B2A: Billing Benchmarks for Anesthesiology

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This session will provide you with the knowledge to:

- Identify which billing components to monitor – accounts receivable, date of service, and date of entry revenue per care/unit
- Determine the available resources for benchmarking anesthesiology
Benchmark – Origin

Wikipedia

The term **bench mark**, or **benchmark**, originates from the chiseled horizontal marks that **surveyors** made in stone structures, into which an angle-iron could be placed to form a "bench" for a **leveling rod**, thus ensuring that a leveling rod could be accurately repositioned in the same place in the future. These marks were usually indicated with a chiseled **arrow** below the horizontal
We will look at benchmarking from the point of view of the anesthesia practice and its owners and management – Not the internal or external billing operation.
Benchmark Definition

• A standard of excellence, achievement, etc., against which similar things must be measured or judged

• Any standard or reference by which others can be measured or judged.
Anesthesia Billing Benchmark Examples

• Days in A/R < 38
• % A/R over 120 days < 8%
• Bad debt < 5%
• Net Collection Ratio > 97%
• Clean Claims > 95%
• Pay per 15-minute unit > $40
Anesthesia Billing is Unique

- Virtually no up front payments
- Patient faced with large bills from other providers
- All large bills compared to office based
- Dependent on facility for demographics and verifying eligibility
- Delays receiving documentation
- Non-profit hospitals accept no insurance or patients not yet Medicaid qualified
- Patients don’t remember provider
- Patients seen once – no incentive to pay quickly
Anesthesia Benchmarks are Unique

Compared to many other specialties:

• Bad debit greater
• A/R days greater
• CRNA split charges can inflate A/R
• Many “unclean” claims due to bad hospital demographics
• Patient A/R greater due to slow payment from greatly indebted patients
• CRNA credentialing problems increases A/R and A/R days
What Can Be Benchmarked

- Practice Revenue
- Staffing Costs
- Physician Production
- Physician Compensation
- CRNA Productivity
- Billing Operation Internal Productivity
- **Billing and Collections**
Intertwined Benchmarks

• Anesthesiologist Production:
  ✓ Cases, Units, Minutes, Charges

• Billing and Collection Performance:
  ✓ A/R, Net C/R, Gross C/R, Days in A/R,
  ✓ Bad Debt, Days to Bill, Clean Claims %,
  ✓ Collected per Unit

We must separate production effects from billing and collection performance
Sources of Benchmarks

• Industry Standards (MGMA, etc.)
• Internal Historical
• Internal Subunits (facilities)
• Set Goal
Source of External Billing Benchmarks

- MGMA
  - Cost Survey – Single Specialty
  - Cost Survey for Anesthesia & Pain
  - Above in print or MGMA Data Dive
  - MGMA Performance and Practices of Successful Medical Groups

- AMA
- HFMA
- HBMA
- Vendor Publications
- Your Outsourced Vendor
## Benchmarking resources

**USE THESE RESOURCES TO EXPAND YOUR BENCHMARKING EXPERTISE.**

<table>
<thead>
<tr>
<th>What is benchmarking?</th>
<th>Benefits of benchmarking</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benchmarking is comparing performance to industry standards.</td>
<td>By conducting periodic benchmarking, you can track your progress and keep your finger on the pulse of the industry. You can assess and compare performance metrics such as:</td>
</tr>
<tr>
<td>• It helps you understand how your physicians and your medical practice perform compared to similar practices.</td>
<td>• physician compensation</td>
</tr>
<tr>
<td>• It’s one of the first steps in evaluating provider and organizational performance and one of the best ways to identify problems and opportunities for improvement.</td>
<td>• productivity</td>
</tr>
<tr>
<td></td>
<td>• number of patients</td>
</tr>
<tr>
<td></td>
<td>• staffing</td>
</tr>
<tr>
<td></td>
<td>• revenue</td>
</tr>
<tr>
<td></td>
<td>• operating expenses</td>
</tr>
<tr>
<td></td>
<td>• accounts receivable to industry standards</td>
</tr>
</tbody>
</table>
Additional Sources of Billing Benchmarks

• State or local anesthesia organizations
• Your facility with “best practices”
• Informally through colleagues
• MSO or divisions within PWOW
• MYOBM
External Benchmark Barriers

- Benchmarks are usually subject to copyright laws
- Membership and/or survey participation required
- Cost
- Need to replenish at least annually
Applicability of External Benchmarks to Internal Measurements

- Apples to apples
- Check math and assumptions
- Time periods must match
- Internal data must be accurate
DOS vs DOE vs DOD

• Billing reports usually done by date of entry

• Delayed or accelerated transaction entry can alter benchmarked measures

• Payments should be reported by date of deposit to match financial & banking

• Production reports should be done by date of service
Benchmarking CRNA/AA Billing Issue

