

Case Study: Collections Decline after Urgent Care Centers Switch from PV Billing® to In-House Billers

Abstract: Are practices able to obtain similar collections results after taking billing processes in house? In order to answer this question, actual collection rates of three practices that transitioned to in-house billing (IHB) are reviewed to evaluate the effect on collections. After switching from PV Billing to IHB, the practices experienced decreased collections of:

- ✓ **Practice A:** \$11 less per patient visit
- ✓ **Practice B:** \$14 less per patient visit
- ✓ **Practice C:** \$28 less per patient visit

Introduction: PV Billing is often asked to cite the benefits of its billing service. Practices that switch to PV Billing typically experience more than a 20% increase in collections. This study was undertaken to determine whether a converse decline in collections would occur after the practices switched from PV Billing to IHB. Since the practices studied continued to use Practice Velocity for software solutions (including billing software), the variable factor would appear to be limited to the persons performing the billing service.

Methods: In order to investigate this question, we did an analysis of collections data taken from three practices utilizing PV Billing comparing collections yielded by:

- ✓ PV Billing and
- ✓ each practice's in-house biller.

In 2006, PV Billing took on **Practice A**, which ran six urgent care centers located in the mid-Atlantic states, when the practice opened a new center. Although Practice A did have their own billing department with six employees and continued to perform IHB for the other five centers, they hired PV Billing to do billing for this one new urgent care center. In October 2007, Practice A decided to bring billing back in house. Results of collections were followed for the subsequent three years.

Practice B has been open for approximately three years; it was a startup urgent care center that began using PV Billing shortly after the center opened in 2009. The practice's initial biller yielded poor results, so the practice switched to PV Billing. Due to low patient volume, however, the clinic struggled financially despite excellent collections per patient by PV Billing. In an attempt to reduce expenses, Practice B took over its own billing in November 2010. Results are limited to November and December 2011 for this practice.

Practice C opened in July of 2008 and used PV Billing from that time until the practice took over its own billing in September of 2009. The practice now uses a biller who works out of their home. Results of collections were followed from the time the clinic opened in July of 2008 until May of 2011.

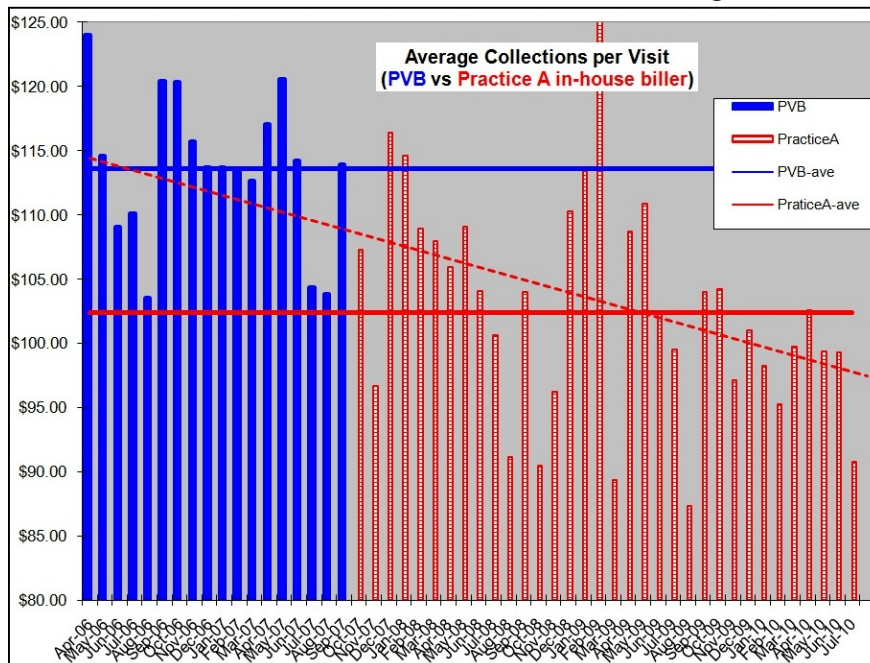
Results:

Practice A:

Four years of data collected from Practice A spanning January 2006 to December of 2009 revealed that Practice A experienced an average decrease in revenue of more than \$11 per patient after reverting to in-house billing. Average collections with PV Billing **exceeded Practice A's in-house biller's average collections 19 out of 21 months**. While Practice A was doing their own billing, **average collections were less than the PV Billing average for 24 of 27 months**. During this time, Practice A transitioned to a new billing director, but results did not improve.

See *Figure 1*.

Figure One



Practice B:

Twenty months of data collected from PV Billing and from Practice B from May 2009 to December 2010 revealed that within the first two months of doing in-house billing, Practice B's average collections per patient declined dramatically. **PV Billing's collections per patient visit averaged \$126 per visit, while Practice B's IHB averaged \$112 per visit.** See Figure 2.

Practice C:

Thirty-four months of data collected from PV Billing and Practice C from July 2008 to May 2011 revealed that average collections plummeted within the first month the practice started doing its own billing. **PV Billing's collections averaged \$132.52 per patient, while Practice C's collections averaged \$104.39.** Over time the data shows that **Practice C experienced an average decrease in revenue of \$28.13 per patient after taking over its own billing.** See Figure 3.

