Lessons for Financial Success

CHAPTER 3

Accounts Receivable and Collections

WHAT YOU WILL LEARN

✓ Effective billing procedures to maximize revenue
✓ Techniques to manage accounts receivable
✓ Ideas to avoid fraud in the practice
INTRODUCTION

Medical practices serve patients. Most (if not all) practices write this in their mission statement. However, medical practices are also businesses and have the same aspects and concerns of any business – getting paid for services, using effective billing processes, maximizing revenue, managing client payments and overdue accounts, and ensuring that office employees operate in a trustworthy manner.

Your practice exists today because it has in place processes that address all of these business practices. This chapter will help you improve those processes and perhaps introduce a few new concepts that will improve your medical practice’s efficiency and bottom line.

WHAT’S COVERED

This chapter covers incorporating billing procedures that fit your practice’s style, maximizing revenue, managing accounts receivable (A/R), strengthening internal controls and ensuring that your practice is free of employee theft. You will also find best practices and examples that you can use in your practice’s daily operations along with excerpts from success stories in the MGMA Performance and Practices of Successful Medical Groups Report that describe real-life medical practice examples.

IN THIS CHAPTER

✓ Overview
✓ Accounts receivable and collections essentials
✓ Success stories
✓ Best practices
✓ Examples
✓ Summary
✓ Discussion topics
✓ Glossary
✓ Benchmarking data from MGMA survey reports
✓ Appendix

OVERVIEW

A/R and collections relate to the business side of a practice. After patient care, practices consider maximizing revenue as an important aspect of running a successful business. This aspect includes more than just getting paid for services. You need to consider your billing cycle (which starts when a patient calls for an appointment), billing processes and technology.
Secondly, services rendered by medical practices must be paid by a third-party payer, such as an insurance plan and/or the patient. How quickly does your practice get paid? How can you accelerate collections? Managing this aspect of the practice ensures a better cash flow that can be invested back into the practice to improve processes and provide better services to patients.

And, finally, managing your revenue cycle processes and revenue will be of no use if someone steals from your practice. Theft can be a major barrier to a practice's success. Learning steps to prevent theft will help you maintain a trustworthy staff.

ACCOUNTS RECEIVABLE AND COLLECTIONS ESSENTIALS

Manage accounts receivable

Medical practice A/R equates to patients’ open accounts and the amounts due from insurance payers. To manage A/R (keep the amounts due you to a minimum) requires an effective billing process. This process includes more than sending out a bill, and it starts when a patient calls to schedule an appointment. Processes will vary among medical practices, but some key elements that should exist for all practices so that managing A/R can be done more effectively are:

- Gather all patient information at the time the patient calls in for an appointment;
- Obtain insurance information and verify it when the patient visits;
- Establish and communicate the expectations that patient balances are due at time of service;
- Collect all copayments and deductibles when the patient checks in;
- Work with the patient who owes past due amounts by setting up payment plans and explaining what their insurance covers and what it does not;
- Accept credit and debit cards as a method of payment;
- Educate the staff on collection techniques so that they understand the most effective methods of obtaining payment such as not arguing with a patient, not becoming emotional and sounding confident; and
- Implement a collection process that includes steps based on the time and amount past due.

During the patient visit, a physician will document what occurs in the patient record using diagnosis codes such as the International Classification of Disease (ICD-9) and procedure codes such as current procedural terminology® (CPT®) codes. Capturing this documentation becomes critical in obtaining payment for physician services from insurance payers. Why? Medical practices have contracts with payers that include fees associated with each CPT code billed.
So, it’s important that the correct CPT code be documented so that correct payment can be obtained.

Further, much of your cash flow comes from these insurance payers, which affects your A/R balances. Handling this area of the business also requires a skillful process:

- Understand the individual payer contracts and the amounts negotiated for CPT codes billed;
- Encourage physicians to thoroughly document the patient encounter so that charges can be submitted accurately;
- Review payer claims for errors before submitting them;
- Submit claims on a timely basis;
- Create reports that classify past-due accounts and assign collection procedures to them; and
- Follow up on unpaid claims so that they do not go unnoticed and payment never occurs.

