Improving Your Practice Management Through Outsourcing: Part I—Managed Care Contracting and Billing and Collections

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If you are like most physicians in private practice, you know that running your business can sometimes seem as challenging as practicing medicine. Even if you have supplemented your clinical training with a business degree, you realize that you are dealing with a wide variety of issues that include quality of care, patient satisfaction, financial management, people, and supporting information technology.

My clients tell me that the longer they practice, the more complicated practice management becomes. Managed care companies and government payers continue to impact your revenue in unpredictable and usually negative ways. Patients expect more from their physicians and don't hesitate to say so. You keep operating expenses at a reasonable level by asking your staff to assume more responsibilities. If you are a small practice with 10 or fewer physicians, your practice manager, if you have one, may be deluged with the details of day-to-day operations. The very thought of taking responsibility for special projects that require a new knowledge base may be overwhelming.

You may be able to improve the management of your practice by outsourcing one or more functions that require specialized expertise that you don't have and are unlikely to hire. In this two-part article, I review five functions that you may be able to outsource to your advantage: managed care contracting, billing and collections, information technology, human resources, and financial planning. For each of these areas, I identify the problems that outsourcing may help you address, review the advantages and disadvantages of outsourcing, and offer helpful hints for selecting a vendor or consultant to help you. In this first part of the article, I deal with managed care and billing and collections. In the second part, which will appear in the next number of the *Forum*, I'll cover information technology, human resources, and financial planning.

Managed Care

Let's face it—physicians would be happy if managed care would go away. For the time being, however, managed care is here to stay, and for most practices, it accounts for a very large proportion of practice revenue. Although revenue from managed care contracts is very important for most physician practices, ask any group of practice managers how they handle managed care and you'll get a similar response. Most managers hate it, avoid it, and rarely give it the attention that it warrants given its place as the financial foundation of the practice. Here's what I see on a regular basis.

- Many practices don't know which managed care contracts they have in place, when they last negotiated these agreements, the contract terms, and the financial obligation of the payers. It goes without saying that if you don't know what you have, you can't determine whether or not your situation is good or bad.
- Although North Carolina requires payers to give providers CPT-code-specific reimbursement for the most frequent 30 codes annually (and for the full list of codes upon request), many practices don't ask for this information. If I ask about their reimbursement level, physicians and practice managers tell me they'll check a recent sample of payments by the plans. Unfortunately, that type of check won't tell me if the actual payment matches the expected payment as stated in the contract between the plan and the practice.
- Although many practice management systems have features that compare actual with expected reimbursement, many practices don't recognize the importance of using this function. Well-run practices make this comparison regularly by automatically checking each remittance when it comes in or by running a regular report.
- As one managed care representative said to me, "We generally don't go out and offer to pay physicians more money. If you want an increase, you have to ask for it." There are occasional across-the-board fee increases, but in most cases, physicians must take the initiative.
- Each managed care plan has a unique method of reimbursement. Some plans pay a fixed percentage of Medicare, but not all plans relate this percentage to the same Medicare year. Other plans use proprietary fee schedules. It's difficult to compare reimbursement across plans—unless you know what information you need and how to make the comparison.
- Although one might think that all physicians receive the same amount of money for the same services, that's not how it works. The size of your practice, your location, and your importance to the network in which you participate are all contributing factors.

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Outsourcing your managed care to a consultant who looks at both rates and contract language makes sense for the following reasons.

- Consultants that represent multiple clients have working relationships with the managed care plans. They know whom to call at each plan and how to frame the

request for a rate increase in a way that is most likely to get a favorable result.

- Contract language review is a tedious task. You must review not only the legal agreement, but also information that is contained in detailed administrative manuals and extensive Web sites. Consultants with experience in reviewing and organizing this information into an easily understandable format can save you hours of reading and analysis.
- Depending on your selection of a managed care consultant, you can pick someone who will teach your staff what to do. Once you learn the steps, you can decide whether or not you want to ask the consultant to do all your contracts or teach your staff how to do the work.

I see only one disadvantage with outsourcing managed care contracting. If you engage a consultant that insists on doing all the work for you without teaching you how to do it yourself, you'll set up a dependency relationship that you may not need or want in the future.

If you want to outsource your managed care contracting, here are questions you should ask potential consultants.