Figure Two

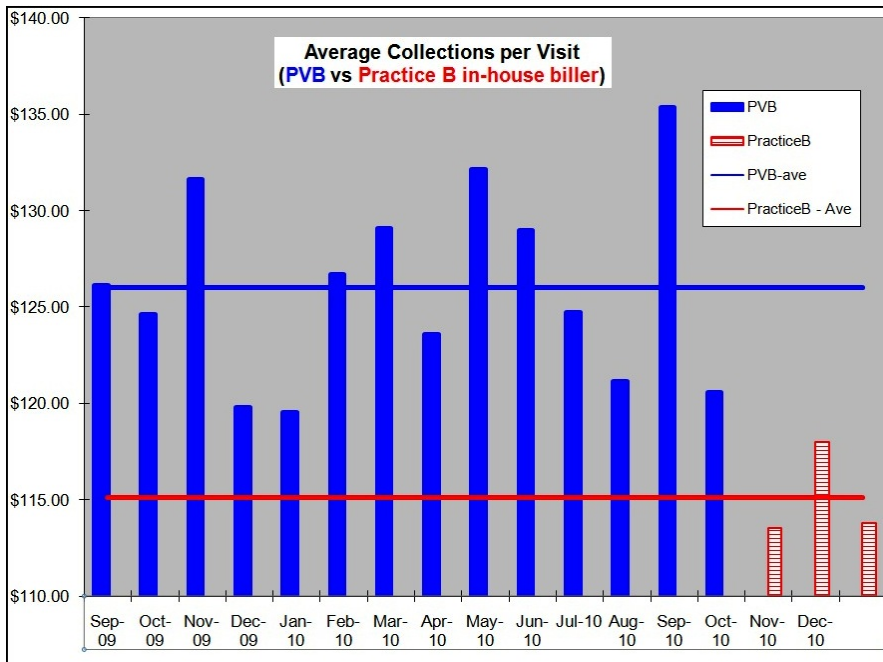
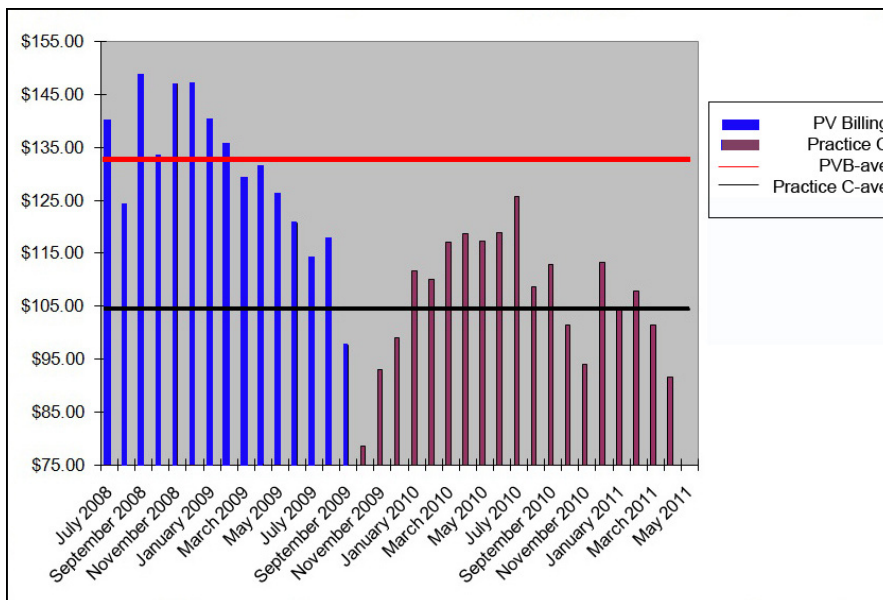


Figure Three



Discussion: All three practices experienced a reduction in average collections per patient after transitioning from PV Billing to an in-house biller.

The difference in collections between PV Billing and the three practices' IHBs cannot be attributed to differences in software because Practice Velocity software (EMR, practice management, and billing) was used during the entire time studied. Additionally, initial set up was not a factor because set up was performed by PV Billing, so the practices did not need to perform any set up to make the transition to bring billing back in-house.

After paying PV Billing fees of 8% of collections, **Practice A** would have a net collected revenue of \$105 (92% x \$114), which exceeds the gross collections with Practice A's IHB, and **Practice B** would have a net collected revenue of \$116 (92% x \$126), which is 3% more than the gross collections of Practice B's IHB. **Practice C** would have a net collected revenue of \$120 (92% of \$130), which is 15% more than the gross collections of Practice C's IHB.

Assuming a conservatively lower cost of 5% of collections for IHB, bringing billing in house produced increased losses of 7-9% for net revenue. While there are many factors that could have contributed to improved collections with PV Billing, none of the practices were able to produce equivalent collections. Thus, with in-house billing, even after accounting for the cost of PV Billing, both practices experienced increased costs and decreased net collections, resulting in substantial reduction in profits.