Today’s economy has left many without medical insurance or insurance with very high deductibles (high-deductible health plans) that may include provisions for a Health Savings Account (HSA) to cover the patient’s portion of the bill. Your practice needs to be aware of this and create processes to handle each situation. Accepting credit cards affords you the ability to obtain payment without incurring significant additional fees because the burden has been shifted to the patient who will pay potential finance charges to the credit card company. The practice will pay a percentage to the credit card company. However, you will still save money because you do not have to use a collection agency or maintain a past-due balance for the patient.

Some practices offer these self-pay patients a discount for paying in full with cash. This lowers your A/R and saves time and money because you receive payment up front and avoid sending patient statements. However, the charges can’t be less for these patients than you would charge Medicare or commercial payers. Beware of the language in your payer contracts. Practices should have in place a written policy on how self-pay discounts are handled.

HSAs may be more complicated because plans operate differently. For example, some plans manage the employee accounts and send the payments to the practices. Other plans require the medical practice to send a bill. Although this aspect sounds no different from what other payers currently do, patients may not fully understand this new plan, which could delay payments or create an additional burden on medical practice staff in answering questions.

Overall, the goal in managing A/R is to collect what is due you in a timely manner. The longer patient or payer accounts remain past due, the longer the practice waits for what it is owed. In some cases, you may never collect.

In chapter one of *Lessons for Financial Success*, we show you a few formulas and benchmarks to help you measure your progress in managing your A/R. These
benchmarks look at areas of your practice such as the percent of A/R over 120 days and your total A/R per full-time-equivalent (FTE) physician. Take a look back at chapter one for more formulas. Also, at the end of this chapter, we provide median A/R data from MGMA’s *Cost Survey Report* and *Performance and Practices of Successful Medical Groups Report*. Both can give you an idea of what you can measure in your practice against other successful practices.

**Monitoring cash flow and effective billing procedures**

Effective management processes improve cash flow and generates income for future investments and operating revenue. Here are some ideas to improve your cash flow:

- Collect at the time of service – ask patients for payment before they leave the practice;
- Time vendor bills – work with vendors to set convenient payment dates for your supplies; and
- Don’t pay bills too early – make payments at the end of the discount period (net 30 – make the payment in 30 days) or at a time when you benefit from further discounts.

As mentioned before, insurance payers play a major role in your cash flow. To obtain payments from payers, you must have an effective billing system. This system must fit your practice’s needs but must be able to deliver a clean claim to all payers. Some practices outsource this function to outside companies because billing has become complicated and ever-changing. Outsourcing may be right for your practice if it is smaller and the cost of outsourcing is less than that of hiring one or two more employees.

Some practices keep all billing functions in-house and rely on electronic billing and claims processing to ensure that claims are submitted with limited errors. Submitting claims electronically provides advantages such as:

- Editing and correcting claims before submitting them to payers;
- Creating reports;
- Reducing the number of bills that must be resubmitted; and
- Reducing billing processing costs.

Whether or not you use electronic billing, you should track total billing amounts by payer. Tracking can be done daily as well as monthly and can help you determine payer trends (who pays, who doesn’t and how long you wait for payment). Using a tool such as a daily billing control sheet (see *Examples* section), helps you monitor the activity by payer.

Overall, your practice should serve patients to the best of its ability. However, situations arise where patients may not pay their bills. And it’s up to you to get the money owed without damaging the practice’s reputation. For ideas on
how to accomplish this, refer to the code of ethics (see Best Practices section) that will help guide you and staff in the appropriate aspects of collecting from patients while keeping a positive public image.

**Prevent employee theft**

Employees steal for many reasons. Patients may also attempt to steal services by using someone else’s identity and insurance information. Implementing steps to prevent theft and creating an environment that encourages trust are your best methods to keep your practice free of workplace crime.

