

Earn Top Billing in Radiology

Improve your accounts receivable management by evaluating these key areas

By Lale White

Health care is a highly complex and regulated industry, and today's radiology managers face numerous challenges in maintaining their fiscal fitness due to the growing complexity of the reimbursement system, their patients' inability to remit copayments or deductibles, reductions in third-party payer reimbursements and the competitive imaging landscape.

The difference between what a radiologist charges and what he or she actually collects is highly variable due to reductions in fee for service, managed care contractual allowances and bundled payments that lower reimbursement. To compound matters, simple billing, coding or collection mistakes can delay payments for claims submitted in good faith, significantly affecting profitability.

As a result, diagnostic service providers need new levels of automation and actionable management information to refine revenue cycle processes, improve cash collections and reduce operational costs. Radiology providers looking to improve billing and accounts receivable management should evaluate themselves for adherence to the following best practices:

Managing by Measurement

The backbone of effective revenue cycle management is access to financial management capabilities that provide total visibility into your revenue and billing systems—from critical business metrics to account and payer details. Radiology providers should look for systems that help measure and manage accounts receivable (A/R) in detail, including the precise calculation of net revenue based on contractual expected price, denial rates and contract compliance, while also enabling decision makers to see the big picture.

Financial reports that detail profitability by individual payer, referring physician and/or modality are essential tools when negotiating new contracts with payers and clients or when determining which areas in which to invest.

Financial management systems can provide access to information about the organization's performance and overall operations, as well as a framework to

measure and act on the information generated by daily processes.

Maintaining Billing Timeliness and Accuracy

To maximize receivables, providers should submit claims for completed services immediately and bill for additional charges at a later date, when supporting documentation becomes available. Billing accuracy can be maximized through the use of automated pre-submission edits to ensure that claims are accurate before submission. It is also important to review all electronic claim rejection reports to determine why a given claim has been rejected, and to actively investigate patterns in rejections. Among the most common reasons for rejections are invalid subscriber ID numbers, demographic errors and/or invalid diagnosis codes.

Automating Decision Making

An automated review process to check claims for compliance issues, diagnosis discrepancies and other possible coding errors greatly improves your chances of submitting a clean claim. This reduces time in A/R, increases receivables and increases your staff productivity. Look for systems with embedded, rules-driven business logic that creates automated requests for information, standardizes workflow and minimizes billing decision-making as much as possible.

Pursuing Proactive Measures

Evaluate software that is updated frequently and automatically checks for third-party payer compliance issues such as diagnosis codes that are not covered or procedures not supported by the diagnosis. It is also important to track changing compliance requirements such as standing order guidelines, disclosure rules, NPI exclusions and evolving standards.



Look for solutions that build compliance requirements into daily workflow and processes with a user-level audit trail, and context sensitive compliance guidance. In addition, medical record documentation is critical to ensure compliance with government and third-party payer billing requirements. Incomplete documentation has been shown to be the single most common reason for payment errors and denials.

Understanding Root Causes of Denials

It is essential to categorize third-party payer denials and to implement a system of tracking and trending denials to identify the root causes (errors and omissions) that most frequently result in denials. Gathering data on the number and dollar amounts of denials by payer can also provide additional insight. The goal is to develop relevant and actionable denial intelligence to understand the most frequent type of denials, top areas of denial by payer, and the root cause for high-value denials to identify where to best focus billing resources to recover revenue.

Using Detailed Financial Metrics

To have the greatest impact on improving your bottom line, routinely evaluate metrics that provide reliable indicators of business performance and billing and revenue cycle health. These include accounts receivable performance, claims submissions and status, and managed care contract performance. In addition, to get the most comprehensive picture of revenue cycle performance and capitalize on the best opportunities for improvement, key performance indicators must be monitored and trended on an on-going basis, and at various phases of the revenue cycle.

For performance metrics to be most meaningful, they should be updated in a near real-time environment and empowered by root-cause drill path analysis if possible.

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