

A FIX

How clearinghouses' Web-based applications can "integrate" your new organization for payers

for multiple database billing

Meet a key challenge of mergers and acquisitions

One of the great challenges of medical practice mergers and acquisitions is integrating the accounts receivable (A/R) billing of the merged groups if you can't immediately initiate all billing in a centralized practice management system. In an ideal world, you'd have plenty of time to prepare for these scenarios and coordinate a smooth transfer. In the real world — in particular, when a hospital or health system acquires a physician practice — lead time is rarely abundant.

In an ideal world, once the acquisition is complete, all billing from the effective date would go out under the tax ID of the new entity and its group billing number (now the group National Provider Identifier [NPI]). If you must continue to use the existing practice tax ID and NPI, then you must acquire the practice's existing A/R to be able to collect for services rendered and have a mechanism to separate the old (acquired) A/R from the new A/R for accounting purposes. This complicates the process if the acquired providers did not participate with the same health insurance plans as the parent group, restricting referrals and integration of the providers.

With advances in technology for practice management systems and greater functionality offered by clearinghouses, especially

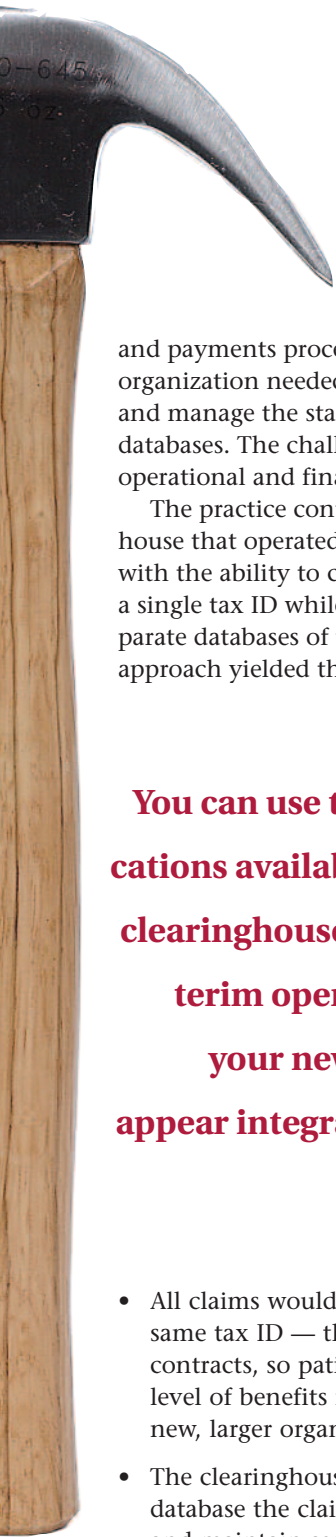
those with so-called "enhanced" claims-management programs, you can get closer to the ideal world while continuing to live in the real world. You can use third-party applications available through some clearinghouses to create an interim operation that allows your new organization to appear integrated to insurance carriers.

Case example: Disparate practice management systems hamper effective billing

Let's look at a case study from the real world. A community hospital created a hospital-affiliated medical group of 20-plus physician practices, bringing together 100 physicians and nine nonphysician providers. The new, enlarged organization continued to run the majority of A/R through the acquired practices' tax IDs. Management of this distributed A/R was obviously difficult. Moving the groups to a centralized practice management system was slowed by the rapid growth of the organization and a limitation on resources (the real world). The disparate practice management systems used by the medical groups could all separate the acquired A/R from the new A/R by creating new "companies" and isolating the charges generated



By Randall S. Shulkin, MBA, FACMPE, MGMA member and principal consultant, Culbert Healthcare Solutions Inc., Woburn, Mass, rshulkin@culberthealth.com



and payments processed, but the expanded organization needed to consolidate data and manage the staff working the various databases. The challenge hampered overall operational and financial performance.

The practice contracted with a clearinghouse that operated a Web-based program with the ability to consolidate billing under a single tax ID while maintaining the disparate databases of the merged groups. The approach yielded three benefits:

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- All claims would be created under the same tax ID — therefore under the same contracts, so patients received the same level of benefits from providers in the new, larger organization;
- The clearinghouse could identify which database the claims were coming from and maintain separate dashboards in the Web-based claims management program. This meant that the receivables-cycle management (RCM) employees who dealt with claims after submission to the clearinghouse could all work from

Prefix codes to patient account number

Prefix	Database	Program
MG	New entity central system	PM A
MF	Midtown Family Medical	PM B
NF	Northtown Family Practice	PM C
SF	Suburban Family Practice	PM D
JS	John Smith, MD	PM E
JJ	Julie Jones, MD	PM F

the same program, consolidating staff and enhancing efficiency prior to software integration.

- The clearinghouse could separate the electronic remittances (electronic explanations of benefits for the ANSI 835 form) for the disparate practice management systems and databases, taking full advantage of this time-saving technology.

To accomplish this, the new medical group needed its practice management system to provide a unique identifier in the claim output file (ANSI 837) that would be retained throughout the life of a claim. The system had to be able to identify which database and practice management system generated the claim. Billing staff chose the patient account number field to create this unique identifier. All of the practice management systems in use at the organization created a unique patient account number for each claim generated (although it might be called a claim number, an invoice number or something else, but it populated the patient account number field in the 837 and CMS 1500 forms). All the practice management systems could assign a two-digit alphabetical code to the patient account number (see table above). The clearing-

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- mgma.com/billing
- Search: “clearinghouses”
- Store: Item 8139 for the MGMA *Performance and Practices of Successful Medical Groups: 2009 Report Based on 2008 Data*; 9001 for the book *Get the Money in the Door: Physician Billing Basics*; 8079 for the book *Physician Billing Process: 12 Potholes to Avoid in the Road to Getting Paid, 2nd edition*
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house would use this system as the basis to identify the source database.