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1. What is your experience with managed care contract review and rate negotiations? Consultants vary in their experience. Some have been doing managed care work for many years, and others are relatively new at the game.
2. What kind of practices has the consultant represented? Every practice is different, so look for a seasoned consultant who has worked with practices in your specialty.
3. Is the consultant willing to work with you on some but not all of your managed care contracts? It is important to know what all the plans are paying you, but in some instances, the reimbursement is fine as it is. Some consultants insist that they work on each and every managed care contract that a practice has in place; others are amenable to working on those that the practice believes are the most important.
4. How will the consultant work with your practice? Consultants come in three varieties. "Messiahs" do the work for you; they save the day. Other consultants convince you that you can't get along without them—ever. You are best off with a consultant who fosters a collaborative relationship with your practice. Let the consultant teach you what he/she is doing, and then decide if you want to farm out all of the work or do some of it yourself.
5. How will the consultant charge you for the service? The most common methods for pricing managed care consultation are on an hourly basis or by the project. In my experience as a consultant, it is hard to predict how many hours each project will take. I know the average number of hours I spend reviewing contracts, administrative manuals, and Web sites, but I don't know when I begin a project for a new client how long it will take me to organize baseline information. I also can't predict how many rounds of negotiations will be required to reach a mutually acceptable conclusion.
6. What do references say about the consultant? You can't ask other practices about reimbursement rates, but you can ask about overall results, accessibility, and timely response to your needs. You don't want a consultant who has so many other clients that you don't get the attention for which you have paid. You can also ask the North Carolina Medical Society or your state professional organization for suggestions.

Billing and Collections

You've probably heard the term "revenue cycle management." You need to set your fees at an appropriate level, negotiate your managed care contracts to bring in reasonable reimbursement, and make sure that your billing and collections processes support your efforts. Even if you regularly reevaluate your fee schedules and renegotiate your managed care contracts, the billing and collections portion of the revenue cycle process may malfunction, causing receivables to skyrocket. Here are the problems that I commonly see.

- In many practices, billing and collections is accountable to a practice manager who lacks the experience to supervise the function. Many practice managers began their careers in clinical positions and worked their way up the ranks. If their previous responsibilities never included billing and collections, they may lack the expertise to supervise the billing and collections staff.
- High staff turnover is another common problem. Let's face it; asking for money all day long, primarily over the telephone, can be a frustrating experience. In my years as a practice management consultant, I've met only one collections person who loved what she was doing. In dealing with patients, as opposed to payers, she actually functioned somewhat as a social worker. If burnout in your billing and collections staff is common, it is costly to your practice to repeatedly recruit, hire, and train—over and over again.
- Inability to focus is a common problem. In many small practices, the billing and collections staff multi-task, and they may not focus on the billing and collections aspect of their job with the concentration needed to get the job done. I've seen practices where the billing and collections people are not methodical in the way in which they organize their work. Rather than batch the unpaid claims for a single payer, they call or e-mail about individual claims, dragging out the resolution process.
- Billing and collections staff may lack good working relationships with payers. Payers are more responsive to problems if they are consistently dealing with a single individual from your practice rather than with multiple people.
- Self-pay by patients is becoming more and more important for several reasons. Employers are shifting the burden of health insurance to employees, and some are now opting for health savings accounts. People who are between jobs or are self-employed may have no health insurance at all. Many practices have a long-standing tradition of not asking patients for money, and staff may have trouble transitioning to a different modus operandi that requires payment at time of service.

Outsourcing billing and collections has both advan-

tages and disadvantages. The following are the advantages.

- You may reduce your accounts receivable and bring more revenue into your practice sooner than you are doing now.
- Within your practice, you can focus on clinical care, not billing and collections.
- You'll have access to experts in coding, management, and insurance who will focus on these tasks and not be diverted by other pressing needs.
- Staff turnover and the accompanying costs of recruiting, hiring, and training new staff may decrease.
- As physician owners of your practice, you'll have more, not less control over billing and collections processes than you would if these are dependent on your in-house personnel—who keep leaving.
- You free up space previously taken up by billing hardware.
- You can reduce the number of phone calls about billing and collections that come directly into your practice. Billing and collections companies answer the phone with your practice name, so patients do not think their calls are being diverted.
- You increase the hours of coverage for questions related to billing and collections.

Outsourcing billing and collections can have three disadvantages. You can anticipate and address all of them.

- Your practice manager may be very threatened by the outsourcing of billing and collections. If, however, the decision to outsource allows more time to concentrate on other projects, he/she may welcome the approach.
- Your practice may feel as if it has lost control over its receivables. Indeed you do give up the responsibility for day-to-day aspects of billing and collections, but you don't give away your responsibility to direct your vendor in how the work is done. Here's an example: the vendor sends letters to patients who don't pay, and your practice, not the vendor, should write those letters and decide when to send them..
- As you plan the information technology support for your practice (ie, practice management system, electronic health records—EHR, and/or functional Web site), you should be looking at a practice management system and an EHR system that are integrated (ie, built off the same operating platform). If the vendor that you select for outsourcing your billing and collections uses a practice management system that does not have EHR or that has an EHR system that you do not like, you will limit your choice of information technology applications that appropriately support your practice.

If you would like to explore outsourcing billing and collections, here are questions you can ask potential vendors.