Some ideas to help limit unethical employee conduct include:

- **Tighten the hiring process**: Conduct complete applicant interviews, contact previous employers to verify dates and positions, verify graduation records, interview personal references with detailed questions and conduct background checks.
- **Develop policies and procedures**: Create and distribute an employee handbook that details the expectations and accountabilities of each employee and the consequences associated with not adhering to them. Job descriptions should be well defined and list the specific aspects of the job.
- **Separate duties**: Specify which employees are responsible for handling cash, set up accounting records to be managed by employees not responsible for handling cash, create an auditing process, assign the monthly task of reconciling bank accounts to someone who does not handle cash and does not maintain the accounting records, and confirm patient identities.
- **Install and update computer security systems**: The computer has become a tool for employee theft. It’s important to use the latest electronic security tools and limit computer access to only those who need it. You can limit this access based on functional responsibilities, creating access passwords for employees and preventing/limiting Internet access.

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These ideas touch more than just the financial aspects of the practice. Creating a work environment that emphasizes fairness, strong controls, communication and honesty will go a long way in helping you prevent theft in your practice.

**SUCCESS STORIES**

**Cardiology Associates of New Brunswick**

Cardiology Associates of New Brunswick, N.J., was founded in 1938 by Norman Reitman, MD, a pioneer in the practice of medicine in the New Jersey area.
**Success factors**

This well-respected practice has excellent physicians who provide quality care that surpasses any other practice in the area. The physicians ensure that the practice stays on top of the newest technology because it is important to them to provide the best possible innovative care to their patients.

“Not only are the physicians good at what they do, they have good hearts and put patient satisfaction ahead of their own needs,” says Lana Gordover, MPA and practice administrator. “I am proud to work here.”

Adding nonphysician providers to the practice, who make hospital rounds, also contributes to the revenue of the practice. According to Gordover, a hard-working and dedicated staff makes this practice successful. The practice survived a few difficult years with respect to staffing in the billing area, and everyone pulled together to make it work. Cross training all employees helped the department survive this difficult time.

Most importantly, a monthly report card (see “Monthly productivity report” in the *Best Practices* section) distributed to the billing staff helps track A/R progress. The report card, broken up by payer, shows the employee who handles the payer, the payer type, the previous month’s A/R dollars and percentage, the current month’s A/R dollars and percentage, and receipts in dollars and percentage.

“The report card provides a pretty good indicator of how we are doing with A/R,” Gordover says. “I receive a summary version of the report card, which allows me to look at A/R from a summary perspective.”

Employee evaluations are based on this report card, with the goal for each employee to have zero in the column that lists the amount over 90 days. This benchmark is used specifically because there is more involved in managing employee productivity. The employees do not receive an incentive for reaching this goal; instead, they work as a team and understand the importance of managing their A/R accounts.

“Paying someone more is not necessarily an incentive,” Gordover says. “Having pride in your work and access to tools that make your job easier motivates employees to work harder and reach the goals that we established together.”

For example, the practice purchased new software that allows charges for a day to be posted in a couple of hours. As a result, employee time was freed up, which allowed them to learn and do other tasks to increase their efficiency.

Gordover includes the billing staff in decisions during their monthly meetings. Each month they explore new ideas and discuss new payer information and tasks that need to be done. Each employee has a voice, and is encouraged to suggest ideas and challenge current processes.
Most importantly, the billing staff attends conferences that allow them to stay up to date on changes in Medicare and other updates that affect their jobs and the practice.

“It’s important that the staff stay current on health care billing and collection issues just as it is for the clinicians to stay current on technology and innovative solutions,” Gordover says.

**Collecting payment**
Initially, the patient payment process was not efficient. Gordover implemented an approach in which the patient now pays the copayment at check-in. Then, to avoid any embarrassment, when the patient checks out (which is not in the waiting room full of people), staff addresses any outstanding balances and obtains payment for them at that time.

