Financial Management in Oncology Practice, Part 2: Billing and Collections

You may be leaving money on the table if you undercode your services, but that is just what many oncologists do, generally out of fear of penalties for overcoding. Sloppy billing practices, too, can adversely affect your income. It pays to learn how to code accurately and how to make sure that what you legitimately earned is billed correctly and collected on time.

But even though coding and billing are routine parts of oncology practice, they are not routine aspects of residency and fellowship training. Bimal Patel, MD, a senior partner with a practice of eight medical oncologists in northern California, comments that “most people going into medicine are never told it is a business, and in fact are told that business is a dirty thing.” As a result, he says, many physicians are averse to the concept that what they do is a business.

Do not wait until you are a shareholder in a practice—or hoping to become one—to start learning about coding and billing. “New physicians should use their tenure as an employee to develop skills, to become oriented to what it is going to take to succeed,” Patel says. “They really need to develop a basic curiosity to know what happens in the engine room. If they don’t have that, their financial future is in jeopardy, especially in a competitive market.”

John (Jack) Keech, DO, an oncologist in solo practice in Chico, CA, agrees: “It’s imperative that the physician become educated about practice management and continue that educational process.”

Sign Up for Practice Management 101

So where do you begin? Understanding coding and the requirements of third-party payers is fundamental—so make that a priority. “Take the time to learn coding,” advises Barbara McAneny, MD, CEO of New Mexico Cancer Center in Albuquerque. “Recognize that this is truly your responsibility and it’s you on the line if it’s not done well.”

Some practices rely on staff to assign codes on the basis of the medical record or notes provided by the physician. Experts in reimbursement advise against this, arguing that leaving coding to staff is likely to result in errors and undercoding because only the physician knows what actually occurred with the patient.¹ Keech puts it bluntly: “I think it’s unbelievably stupid for billers to have the responsibility of picking codes; they are not knowledgeable enough about the complexity of medical decision making to determine the code.”

Evaluation and management (E&M) services specified by *Current Procedural Terminology* (CPT) are the backbone of

physician coding. The CPT manual explains in detail the methodology to be used for determining the E&M code for a patient visit or consultation. Three components of your patient encounter are key to determining the level of service, and they must be carefully documented to support that level of service: the nature of the history taken, the physical examination, and the complexity of your medical decision making. Read the E&M definitions in the CPT manual and understand the documentation guidelines issued by the Centers for Medicare and Medicaid Services.

For guidance on codes most frequently used by oncologists, ASCO publishes an extremely helpful book on practice management: *Practical Tips for the Oncology Practice*, now in its fourth edition.² “ASCO’s book is the bible,” Keech says. He suggests that the senior physician and practice manager use ASCO’s book as a reference and educational tool with new oncologists to help them learn the ropes about documenting levels of service.

Practical Tips also provides useful guidance on coding issues common to oncology practice, such as the distinctions between a consultation and a new patient visit, billing for counseling, and how to use prolonged service codes, as well as insurance coverage for clinical trials and coding for specific services such as bone marrow procedures, transplantations, and blood transfusions. Periodic updates are published on the ASCO Web site to keep *Practical Tips* current and up to date.

Numerous online courses and webcasts on coding are also available, and many practice management and consulting firms have useful articles and updates on their Web sites, and also offer instructive newsletters.

In addition to reading on your own and asking your practice manager and senior partners for guidance, go to school. Educational offerings on coding and other aspects of reimbursement and management abound—from seminars offered by your local hospital and your state medical society to sessions at ASCO’s Annual Meeting and numerous workshops offered commercially. Participating in conferences also gives you the opportunity to network with your peers and learn about their reimbursement environment.

The authorization requirements and approved formularies of different payers are other aspects of billing you should learn about. Admittedly, authorization requirements can be frustrating and even infuriating. Patel finds that when young physicians first encounter the processes required for authorization to treat, they often become negative and resistant to the requirements. “They want to be a doctor and

don't want to waste time with it. They think authorization is unnecessary. But somebody thinks it's necessary. Doctors should find out why it exists and ask, 'How do I learn about it? What do I need to know and do to make the process better?'"

McAneny suggests turning to the staff for help on learning which plans require authorization and what drugs are approved. "In an established practice where they've been working with a payer for a long time, the billing and scheduling staff will have it down."