The clearinghouse's Web-based claims management system produced a user-specific dashboard for each database based on the prefix for the RCM staff to view and process rejections and denials. Employees could view these online, make necessary corrections and resubmit claims from the Web site rather than through the practice

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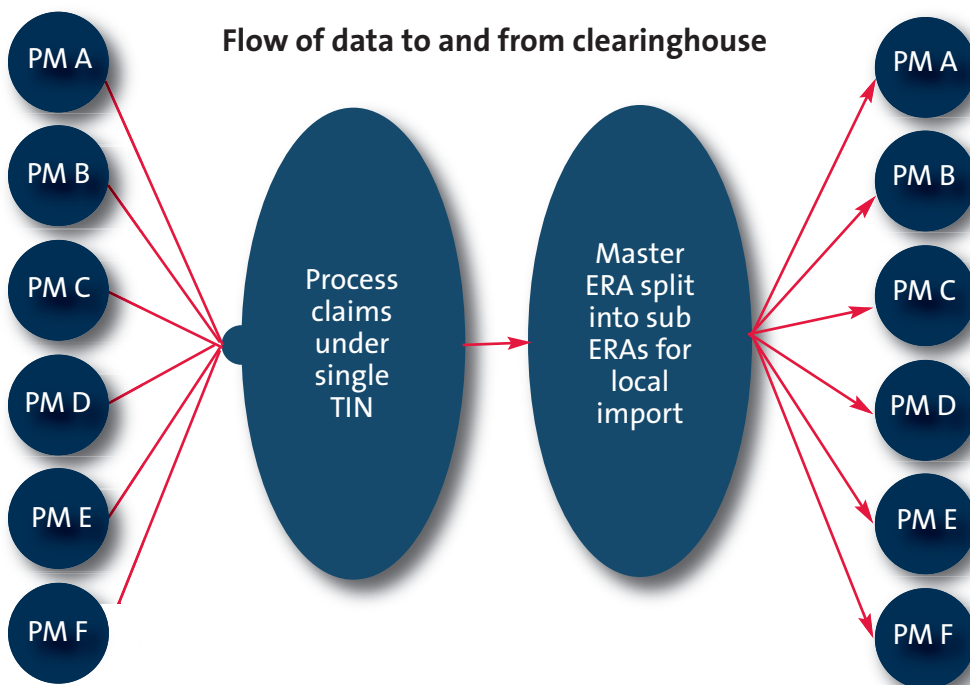
management system. This significantly reduced the timeframe for insurers to accept claims for processing and payment.

The clearinghouse created a daily report that identified changes made to claims so the data-entry staffs working on the acquired databases could update claims information for documentation and reporting purposes. Because the employees involved in claims follow-up — prior to the practices' integration with the centralized practice management system — now worked on a single system, staff consolidation was possible.

Algorithm separates master ERA into its subordinate parts

Because the medical group submitted claims from the disparate systems under a single billing number, the insurance carriers generated a single electronic remittance advice (ERA) for all claims submitted from the multiple databases. The practice management systems could not import this ERA without rejecting a significant number of claims as unpostable payments because each system only handled a portion of the information in each file.

Using the unique prefix code to the pa-



tient account number, leaders in the billing department used an algorithm to separate the master ERA into subordinate ERAs for each of the databases. The practice management systems could then import the payments and adjustments and post them to the correct practice management system without unnecessary rejections.

The clearinghouse also created a consolidated report for RCM management to balance all payments from the original ERA and ensure that all of the subordinate ERAs totaled against the original check and master ERA. In case any claims lost the patient account number, the clearinghouse also created a separate, subordinate ERA for claims that could be printed, researched and posted manually. The diagram on page 48 outlines the basic flow of data from the enlarged group practice to the clearinghouse.

The clearinghouse could provide consolidated reporting to practice leaders. This saved countless hours of exporting data and/or manually entering data to evaluate RCM operations. These reports included all third-party outbound claims because the medical group could submit both paper and electronic claims. The group could now send consolidated electronic statements to patients via the clearinghouse rather than a separate statement from each database because the clearinghouse processed almost all billing data. It also included all inbound electronic payment information.


Future enhancements include importing paper explanations of benefits and lock-box self-pay remittances and converting them to electronic form, allowing all reporting to occur via the consolidated clearinghouse database.

Smaller billing staff, greater efficiency

In summary, this process allowed the new, consolidated medical group to integrate the most complex and labor-intensive components of the RCM process, follow-up of claims with payers and payment posting. Depending on the software and network capabilities of your organization, these disparate systems could be located on your practice's network rather than as stand-alone systems, which would allow the phys-

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ical relocation and integration of staff involved in data entry and payment posting to the central billing office.

At the least, consolidating the operations of billing employees responsible for claims follow-up and providing them with a single Web-based system to process claims and work rejections and denials creates the opportunity to improve staff efficiency. It should also promote employees' satisfaction because their work is more effective. Simply put, you need fewer workers, yet realize the gains of a larger organization — meaning a better bottom line. This process allows complex, growing organizations to maintain a higher level of control during an often tumultuous period of growth. 

join the discussion: Does your organization use a claims clearinghouse with enhanced claims-management capabilities? Tell us at mgma.com/connexion-community or connexion@mgma.com