New processes and procedures also help the billing staff manage their accounts. Employees run A/R at the beginning of the month, review it and determine the amounts that are more than 90 days. These items gain their initial focus for the month, but employees still focus on the remainder of the A/R that is under their responsibility in these first two weeks.

“We work our A/R from right to left and use a method to determine the minimum number of pages an employee must work on each day,” Gordover says. “The A/R that needs to be addressed must be completed in the first two weeks. Then the staff reviews their A/R again in the second half of the month. Reviewing A/R twice in a month – that’s the secret recipe.”

**Final thoughts**
Reaching better-performer status makes Gordover proud, but she is not finished yet.

“It isn’t about getting there, it’s about staying there,” Gordover says. “We will continue to stay on top of our accounts and do better on all levels.”

Gordover is happy with her team and without them could never succeed. Each and every person is needed to make the practice a success — now and in the future.

**Dublin Primary Care**
Dublin Primary Care, Colorado Springs, Colo., started as a physician practice owned by an independent practice association (IPA) where the physicians worked as employees. In 1999, the physicians bought the practice, and it continues to operate as a physician-owned primary care practice for patients of all ages.

**Success factors**
“Several factors contribute to the success of Dublin Primary Care,” says Deborah D. Milburn, CMPE, practice administrator. “Our policies and
procedures are known and understood; physicians turn in their charges in a timely manner; and charges are sent to the payer the same day they are received all contribute to how well the practice functions.”

All staff, including the physicians, are accountable for their tasks and understands how their individual roles contribute to the success of the whole practice. The physicians are keenly aware of the importance of billing out their charges quickly. The process starts with the physicians – once their goals and deadlines are met, the staff can meet their goals. They are all encouraged to perform their tasks right the first time, as rework is expensive.

Further, open reporting (physician names appear on the report) on production, collections, overhead and salaries are reviewed each month. All information is shared. Physicians understand all reports and review them as a group twice a year. They look at key indicators such as days outstanding, and understand the components of collection percentage and how it may compare to other practices. They also receive payer reports each month that indicate the percentage of the patient base and how fluctuations in that payer could disrupt business.

**Communicating with patients**

It is vital to get the necessary billing information up front from the patients. Dublin Primary Care follows the policy of collecting copayments prior to service, checking patient demographics and verifying insurance information at each visit. If patients do not provide their insurance card, they are considered self-pay patients and will be billed as such until they present their insurance information to the practice. This is all explained to them before services are rendered.

“Self pay/patient pay takes on a different meaning today,” Milburn says.

“With payers shifting more of the payment burden to the patient, we see more patient responsibility as part of our A/R and collections.”

Dublin Primary Care accepts credit/debit cards, but doesn’t track whether it is a Health Savings Account or a Visa debit card. The practice likes accepting credit/debit cards because it eliminates a billing factor and thus lowers costs.

**Technology, billing and collecting**

Information technology plays a large role in this practice. Just a few years ago, the physician and staff implemented electronic health records (EHR). They are more than happy with the results and realized benefits within a month of installing the system.

“A physician completes a note and codes it at the same time, just as if they were circling an entry on an old superbill,” Milburn says. “Now they point and click.”
Before loading a file into the practice management system, all charges are reviewed and accepted. A staff member reviews the patient report generated from the system and bills out the charges before noon that day.

“We used to have two full-time charge entry people; now we have one part-time person to complete charge entry,” Milburn says.

On the back end, the staff posts payments. However, the practice also implemented electronic remittance with three of the payers, which allows staff to review and verify the information. This reduced the billing staff as well, from eight people to three full-time A/R staff and one-half person on charges. All billing staff members pay attention to details, alert Milburn of any trends they see with payers and address any outstanding patient balances before they reach the 90-day window.

Final thoughts
As technology moves forward, Dublin Primary Care will add more payers to its electronic remittance function and continue to use its Web site to help market the practice.

In the ever-changing, difficult health care environment, many unknowns exist, and planning for them is difficult. Milburn will continue to watch the trends, pay their staff well and stay within their primary care niche.