Check Your Productivity Reports

Your practice manager or senior physicians should distribute a variety of productivity reports at least quarterly, with details on the practice as a whole and on individual physicians. The number of new patients and follow-up patients, how many received chemotherapy, the drugs used, and the amount of money collected for each type of service are typical types of data reported.

The variety of reports available is a function of the versatility of your practice management software and what the practice leaders are interested in. "The practice can slice and dice the data to find which codes and activities are more profitable than others," Patel explains. "For example, the reports may show that breast cancer patients are more profitable, given the cost structure and efficiencies of the practice. This analysis can help educate the physicians on how to navigate the business and where to build the practice."

You can use these reports to learn about the business aspects of the overall practice and also to assess your own productivity. "These reports will give you a sense of whether you are efficient or not," Patel says. "If another physician is looking twice as good, ask yourself, 'Am I inefficient? Are my prioritization or delegation skills poor? What's going on here?'"

You should also use these reports to assess your E&M coding pattern. Compare the distribution of your codes with that of your colleagues for each category of patient and level of service. When you are just starting practice, your distribution of codes will not show any established patient visits, Keech points out, and during the first year you will likely have a high number of referrals. But eventually "the coding pattern for each physician should show a mixture of codes reflecting the work in the office," says McAneny. This is something that she, as CEO of her group of nine oncologists/hematologists, looks for.

You should also compare the distribution of your E&M codes to the national averages from Medicare claims (Table 1). Although the average distribution reported by Medicare does not signify coding accuracy, comparing your coding pattern to national data can quickly show you variances that could be

outliers in an audit or reveal a pattern of undercoding or overcoding.

The physician new to practice is not the only one who needs schooling on coding and billing. The CPT manual is updated every year, incorporating new codes and new definitions of some old codes. Medicare rules and managed care plan protocols change regularly, too. Even if you are experienced in practice management, you need to stay abreast of regulatory changes. Participating in educational sessions or subscribing to a management newsletter can keep you current while also helping you garner practice efficiency tips. As Keech says about attending management courses, "You always pick up a little something."

Conduct Coding Compliance Audits

Although comparing your code distributions with those of others can help identify patterns, the only way to determine if your coding is appropriate is to compare it against the clinical documentation in the medical record. Practices should regularly conduct an internal audit to make sure what was billed and what was documented accord with each other and comply with Centers for Medicare and Medicaid Services guidelines, according to Martin Shenk, CEO of Vista Group Consulting in Danville, CA.

For a coding audit, Shenk advises pulling about five charts for each physician and reviewing the patient service and what was coded in the previous 30 days. Select charts randomly, but use a system, such as pulling every fifth or every 10th chart. In an internal audit such as this, do not review your own charts. It is best for a practice to have one individual conduct the coding audit for all physicians, using a standard worksheet or compliance tool developed for the purpose. The person reviewing the charts may be a physician, a nurse, a coding specialist on your staff, or a reimbursement consultant. The audit should be repeated regularly—at least quarterly—to ensure new physicians are learning to code appropriately, to avoid slippage in coding and documentation patterns by experienced physicians, and to ensure everyone stays current with changes in coding rules.

Shenk says that when his staff conducts compliance audits, they review the documentation for chemotherapy, such as the start and stop times for each medication and the nursing notes, as well as E&M documentation. Systematic undercoding is often discovered through a compliance audit, he says. "The argument has always been that if you downcode, no one can accuse you of fraud. But Medicare will whack you with noncompliance for undercoding as well as overcoding, even though no fines are involved. You're supposed to bill what you document—that's the basic rule."

McAneny puts it this way: "You don't want to bill a higher level than the work you actually did, but you can't afford to undervalue it. If you're billing incorrectly, that's fraud. That's

Table 1. Distribution of Levels of Service From 2005 Medicare Claims²

Service	Code	Medical Oncology (%)	Hematology/Oncology (%)
Established patient visit, level			
1	99211	6	7
2	99212	7	7
3	99213	42	41
4	99214	39	40
5	99215	6	6
New patient visit, level			
1	99201	0	0
2	99202	0	0
3	99203	0	0
4	99204	0	42
5	99205	100	58
Hospital admission, level			
1	99221	6	5
2	99222	34	31
3	99223	60	64
Subsequent hospital care, level			
1	99231	24	21
2	99232	54	54
3	99233	22	25
Outpatient consultation, level			
1	99241	0	0
2	99242	0	1
3	99243	0	10
4	99244	42	37
5	99245	58	52
Initial inpatient consultation, level			
1	99251	1	1
2	99252	4	4
3	99253	18	16
4	99254	40	41
5	99255	37	38

a big fine, and jail time, and I haven't met a doctor yet who looks good in an orange jumpsuit."

