of information transported. Know what information is regulated and what is not. Any Electronic Patient Health Information is required to be protected, preferably encrypted, during transmission to or from the originating system. Although summarized financial information is not

regulated, it should still be protected during transmission for privacy purposes.

Now Back to the Big Bang Theory

Of course, you will get the most impact by addressing the higher-ticket, more visible items on the *Things to Automate* list. *The Things to Correct* list will have a more subtle impact on optimization, as users no longer need to work around system deficiencies.

You have two options. Do nothing and keep taking it on the chin for ongoing system-related issues, or systematically review your system and implement appropriate changes. The gain is worth pain.

Larry Houghton is a Beacon Partners Senior Consultant. Beacon Partners is one of the fastest-growing privately-held healthcare management consulting firms, coaching organizations in the development of strategies that are centered on maximizing Enterprise Yield performance. To achieve top levels of performance, an organization must factor strategic direction, physician alignment, economic incentives and overall market impact. Our experience has proven that focus on these critical success factors will strengthen an organization's position in the market and, ultimately, improve the patient's experience with the provider.

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