1. Is the vendor independently owned or a subsidiary of another organization? One of my clients that had previously been managed by a hospital and that had bought the practice back ruled out a potential vendor because that vendor was owned by a hospital.
2. What are the vendor's history and future plans?
3. How does the vendor service new clients? Does it add new staff or assign additional clients to current staff?
4. What is the vendor's attitude toward practices of your size and specialty? Some vendors are only interested in large practices, so make sure you ask this question early in your discussions so you can rule out vendors that won't meet your needs.
5. What practice management system does the vendor use? Most vendors will ask you to use the particular practice management software that they use. Some will give you options. One of my clients selected a billing and collections vendor that used the same practice management system that was already in place and found the transition relatively easy.
6. Can you check vendor references and make a site visit to client sites to see how the system works from the client's perspective?
7. Can you visit the vendor's site and meet the staff that will handle your account? I accompanied one client on two vendor site visits. The experience level and professionalism of one vendor clearly outshone that of the other and contributed to the final selection.
8. Check on staffing. Who will handle your account, and what is the staff turnover? Is there a certified coder on site?
9. How does the vendor charge? Some vendors charge a percentage of net collections and others charge a flat monthly fee. What is the fee for software licensing and set-up? What will you spend on hardware and connectivity?
10. Is staff training included in the start-up fee or is it extra? How does the vendor charge for ongoing training?
11. Will the vendor help you clean up past claims, and if so, will this service be included or will there be an extra charge?
12. What is the vendor's target for accounts receivable? You should be able to get targets for percentage of claims over 90 days old and for average days in receivables.
13. Given your particular situation, what financial savings does the vendor expect to produce for your practice?
14. What are the details of the transition process and how long will it take?
15. How frequently will the vendor meet with your practice?
16. What reports will you get on a regular basis? If the practice management system that the vendor uses does not produce clear reports that can help your practice, you may find yourself struggling to understand the financial health of your practice.

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Physician, Protect Thyself!

A North Carolina Physician

I am a physician in North Carolina, board certified in anesthesiology and pain management. I trained at one of the best medical schools in the country and completed an excellent residency program. I served honorably as an officer in the armed services. After coming to North Carolina, I built a successful practice and found a great deal of satisfaction in helping patients with severe pain.

The physician who offers pain management care to his/her patients discovers very quickly that the patients being seen are generally extremely ill. These patients suffer chronic, debilitating pain, and in many cases palliative care is offered where there is no other meaningful care or cure available. The "symptom" of severe pain, which often accompanies trauma or disease like cancer, finally becomes the primary disease, at least in terms of what may be treatable.

"Gradually, I lost sight of those necessary and appropriate boundaries between my personal life and professional life"

We all became physicians in order to help others, to offer care and solace to our patients. Our patients in pain come to us for that help, and they often demand much from their physicians. Often, it becomes difficult for the physician to maintain the clear, definitive boundaries that are so necessary to keep both the patient and the physician healthy and productive.

Neglecting My Own Well-Being

In the area where I practiced, there were few pain management physicians; this is, unfortunately, the case in many counties in North Carolina. Patients, driven by the agony and frustration of unrelenting pain, often seek relief from nonphysicians, or from foreign markets. Most of the time, these "treatments" don't work—the treatment may actually exacerbate the pain—and the patient is forced once again to try another remedy. There is an overwhelming need in these people's lives for some—any—relief from pain.

As a "workaholic," I put no limitations on the demands I made of myself or the demands I allowed others to make of me. I saw patients long into the evening, resulting in excessively long workdays. If there had been 36 hours in the day instead of 24, I could have filled that time with more patients. I had medical staff privileges at two hospitals and saw walk-in patients at both hospitals. I was willing to drive hundreds of miles each week to visit patients; back and forth, between the two facilities daily. In addition, I took call (much of it involving my post-surgical patients) and attended to my busy office practice. I played the role of Superman. When other physicians had cases that no one else could or would handle, I was the "go-to" pain management specialist. The more difficult the challenge, the more quickly I accepted it. I wanted above all to make a difference in my patients' lives; unwittingly, I was setting myself up for a fall.

It was impossible to schedule my days and nights in this way without ignoring my own well-being. Gradually, I lost sight of those necessary and appropriate boundaries between my personal life and professional life. My entire life was out of control, but I was so busy, so tired, so stretched that I wasn't even aware of it. As events continued to spiral more and more out of control, I thought, of course, everything remained under *my* control.

Eventually, my hectic lifestyle resulted in behavior that was erratic enough to attract the attention of a person who, erroneously, reported me to the administration of one of the hospitals as being on drugs. When approached by a North Carolina Physicians Health Program (NCPHP) member, I not only denied the charge but was quite upset that I had been turned in; I certainly was not a user or abuser of drugs! Thank you, NCPHP, but I can handle this myself, I thought. Unfortunately, my way of handling the situation was not to cut my work load or take care of myself personally.

Of course, the fact that I knew I wasn't on drugs didn't keep the gossipers from continuing to talk: my lifestyle was as chaotic as ever, my demeanor just as frenetic, and I'm sure, in hindsight, that I was missing cues right and left that I was being watched. If some of the folks watching me were waiting for me to prove I was taking drugs, it didn't happen. But if they were waiting for me to prove I was in trouble, I gave them all the proof they needed.

In what was an out of the blue scenario for me, I was notified that my staff privileges at one of the two hospitals where I practiced had been summarily suspended. It was felt that I was a serious danger to pa-