Medical Direction Split Billing “Inflation”:
Some billing entities and PM software enter QK and QX charges in A/R at > 50% each (units and minutes also doubled)

Introduces problem of benchmarking payers with “inflation” vs. payers w/o
Reasons to Use Benchmarking

• Independent Validation of Your Operation
• Timely Identification of Problems
• Monitor In-House or Outsourced Billing (include benchmarks in billing contract)
• Set Future Goals
• Modify/Improve Processes
• Alternative to Expensive Payment & Performance Auditing
• Meaningful Reporting to Practice Owners
Impediments to Benchmarking

• Expense of benchmarking publications and organization membership

• Time to assemble benchmarked measures

• Management does not understand or disregards comparisons

• Inapplicability of external benchmarks to this practice
Benchmarking Issues to Resolve

• Many external benchmarks are too general to be applicable to a specific practice

• Which %ile or median or mean to use?

• Many benchmarks are useful only if reported by payer category
Why Benchmarking is More Important Now

- Payer Resistance
- Pressures from Hospitals for Efficiency
- Expenses and Salaries Rising
- Need to Document Billing Performance for Owners and Stakeholders
Where Should Benchmarks be Reported?

• Billing reports, if billing entity will cooperate (for example, place MGMA A/R benchmarks at bottom of aged A/R report.)

• Management reports summarizing billing performance

• Dashboards
Steps to Provide Benefit from Benchmarks

• Select the measures/indicators you want to benchmark
• Acquire external benchmarks.
• Produce current billing reports
• Compare benchmarks and current measures
• Analyze and explain significant differences and trends
• Determine source of deviations
• Take corrective action, when necessary
Anesthesia Measures to be Benchmarked

• Billing delay – Number of days agreed by practice to wait before billing to payers plus unanticipated delays
• Percent of charges held for credentialing
• Percentage of “clean claims”
  o This needs to be defined and reported by your billing provider. Possible definition: percentage of cases on which some payment was made within 30 days of initial filing
• Percent denials by denial category and payer
Anesthesia Measures to be Benchmarked

• A/R Days (aka: days on books, days in A/R)
  o Current A/R divided by average daily charges measured over last 3 months

• Net Collection Ratio
  o Payments divided by gross billing less adjustments

• Bad Debt % – Gross
  o Bad debt write-offs divided by gross billing

• Bad Debt % - Net
  o Bad debt write-offs divided by gross billing less adjustments
Anesthesia Measures to be Benchmarked

• Coding accuracy – percentage of claims paid without being recoded.
• Bill frequency – days between patient bills after first bill
• Days to pay initial clean claim by payer category – this measures the speed at which payers pay clean claims and should stay at a low (benchmarked) constant level
• Credit balances > 60 days
• % of receipts via ACH
<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>25th %ile</th>
<th>Median</th>
<th>75th %ile</th>
</tr>
</thead>
<tbody>
<tr>
<td>A/R 120+</td>
<td>16%</td>
<td>10%</td>
<td>9%</td>
<td>12%</td>
<td>22%</td>
</tr>
<tr>
<td>Re-aged 120+</td>
<td>18%</td>
<td>14%</td>
<td>8%</td>
<td>11%</td>
<td>26%</td>
</tr>
<tr>
<td>Not re-aged</td>
<td>16%</td>
<td>8%</td>
<td>10%</td>
<td>13%</td>
<td>21%</td>
</tr>
<tr>
<td>Days gross in A/R</td>
<td>52</td>
<td>56</td>
<td>40</td>
<td>50</td>
<td>61</td>
</tr>
<tr>
<td>Gross Collection %</td>
<td>44%</td>
<td>10%</td>
<td>40%</td>
<td>46%</td>
<td>50%</td>
</tr>
<tr>
<td>Net Collection %</td>
<td>88%</td>
<td>15%</td>
<td>68%</td>
<td>93%</td>
<td>98%</td>
</tr>
</tbody>
</table>

See Survey Instructions for Definitions
### Laden Benchmarks 2014

<table>
<thead>
<tr>
<th>Benchmark</th>
<th>Value</th>
<th>Period</th>
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<tbody>
<tr>
<td>Days in A/R</td>
<td>38</td>
<td>Monthly</td>
</tr>
<tr>
<td>A/R &gt; 120</td>
<td>8%</td>
<td>Monthly</td>
</tr>
<tr>
<td>Gross C/R *</td>
<td>25%</td>
<td>Trail 6 Months</td>
</tr>
<tr>
<td>Net C/R</td>
<td>85%</td>
<td>Trail 6 Months</td>
</tr>
<tr>
<td>Bad Debt Gross</td>
<td>5%</td>
<td>Trail 6 Months</td>
</tr>
<tr>
<td>Bad Debt Net</td>
<td>12%</td>
<td>Trail 12 Months</td>
</tr>
<tr>
<td>Billing Days Lag</td>
<td>7</td>
<td>Monthly</td>
</tr>
<tr>
<td>Clean Claims %</td>
<td>95%</td>
<td>Monthly</td>
</tr>
<tr>
<td>% Electronic</td>
<td>85%</td>
<td>Monthly</td>
</tr>
<tr>
<td>% Not Credentialed</td>
<td>0%</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

