

Medical Billing: In-House vs Outsourced



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Billing is a key component to revenue cycle management. Unless one is in the business of providing free health care, it is impossible to survive without an appropriate billing function. Just sending a make shift “bill,” “invoice,” or “claim form” will not result in successful reimbursement either. Depending on which service line one works in, the billing team will need to know all the service specific rules that many different payors have established.

For a health care business to have an efficient and effective revenue cycle process, one must carefully create and/or manage a good billing process. The following information will help provide one with a general understanding of ways in which health care billing is handled, a billing company or department’s function, and how to appropriately evaluate a billing company or department to ensure the company is the right choice for the business. This document is far from a comprehensive education in medical billing, but it is intended to introduce the reader to this very important subject.

1) In-House versus Outsourced Billing

One of the biggest differences between the business of health care and basic retail business is that payment for services rendered typically come from a third party payor (health insurance), and the payment normally does not occur for several days, weeks, or even months. Due to these variables, the billing and collections process of the revenue cycle in health care typically requires a greater investment of time, money, and manpower. Some businesses are capable of handling this service on their own, while others may rely on outsourced professional billing services.

a. In-House Billing

i. Pros

1. Retaining control – Works best with experienced long term employees who know all the ins and outs. Does not work well with high turnover or employees new to the service line or new to billing.
2. Return on Investment – As long as there is good control over the process, a refined internal workflow and good software systems – can lead to greater return on investment (ROI) long term.
3. Close Proximity – Always much easier to call a meeting or talk in person when billing is in-house versus outsourced.

ii. Cons

1. Higher Costs – Paying salaries and benefits of experienced coders/billers, in addition to buying technology systems, can often be much more expensive than paying an outsourcing company to take on the responsibilities.

2. Liabilities – Billing departments can be hotbeds for embezzlement. Managers must keep a close eye on the process to ensure proper compliance.
3. Support issues – When employing your own staff, the cash flow process can take a major hit when one takes vacation or is out sick for a brief period of time.

b. Outsourced Billing Service

i. Pros

1. Less Expensive – For most businesses, an outsourced billing solution will be more cost effective than an in-house option. Whether the business is a start-up, experiencing staffing transitions, or simply does not have the resources and knowledge to run an efficient billing practice, most cost analyses will demonstrate the outsourced option to be the most cost effective.
2. Transparency – Outsourced billing companies typically have the software programs to provide very detailed performance reports. Since the outsourced firm may have multiple billing accounts, it makes sense for them to invest in such software, versus a single health care practice having to make this investment on their own.
3. Enhanced Consistency – Contractual obligations will hold an outsourced company to a certain standard. Further, there should never be any staffing issues, as the outsourced firm will have a greater pool of employees and other resources.

ii. Cons

1. Hands-off – Management must be able to step back and avoid micromanaging an outsourced firm. This can be difficult to do when companies make a transition from in-house to outsourced.
2. Variable costs – Typical contracts with an outsourced firm contain variable cost structures. For example, one cost may be a percentage of collections. The greater the amount of money collected, the more is paid to the firm. As compared to fixed cost methods, this can make budgeting more difficult.
3. Hidden fees – As with any other contract, be sure to read all of the fine print. Some companies can sneak in hidden fees such as reporting fees, statement/printing fees, and/or customer service fees.

2) Functions of a Billing Service

a. Claim Generation and Submission

- i. There are approximately 40 different fields that can be filled out on a claim form. The fields that are filled out may depend on the payor type, provider type, and services provided. It is critical that the right information is placed in the right spot or a claim may be denied.
- ii. Claims may be routed through several different paths. This may depend on payor type, provider type, and services or items issued. Sending a claim to the wrong clearinghouse will likely end up in a denied claim or at least a significantly delayed payment, both of which affects cash flow.

b. Carrier Follow-up

- i. Due to the large number of variables in the generation and submission of a claim, it is not uncommon to receive a denied claim. When this occurs, it is critical that the billing team understands the denial reasons and quickly resubmits the claim.

c. Payment Posting and Processing

- i. Given that the billing companies are submitting the claims and bills, they often are the ones to collect the payment. Once collected, it is important that the payment is quickly processed and posted to the patient's account. If this is not correctly handled, automatic bills may continue to be sent to the patient, creating issues with the customer relationship.

