Flat Rate Per Claim -vs- Percentage Billing Fees

A Devil's Advocate View

Assuming a full service solution, there are basically two methods billing services use to charge for their services, either a percentage of receipts or a flat rate per claim. The vast majority (over 90%) of billing services use the percentage basis to calculate their fees. As you read on, you'll understand why. Typically, the percent they charge is based more on what the market will bear than a number derived from actual analysis. Many physicians choose their billing service based soley on who charges the lowest percent. This would be okay if every billing service 's work ethic and services provided were the same. Billing services are not equal, and to assume all will collect the same amount, in the same time, or offer the same level of service is a big mistake.

Percentage Basis

Generally speaking, billing services charge a percentage of all revenue collected. Depending on the rate they charge, you could still get charged additional fees for patient statements, postage, or other EDI costs like Eligibility Verification or text mesaging.

On the surface, you'd assume a billing service works hard to collect every dollar possible because they get a percentage of it. Right? In fact, they often use the phrase, "If you don't get paid, we don't get paid" to convince you you're getting true value from them.

Percentages typically run between 3% and 8% but can be higher depending upon the type of practice, volume, average claim amount, and other factors. It's very important to realize there's practically no difference in work or costs required to file a $100.00 claim or a $1,000.00 claim, or a $10,000.00 claim. That's why the percentage rate you pay should be less if your claims average higher amounts. The claim amount has no affect on how much a billing service employee gets paid per hour, or while they sit on hold for 15 minutes waiting to talk to a person at the insurance company. Assuming the employee gets paid $20.00 per hour, that 15 minute phone call will cost the billing company $5.00.

Lets consider an example of a billing service charging 6%. If they collect a $1,000.00 claim, $60.00 will be paid to the service regardless of the work required to collect that $1,000.00. It appears the billing service has great incentive to work everything really hard so they make the maximum for themselves, but this is all too often, not the case. Unfortunately, a majority of billing services simply just skim the cream. They get away with it too, because most physicians aren't paying attention and transparency isn't offered.

The easy money is on the majority of claims that pay on initial submission. It costs a lot to go after the others, even to the point of costing more to the billing service than the fee derived. The dollar amount of a secondary claims is much lower than a primary, but the followup costs are the same.

Please follow this example: you file a Medicare claim for $150 procedure where Medicare allows $100. The difference of $50 is written off as the non-allowed amount. Medicare pays 80% of the allowed amount or $80.00. If the patient had secondary insurance, the most you can hope to collect from the secondary is the remaining portion of the allowed amount, or $20.00. If the secondary happens to be Medicaid, you'll probably receive nothing additional. The Medicaid EOB usually says "you already got more from the primary than they would have paid in total". IF the secondary does pay, the billing service collects a whopping $1.20. That barely covers the actual costs to do the accounting. If Medicare automatically crosses over to the secondary, some money is saved, but for other payors, a secondary claim needs to be filed upon primary payment. This will cost the billing service more if they pay the clearing house on a per claim basis. It will definitely cost them more if it has to go on paper. If the secondary doesn't respond, the billing service will certainly spend more than $1.20 in labor following up on the $20 claim, plus, if the claim requires refiling, the costs increase even more. In this example, the billing service looses money following up on the unpaid claim, even when they're successful getting it paid.

So where's the incentive? Theoretically, the billing service should be charging a high enough percentage to cover those tasks which pay little or nothing yet still have an associated cost. Not working the little stuff keeps more money in the Billing Service pockets, but costs the physician plenty. While the Billing Service gets $1.20 on a $20 payment, the doctor gets $18.80 or looses $18.80 if it isn't worked.

Patient statements are another example where billing services loose money. Take the $20 remaining balance for example. Perhaps the patient owes $20 because they have an 80/20 plan, or maybe the front office failed to collect the $20 copay when the patient was seen. On average, it costs the billing service $0.75 to send an electronic statement to the patient, more if they print and mail them internally. If the patient pays the $20, the billing service charging 6% gets $1.20, netting a gross profit of $0.55 from which labor may be still be required to enter the $20.00 into the billing system. If the patient doesn't pay, a second statement costing another $0.75 goes out in another month or so, now bringing the total spent on statements to $1.50. If the patient pays on the second statement, the billing service will collect $1.20 reducing their loss on statements to $.30, but it's still a loss, and that's not counting any labor required pushing the

buttons to get the statements sent to begin with. It's easy to see how they can loose a lot of money sending statements month after month to patients who ignore them as many patients do. If the billing service is smart, they'll limit the number of statements they're willing to send before sending a collection letter, if at all. Collection letters typically cost more than statements.

<u>The moral of this story is don't assume the billing service does everything they should to collect all the money you worked hard for, just because "they get a percent of everything".</u>

Flat Rate Per Claim Basis

There's more than one way to handle flat rate billing, including charging a flat monthly fee for labor, plus postage and EDI fees. We're going to focus our comparison on flat rate billing per claim.