* Split billing
### Benchmarking by Payer Category

<table>
<thead>
<tr>
<th>Current Actual</th>
<th>% Charges</th>
<th>Days in A/R</th>
<th>A/R &gt; 120</th>
<th>Gross C/R *</th>
<th>Net C/R</th>
<th>Bad Debt Gros</th>
<th>Bad Debt Net</th>
<th>Bill Days Lag</th>
<th>Clean Claims %</th>
<th>% Elect.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>40%</td>
<td>24</td>
<td>3%</td>
<td>19%</td>
<td>99%</td>
<td>3%</td>
<td>6%</td>
<td>10</td>
<td>97%</td>
<td>100%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>8%</td>
<td>55</td>
<td>12%</td>
<td>12%</td>
<td>97%</td>
<td>4%</td>
<td>4%</td>
<td>7</td>
<td>78%</td>
<td>100%</td>
</tr>
<tr>
<td>Bad Shield</td>
<td>17%</td>
<td>40</td>
<td>7%</td>
<td>45%</td>
<td>95%</td>
<td>7%</td>
<td>12%</td>
<td>7</td>
<td>94%</td>
<td>97%</td>
</tr>
<tr>
<td>GoodCare</td>
<td>15%</td>
<td>15</td>
<td>4%</td>
<td>65%</td>
<td>99%</td>
<td>5%</td>
<td>10%</td>
<td>7</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>Private OON</td>
<td>15%</td>
<td>52</td>
<td>12%</td>
<td>85%</td>
<td>N/A</td>
<td>12%</td>
<td>N/A</td>
<td>7</td>
<td>88%</td>
<td>65%</td>
</tr>
<tr>
<td>Self, No Ins.</td>
<td>5%</td>
<td>96</td>
<td>35%</td>
<td>8%</td>
<td>N/A</td>
<td>45%</td>
<td>N/A</td>
<td>12</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td><strong>NET</strong></td>
<td><strong>100%</strong></td>
<td><strong>40</strong></td>
<td><strong>8%</strong></td>
<td><strong>39%</strong></td>
<td><strong>97%</strong></td>
<td><strong>8%</strong></td>
<td><strong>8%</strong></td>
<td><strong>8</strong></td>
<td><strong>89%</strong></td>
<td><strong>89%</strong></td>
</tr>
<tr>
<td><strong>BENCHMARK</strong></td>
<td><strong>38%</strong></td>
<td><strong>38%</strong></td>
<td><strong>98%</strong></td>
<td><strong>7%</strong></td>
<td><strong>8%</strong></td>
<td><strong>8%</strong></td>
<td><strong>92%</strong></td>
<td><strong>90%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

=SUMPRODUCT($B$18:$B$23,C18:C23)/SUM($B$18:$B$23)
Example: Payments Down This Month! Why?

- Lower Charges?
- A/R Up?
- Days in A/R Up?
- A/R Over 120% Days Up?
- Denial % Up?
- Uncredentialed Providers % Up?
- Collection Ratio Down?
- Bad Debt Up?
- Pay per Unit Down?
Developing Internal Benchmarks

• Select measures – e.g.:
  o A/R days, A/R, pay per unit, days to bill

• Produce reports for these measures over time (2 years)

• Examine reports and determine the magnitude of the measure that should be the benchmark for future performance
Setting Goals via Benchmarking

Example:

A/R Days Currently = 38
Benchmark and Goal = 32

This represents a 15.8% reduction in A/R, if achieved.

If we assume that this reduction in A/R results in a corresponding increase in accelerated payments, there should be a one-time, one-month patient revenue increase of 18.8% over time. If sustained and achieved during the calendar year this will increase annual collections by 1.6%.
Benchmarks Help Track Down Fault

- Lower Volume from Facilities
- Doctors holding up documentation
- Billing company not performing
- Certain payers slow or rejecting claims
- Patient percentage of bills increasing
- Payer mix shift
- Clearing house problem
Questions, Comments?

Contact: joe.laden@gmail.com

www.joeladen.com

Thank you and don’t forget to complete your evaluation form.