Houston Allergy & Asthma Associates
Established in 1957 by two physicians, Houston Allergy & Asthma Associates has grown into the largest single-specialty allergy, asthma and clinical immunology group in the Houston area.

“We are still growing,” says David Reynolds, administrator. “Our goal is to locate clinics so that patients do not have to drive too far to be treated.”

Success factors
When asked, practice leaders attribute their success to a few areas, including hiring knowledgeable and appropriate staff who handle heavy workloads and enjoy their jobs, as well as creating a standard policies and procedures manual for all employees. However, the most important factor is the limited number of CPT codes the staff uses in this specialty. Allergy and asthma have 22 main CPT codes that account for 98 percent of the practice’s revenue. This limited number of codes not only makes billing easier, but it also aids in contract negotiations with the payers.

“We concentrate on just these specific codes when negotiating,” Reynolds says. “If the payer will give us the fee we want on these codes, we take the standard fee on all the others because we rarely use them.”

Growth spurred the practice to centralize its billing processes several years ago, and this has greatly improved collections. Clinics focus on real-time
patient charges and balances and collecting copayments while the billing office manages all aspects of A/R, daily claims filing, insurance follow-up and monitoring the accuracy of payer reimbursement according to clinic contracts.

The key to the practice’s successful collection ratio stems from its proactive approach. Each day, the central billing office creates a daily audit for each clinic (see “Daily audit” in the Best Practices section), containing the following day’s patient schedule. For each patient, the central billing office informs the clinic managers of any outstanding balances, copayments or coinsurance amounts that should be collected and reminded to gather and verify any privacy or benefit information.

“We educate the staff on the importance of keeping up with the expectations of the insurance providers and collect the copays at the time of service,” says Lori Smith, director of operations.

The practice offers an auto-credit card payment option, which allows all copayments and deductibles to be charged immediately for each visit. Today, about 20 percent of patients take advantage of this service.

**Benchmarking**

Monthly meetings with managers address A/R and collections for year-to-date and the current month, as well as the overall days in A/R. These measures are critical indicators when compared with outside data such as the MGMA Cost Survey Report, as the practice can see how it compares with other clinics.

“Collecting dollars is an important benchmark of overall efficiency,” Reynolds says. “We’ve never been above 20 days in A/R, which is stellar for any practice.”

Internally, Houston Allergy & Asthma Associates looks at its clinics as profit centers and compares the patient collections of each. The practice looks specifically at the number of accounts in patient collections. Each location strives to achieve a patient-receivable benchmark of less than 10 percent.

**Information technology and new ideas**

Houston Allergy & Asthma Associates considers technology a necessity when dealing with payers. Today, if a practice wants speed in reimbursement and quicker submissions, it must upgrade its software and hardware.

“Technology is a valuable tool we use to communicate with each of the clinics and billing office, as well as the payers,” Reynolds says.

**Final thoughts**

Each year Houston Allergy & Asthma Associates sets new challenges. In the years to come, the practice will strive to lower the collections rate of patient and insurance receivables and increase the number of patients paying with a credit card.
BVA Advanced Eye Care

The first statewide advanced eye care practice in Oklahoma, BVA Advanced Eye Care was founded in 1998 by an entrepreneurial physician who wanted to establish a world-class practice.

Efficiencies

Sandy Boles, executive director, says the offices are linked by a common management system and have local managers. Each office uses the same billing software for revenue cycle management and is monitored by a centralized A/R team. She reports that BVA's A/R and collections approach features three circles:

- **First circle**: Each practice has its own front-office staff and a billing specialist. This staff generates the documentation needed for accurate claims and fast processing;
- **Second circle**: The centralized team sends electronic claims and statements to responsible parties, handles any denied claims, and solves any other claims-processing issues; and
- **Third circle**: Any unpaid claims go back to the local office for handling. The decision on whether to send the claim to collections is made locally.