A coding audit can determine whether variations from national averages in the distribution of levels of service are the result of inappropriate coding or atypical levels of intensity among the patients seen in your practice. The results of the coding audit should be used to fix any problems identified. For example, one physician may have a tendency to inadequately document the patient history, while another may need improvement in documenting decision making. In either case, education about appropriate coding is called for.

Even if your practice has its own coding audit system in place, having it done periodically by a practice management consultant experienced in compliance is a good idea. "I would argue that small practices will benefit from hiring an outside consultant from time to time," says Keech.

Look at the Overall Financial Processes

In addition to mastering coding, a fundamental step in sound financial management is to be sure the services for every patient are billed in the first place. Shenk recommends that the numbered patient charge tickets be checked off against

Sources for Benchmarking Data

- *Performance and Practices of Successful Medical Groups*, published by the Medical Group Management Association: www.mgma.com/surveys, or call 877-275-6462.
- *Practice Management Check Up*, published by the American College of Physicians: www.acponline.org/pmc/new_checkup.htm.
- *Physician Socioeconomic Statistics*, published by the American Medical Association: www.ama-assn.org/physinfo/products.htm, or call 800-621-8335.

the appointment list before the day's work is sent to the billing department. In oncology, more than in other specialties, he notes, you are likely to have patient visits that vary from the appointment schedule, because someone was too sick to come in, or a patient needed to be seen without an appointment. Because of this, a number of checks need to be in place to ensure that a claim is filed for every patient seen.

Drug inventory, too, is important to control. All of the contributors to this article stressed that the amount of an oncologist's revenue that is tied up in drugs—and the decreasing profit margin in chemotherapy—are compelling reasons for oncologists to become involved in oversight of practice finances. Keech notes that the margin of revenue over costs of supplying drugs used in treatment has fallen in recent years to approximately 2% to 3%. "There's still a value in providing in-office infusion, but it used to be a high-risk/high-reward venture, and now it is high-risk/moderate-reward."

The annual cost of drugs averages \$2.4 million per full-time equivalent medical oncologist.³ "With that amount of money involved," Keech points out, "the physician can't NOT be engaged in office management." Monitor drug inventory closely and develop a system to compare the records for every drug order, the drug that was pulled from inventory, and the drug that was administered. Make sure that all three correspond.

Keech reports about a recent change that significantly improved the cost efficiency of drug management in his practice. He discontinued the automatic overnight ordering that was a function of the practice's electronic drug inventory system. With the automatic system, about \$100,000 worth of drugs had been kept in inventory. Now his practice manager orders drugs on the basis of daily order sheets. As a result, less than \$5,000 worth of drugs are now maintained in inventory.

Discuss Finances With the Patient

Financial counseling of the patient is also a part of the practice's financial picture, and part of your responsibility.

This discussion with the patient should include an explanation of the cost of treatment, insurance coverage, the patient's financial responsibility and payment options, and the office policies regarding billing and payments. Such a discussion eases the patient's concerns and paves the way for addressing finances later on, if necessary.

Counseling patients with no or inadequate financial resources and helping them find resources is an increasingly important and time-consuming portion of most practices. Your practice can assist patients in identifying local, state, and national health assistance programs through the Partnership for Prescription Assistance (www.pparx.org).

A staff member may be assigned to have this initial talk with the patient, but as the treating physician you also may need to discuss finances with the patient. A discussion of the costs and benefits related to different treatment options is definitely part of your role, not that of the administrative staff. "For doctors, it's very hard to talk about money," McAneny acknowledges. "We need to get over that. One of the side effects of cancer therapy is what it does to someone financially."

Efficient Billing and Collection Processes

From the appointment scheduler and receptionist to the person who posts payments, sound policies and thorough training are essential to ensure efficient billing and collection operations.

A good billing department starts with hiring—procedures should be in place to thoroughly check references at the interviewing stage. Shenk reports that practices often hire billers who have little experience or who left another practice because they weren't competent. Patel echoes the need for good billing staff support: "Make sure the billing department has the right people who have good experience, and make sure it has the resources it needs to file clean claims on time." Examples of such resources are sufficient numbers of staff, support for continuing education to stay abreast of changes, and appropriate computer tools and training.

