



## HOW TO INCREASE UPFRONT COLLECTIONS, REDUCE PATIENT ACCOUNTS RECEIVABLE AND IMPROVE YOUR CASH FLOW



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The financial health of a medical practice is heavily dependent upon the billing process. The billing process actually starts when the patient calls to make an appointment. If incorrect information is given during the appointment phone call, your chances of getting paid can be doomed from the start. There are several strategies you can put into place to increase the chances of being paid and improving your cash flow.

### **Hire and Train the Right Staff**

An efficient collections process starts with your front desk staff. You need to hire the right people who are qualified and consistently keep them educated. Front desk staff must have knowledge of CPT, ICD-9 and HCPCS codes as well as how to use your practice management system. They must have excellent communication skills and know how to deal with physicians and other members of the staff. Once the staff is hired, continuing education is essential to keep up with the constant changes regarding reimbursement for medical practices.

### **Create a Financial Policy**

Every practice should have a written financial policy printed out and shared with patients. The policy should explain in detail how the practice handles insurance claims and the practice's expectation of how patients are to settle their account. Patients should sign the policy and a copy should be kept in their file if any questions or billing issues arise. If the patient does not have insurance, payment arrangements must be established at the time of service. Furthermore, if patients have a balance, they should be informed at the time the appointment is scheduled and it should be collected as soon as they come into the office, *prior* to seeing the physician.

### **Collect Copays Up Front**

The average cost of sending a bill to patients is approximately \$7.50. Failure to collect copayments at the time of the appointment is wasted billing staff time and money. Many physicians will not see non-emergency patients who don't pay their copayment prior to being seen. Accepting credit and debit cards can make collecting copayments more convenient.

### **Capture all Services Provided and Documented**

On average, five to ten percent of charges are never billed. The first step in solving this problem is to establish a protocol that provides a cross check process to ensure services are captured. For inpatient services, it's the job of the billing staff to prompt the physician to hand in the charge ticket. If inpatient services are a significant part of your business, you may want to recommend that a billing staff member

make rounds with the physician. Surgical practices should use operating room and surgery center surgical schedules for both major and minor cases as a double check to make sure all surgical charges were received. Some practice management systems interface with Personal Data Assistants (PDAs) which can provide an excellent tool for capturing inpatient evaluation and management services as well as surgical cases.

For office services, clinical staff must be trained to mark all services on the encounter form. These can include vaccines and immunizations, electrocardiograms, pulmonary function studies and other diagnostic test. When the patient is ready to check-out, the encounter form should already have all the services that were provided marked on the form.

Many practice management systems assign a tracking number to every appointment made in the system. Charges are then entered again that tracking number. This provides a mechanism to locate visits for which there were no charges entered.

### **Insurance Submission**

It is now increasingly important that front desk staff is knowledgeable about insurance carrier rules and are educated on insurance and eligibility. Insurance policies have become increasingly complex with high deductible health plans, health savings accounts and health reimbursement accounts. Your staff must know which insurance plans your practice accepts and which plans cover the specific services your practice offers. Patient eligibility should be verified before the patient arrives for his or her appointment so that patients can be made aware if they will not have coverage for the services that they are going to receive in the practice.

Practices should be submitting the vast majority of all claims electronically. Electronically filed claims typically get paid faster. Clean Medicare claims filed electronically are paid in 14 days rather than 28 days for clean paper Medicare claims. Electronic transmission reports must be reviewed carefully so that claims with errors can be fixed and resubmitted. Sending “clean” claims can mean little or no follow up.

A claim can be denied for a number of reasons. The service might not be covered by the subscriber’s plan or perhaps a referral or precertification was necessary for the service. The patient’s coverage may not have been in effect at the time of service. This is why it is imperative to verify patient’s eligibility *prior* to the appointment. Missing or incorrect and incomplete data, diagnosis, procedure codes or incorrect use of modifiers can also lead to denials.

Once payment is remitted, it must be posted properly. This is another facet of the billing process where having properly trained staff members is essential. They must understand insurance contracts and fee schedules. Good payment posters are worth their weight in gold so it is important to keep them happy! Accurate payment posting prevents wasted time spent following up on incorrect accounts.

### **Proper Follow-up Procedures**

Up to six percent of claims can be lost at insurance companies. It is important to make sure your submissions equal what is received by the insurance carriers and then what is paid, denied or pended. Prioritize your accounts receivable efforts and sort by balance due (highest to lowest). You can also sort by account type, payer type, date claim was submitted, date of service, age of account or insurance type. Organization is important and can make follow up and receiving payment significantly quicker.

Patient balance follow up is another necessity for improving collections. Primary care practices may have to address this differently than specialists who often don't have returning patients. Bill the patient as soon as the balance becomes his or her responsibility. If the patient fails to pay their bill, have your billing staff send pre-collection letters and call the patients to remind them of their responsibility to pay the balance. If all else fails, the patient should be sent to a collection agency. Collection agencies vary tremendously in their capabilities and you should choose one that specializes in healthcare.

### Lag Times

Tracking lag days can be a surprising and eye-opening experience for many practices. Take a look at the *average charge entry lag days* which are the number of days between the date of service and the date the charge was entered. Also look at the *average claim lag days* which are the number of days between the date the charge was entered and the date the claim was produced. Both should be 24 hours or less for outpatient services or office visits and 48 hours or less for inpatient services. Your billing software may be able to provide these reports for you.

There are several obstacles that can get in the way of properly entering data and getting claims submitted on time. Some problems to watch out for are physician compliance (or *non-compliance*), IT failures and incomplete or missing data. Coding and documentation issues are also very common barriers. The appropriate level of service and correct procedure must be on the claim form with proper documentation in the patient's medical record. Incorrect coding can lead to reduced or denied charges, delay in payment or uncollectable receivables. Failure to follow up can cost the practice hard earned money. If patients aren't informed that the services they are receiving may not be covered in full by insurance, it may be almost impossible to collect payment at a later date.

There are some specific problem areas that you'll find with coding and insurance denials. Coding at one level of service or failure to code all services rendered can lead to decreased or no payment at all. Using modifiers, multiple surgical procedures, incidental procedures and using wrong or non-specific diagnosis codes could also prevent payment.

### Measure for Success

Insurance denials should be measured in order to improve the entire billing process. The payer, provider, practice, location and major reason for denial should be recorded as well as the number and dollar amount of denied claims. It is important to measure denials as a way of monitoring the performance of both your front-desk and billing staff. Denials should be reviewed on a monthly basis to determine if there are insurance-specific problems that are impacting payment of claims. It's also important to know how many times the denied claim was appealed and the timeliness of the results of the appeal. You should also keep track of the denials that are written off and appeals that were not paid. Any trends that appear in denied claims need to be addressed immediately at both the physician and staff level.

There are different methods of measuring collections and gauging the efficiency of your accounts receivable process. You can't pay your bills faster than you are getting paid so keeping track of days in A/R is a valuable measurement. Days in A/R is measured by average charges per day divided by average A/R. This represents how fast your practice is turning over its A/R. A true measure of the effectiveness of your business operation is the net collection ratio. This is calculated by dividing net collections by net

charges (after contractual adjustments). Better performing practices have a net collection ratio in the mid to upper nineties.

Comparing your practice performance to MGMA, AMA or AOA standards can help keep you on track to reaching your collection and A/R goals. It is very important to be proactive and keep your staff on the same page when dealing with cash flow. The front desk staff is the first line of defense in improving upfront collections. Keeping track of your progress by measuring and monitoring your accounts receivable can help you continue doing what works, and fix what doesn't.

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