- d. Patient Invoicing and Support
 - i. In health care, claims typically are first sent to insurance companies. Once the insurance company has processed everything, they will pay per contract with provider and per agreement with their member (insured patient). This normally results in a partial payment of the bill, requiring the patient to pay the remaining balance. The patient will find out what they owe upon receiving an Explanation of Benefits (EOB) from their insurance company and/or by receiving a bill from the medical provider.
- e. Collection Agency Transfer of Services
 - i. The longer a bill goes unpaid, the less likely it is that the provider will receive payment. Therefore, it is not good practice for a billing company/department to continue to try and collect these payments after an extended period of time. A policy should be developed that outlines the process and timeline for when to turn over an unpaid bill to a collections agency. Once the unpaid bill is given to the collection agency, the provider receives partial payment by the collection agency and moves on. Subsequently, the collection agency will engage in efforts to seek full payment.
- f. Credentialing/Contracting Providers
 - i. One of the major benefits of having health insurance is the ability to trust that your insurance company will only have trustworthy and quality medical providers in their network. One way insurers ensure their networks include reputable providers is by contracting/credentialing with individual providers. This process requires an in-depth review of a provider's background to ensure they are credible and high quality medical providers. Due to the resources required to create and manage the contracting/credentialing for multiple providers, this process often is something that an outsourced billing company will take on, with dedicated staff members.
- g. Coding
 - i. The American Medical Association (AMA) has developed a coding set, known as the Current Procedural Terminology (CPT) coding system. There are a large number of health care procedures and services that can be provided across many different health care specialties. Further, there are many different groups outside of the providers that have to understand these services. Therefore, the AMA has essentially created a standardized language that all of the entities will use so that everyone understands what services were actually provided. It is imperative that a billing company / department have staff that has received specialty training in coding for different subspecialties. Due to the large variation of coding practices across different payors and the high frequency of changes in coding requirements, it is not uncommon to see specific coders assigned to physicians or other health care professionals that provide similar services.
- h. Insurance verification and eligibility
 - i. Prior to services being rendered, it is common practice for health care providers to ensure that a patient has active insurance, which he/she claims to have, and verify that the services that will be rendered are a covered service in the member's insurance plan. Some billing companies will have delineated staff committed to ensuring the services provided are covered by the insurance company.

3) Evaluating Medical Billing Services

- a. Level of Service – One will need to determine that the level of service a billing company may provide will be better than what can be provided in-house. Some examples of where this occurs: pursuing denied claims, billing follow-up, complying with regulations, and reporting and analysis.

- b. Industry Experience – The number of years a company has been in business is a key indicator of success, but one must look beyond this as well. For example, if you have a specialty practice such as orthopedics, or even a subspecialty practice within orthopedics, you may want to know what kind of experience and knowledge the billing company has in this area of health care.
- c. Use of Technology – Most outsourced billing companies will have software programs that the billing process will revolve around. The key to these programs being successful is how well the program bridges the gap between the provider and biller. Examples includes:
 - i. How well does the billing service fit with the provider’s electronic health record (EHR) system?
 - ii. Does the service have an integrated EHR?
 - iii. How does the service ensure data security?
 - iv. What are the disaster recovery procedures?
 - v. Is the technology Health Insurance Portability and Accountability Act (HIPAA) compliant?
 - vi. Where is back-up data stored?
- d. Pricing Model – There are three common price models that outsourced billing companies may work under:
 - i. Percentage Based – Charges are applied as a percentage of collections or a percentage of claims processed.
 - ii. Fee Based – Charges are applied as a fixed dollar rate per claim.
 - iii. Hybrid – A mix of percentage based and fee based, depending on the carrier or payor of the claim.
- e. Capacity to accept new clients – Medical billing companies often service multiple clients. Knowing this, it is important that a provider confirm the billing company will have the capacity to dedicate resources and employees to work on the provider’s account. The following questions may help one understand the billing company’s potential capacity:
 - i. Number of employees.
 - ii. Number of existing accounts.
 - iii. Number of accounts of similar specialty.
 - 1. How many providers of a similar specialty?
 - 2. How many claims processed annually of similar specialty?
 - iv. Average number of days in accounts receivable by specialty.
 - v. Average percentage increase in collections by specialty.

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