The biggest problem Shenk finds in practices he reviews is that the billing staff do not follow-up properly with denials of claims. "In practice after practice, when the claim comes back denied, they just resubmit it. Then it is denied a second time because it's a duplicate claim. After three denials, they can't track why it was denied in the first place." Part of every day in the billing department should be dedicated to denials and fixing problems, he suggests. In resolving a denied claim, as a first step the staff must scrutinize the explanation of benefits to be sure they understand the reason for denial, because different payers use different codes for denial reasons.

An important report for monitoring the soundness of your billing and collections operations is the aging analysis. This

report shows monies owed to the practice. It is divided into categories based on how old the bill is from the date of service: 0 to 30 days, 31 to 60 days, 61 to 90 days, 91 to 120 days, and more than 120 days. The amounts within each category may be divided further by payers, so that you can easily see if you are having trouble with claims submitted to a certain payer. If your aging report shows a significant number of claims that are 90 days old or more, that's a sure sign of inefficiency in resolving denials of claims. Experts advise that the percentage of accounts older than 90 days should not exceed 20%; some say 15%.

Use benchmarks to compare your collection performance with that of other oncology practices. A US survey conducted by Onmark (San Francisco, CA) in 2006 showed that the mean days in accounts receivable for US oncology practices was 35.7 days.³

Tips for Efficient Billing and Collections

Verify insurance information and authorization. The practice should have standard procedures to confirm insurance coverage and verify that the patient has obtained any needed referral. Management experts suggest preregistering new patients by phone because of distractions at the reception desk that can lead to errors. Preregistration also allows the staff to verify insurance coverage with the insurance plan in advance of the patient's first visit.

Confirm accuracy of demographics and insurance. If a preregistration process is in place, ask arriving patients to review the information collected to check its accuracy. At the first visit, copy the insurance card, and make sure the identification number and name exactly match your office record—no nicknames, for example.

Collect copayments and deductibles at time of service. The amount of patient copayments and annual deductibles is rising, adding to the importance of collecting them promptly. Collecting from the patient in person obviates the overhead costs of billing and enhances cash flow. For cancer patients, the services rendered and therefore the copayment amount may not be known until after the physician sees the patient, so set up the process for collection at the end of the visit.

File claims daily. In addition to starting the payment process more quickly, daily billing reduces the effect of a potential submission problem such as a transmission disruption or a lost packet of mail. If claims are batched by the week or

month, such an adverse event could affect a large portion of income.

Submit claims electronically. Electronic submission is the trend, and for good reason. Electronic claims are processed faster than are paper claims, and fewer electronic claims result in denials. According to a 2003 survey by the Health Insurance Association of America (now America's Health Insurance Plans), 97% of physician claims submitted electronically were clean, compared with 89% of paper claims. The processing of electronic claims is faster, too: in a 2006 survey by America's Health Insurance Plans, 69% of clean electronic claims were processed within 7 days, compared with only 29% of clean paper claims.

Use an electronic claims scrubber. A number of software products and online tools are available that will check claims for errors. Some check only for generic errors such as ZIP codes with six digits or a day of the month that is greater than 31, whereas more sophisticated scrubber programs check for required prefixes or suffixes in patients' insurance identification numbers and have edits to check compliance with Medicare's Correct Coding Initiative. Your practice management system may have a built-in scrubber module that incorporates all of these edits. If it does not, discuss options with your software vendor to find the right add-on program or Web-based service for your practice. If you use a service bureau for billing, find out what its claims-editing software includes. Practices that put effort in submitting clean claims, including using a sophisticated claims scrubber, report achieving denial rates of less than 1%.⁴

Physician Leadership Is Key

Accurate coding, clean claims, efficient billing, informed patients—these are all essential aspects of a financially sound practice operation, and part of the physician's responsibility. "The business of financial management has to be top-down—it can't be driven by the staff," Keech comments.

Today's reimbursement environment is a challenging one—for the patient as well as providers—and one in which oncologists must take control to be successful. "The whole idea of going into private practice is that you want to be owner of your own financial destiny, and you can't be unless you dig in and figure out what it takes to secure it."

DOI: 10.1200/JOP.0846501

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