It's difficult finding billing services that offer flat rate because for various reasons, they've never considered it. In their minds, they'd loose out making the bigger money on larger claims when compared to percentage billing. They just can't get their noodle around it. Their systems probably can't track the pieces of work they'd base their fees on. If they can't they tell the difference between a new claim or one that was refiled, are you going to have to pay for refiled claims resulting from their mistakes? Can they tell how many statements they've sent by practice, or how many statements they've sent an individual patient?

Flat rate per claim fees can run from $3.00 per claim to over $10.00 per claim, depending on the level of services provided. At the low end, the fee might only cover filing the claim. You might have to do your own followup and payment posting with these. The higher full service offering would include claim followup, payment posting, patient statements, and maybe an on-line practice management system. Essentially, everything you'd get from any other "full service" offer. Somewhere in the middle, a lower fee per claim might include followup, but then charge for postage, EDI fees, and patient statements.

There are potential problems with flat rate billing services. They get paid when the claim is filed, not when it pays. Percentage billers will tell you "there's no incentive to provide followup on unpaid claims, plus you may get charged again for claims that require refiling." If your billing service doesn't have a high first time pass rate, this could really cost you, not just additional fees, but your cash flow isn't what it could be. <u>While it's possible to save a lot in a flat rate system, if the service doesn't have a good initial claim acceptance rate, or if they don't perform the required followup, you could loose a lot, but this could also be said of</u>

percentage based billing services as well.

Let's take a detailed look at an example of a billing service charging $6.00 per claim and $2.00 per statement, and compare that to the 6% full service example. To gain a real understanding, you may need to read this paragraph more than once, but it's worth it. Lets assume a practice submits 400 claims per doctor per month. Lets also assume a statement ratio 25% of claims. That means 400 claims per month (including secondaries) will result in 100 statements per month (on average). On a monthly basis, 400 claims at $6.00 per claim, and 100 statements at $2.00 per statement would amount to a $2,600.00 fee under flat rate (400x6 + 100x2). The monthly receipts aren't a factor. A percentage billing service charging 6% totaling $2,600.00 would have to collect $43,333.34. If you made the same $43,333.34 from 300 claims and 75 statements, your flat rate fee would result in a sizable reduction to $1,950.00 (300x6 + 75x2) a savings of $650.00! The cost benefit of flat rate billing really shines with practices generating higher claim amounts. If you generated $100,000.00 on 400 claims, you'd pay your 6% billing service $6,000.00 while the flat rate service would still only receive $2,600, saving you $3,400 per month, or $40,800.00 per year. Are you getting it yet?

Another big win for physicians on flat rate basis is they don't pay anything on patient payments! A patient statement only needs to be sent IF the patient owes money. If the physician's office staff does a good job collecting copays or old balances from patients when seen or when making a new appointment, the number of statements required are drastically reduced, saving even more money ($2.00 per statement) for the doctor in our example.

400 claims averaging $250.00 each generates $100,000.00. Anesthesialogists average around $500.00 per claim, gastroenterologists and sleep centers average over $1,000.00 per claim as do most surgeons. To determine if flat rate billing would be a better option for you, you need to know your average claim amount and compare the flat rate per claim to the amount you'd pay on a percentage basis. A $250.00 claim at 6% will cost you $15.00 with the percentage billing company, but only $6.00 under flat rate. On the percentage basis, a $250.00 patient payment at 6% will cost you $15.00, but with flat rate, it's free if you collected it over the counter, $2.00 if one statement had to be sent, $4.00 if two statements were required and so on.

What to do?

Regardless, the most important thing for you do is select a billing service which

will do the entire job, the way it needs to be done, who won't take shortcuts to save them money while costing you. They must approach their role as though the practice was their's, which means all the money is worth collecting. They've got to have a great work ethic.

You must keep regular tabs on your billing service to make sure they're doing the job you expect. With respect to total accounts receivable, most insurance pays in less than 20 days, so the majority of outstanding A/R should be in the 0-30 day column with a decreasing amount in each subsequent 30 day category. Anything in the 90 days or older should be very little if anything. It should also be legitimate and it should be getting worked. If the patient A/R continues to climb month after month, something is definitely wrong and needs investigation. A/R Days should be close to 30, and definitely no more than 45. A/R Days is the average time it takes from date of service to full payment. It should be easy for you to monitor these numbers. Questioning your billing service on numbers which seem too high will go a long way in keeping them down.

Ideally, you'll have access to their system and can pull reports and review individual accounts ANY time you want. All work, including conversations with payors and patients should be documented on the patient's account. It's called "transparency" and if they don't provide it, you shouldn't use them. Ideally, your office staff will use the same system the billing service uses so you're working with the same data the billing service has. Some billing services actually provide you with a full practice management system which allows you to schedule appointments, verify eligibility, or even collect credit card payments. Not all practice management and billing systems are equal. If you get the right combination of system and service, you'll save more than fees. You can increase the efficiency of your office overall, collect more money, and make life easier for everybody. Choose wrong, and the opposite is true.

The majority of billing services don't or can't offer this capability for a number of reasons. Maybe it's because their system can't be easily accessed by their clients if at all. Maybe it cost's them more to provide connectivity, or maybe it's because they don't want you seeing what they're doing (or not doing). Many just want to keep you in the dark to reduce questions and hide their poor performance. Unless this system improves your office efficiency, is it really worth it?