Innovations

BVA uses electronic banking for payer reimbursement, with payments going directly into a lockbox at the bank. This eliminates cash handling, except for front-desk staff who collect patient payments. Managers use online banking services to retrieve explanation of benefits and check accounts.

Boles feels that “the secret of our success in A/R and collections is our A/R team and related internal controls. The team leader, one of the seven office administrators, and four assistants, manage the centralized A/R effort. The A/R manager analyzes ‘days outstanding’ reports and other data to spot any problems. Each local manager also watches the accounts and knows where more training may be needed.”

The goal is a 100-percent clean-claim result. When the managers review the weekly audit report, there is a friendly competition to see which office comes closest to hitting the target. The executive director reports that BVA averages a 35-day days-outstanding mark.

“If it is 37 to 39 days, we look for the reason, which might indicate a problem or not. Aging buckets can be affected by a physician who has been out for a week or the way the workdays fall in a given month.”

Billing

BVA educates all staff and its physicians about billing matters. The A/R team keeps everyone informed via reports and meetings. They all see the efficiency
level of the payment process, including copayments and deductibles not collected at the time of service. To stay on target with billing, BVA keeps a coding consultant on retainer. Boles reports that the consultant visits the practice every other year to conduct a chart audit, and is available by phone anytime. Every office has a go-to person to answer coding questions. Those who become certified as ophthalmic coding specialists get a $500 bonus. Everyone completed a recent course on coding new treatments. Boles says, “The managers also call each other about coding matters and learn from each other. We remind the physicians that staff helps with coding, but they are ultimately responsible for correct documentation and coding. There usually is one physician in each practice who really enjoys coding and helps the other physicians and staff.”

Collections
Each local administrator takes this approach to collections:

1. Send statements to patients for 90 days, supplemented by phone calls.
2. Check with patients’ physicians to determine whether to go to collections. They may be willing to write off the bill. If not,
3. Send a 10-day notice stating “We will be forced to go to an outside collection agency if the bill is not paid.”
4. Send to a collection agency. Result: Typically, BVA turns over less than 10 percent and, of that, collects about 20 percent. The old balances are written off as bad debt.

Boles states, “We’re lucky that most Oklahoma people pay their bills on time. Most still honor the values of farm people who would rather go without than leave a bill unpaid. So, collections, for us, are not a major problem.”

BEST PRACTICES

Collection code of ethics

1. Medical groups should fully explain the terms of any collection transaction to their patients.
2. Bills should be sent as soon as possible after the billing cycle ends – at least two weeks before the next payments is due.
3. Calls or correspondence from a patient claiming a billing error should be acknowledged promptly.
4. Collection practices should be based on the presumption that every debtor intends to pay or would pay if able.
5. Late charges should be assessed only to the extent necessary to recover overall expenses caused by the delinquency.
6. Patient complaints concerning collection practices should be investigated immediately.
7. Collectors should be instructed to attempt to determine the cause of a delinquency and to indicate willingness to arrange a mutually satisfactory repayment schedule when appropriate.

8. Patients who show a sincere desire to pay their debts should be offered, if necessary, extended payment schedules, financing arrangements or similar methods that would help re-establish solvency.

9. If the patient does not respond to an offer to help make alternative arrangements, the collector should explain the seriousness of continuing delinquency and advise the patient regarding courses of action.

10. While collectors have an obligation to disclose to debtors and endorse the remedies that may be invoked against them, legal action should not be cited unless it can and will be used.

11. Telephone calls must be placed between the hours of 8 a.m. and 9 p.m. in the patient’s time zone, unless other times are more convenient for the patient and have been previously noted by the patient.

12. Outside collection agencies, attorneys, process servers and other agents employed to collect delinquent accounts should be furnished with written instructions on how patients are to be approached and what practices are and are not sanctioned.

13. Medical groups should be particularly careful in handling delinquencies due to a patient’s dissatisfaction with services.

14. A patient’s medical complaint, as a reason for not paying, should be referred immediately to the patient’s physician for reconciliation.

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### Monthly productivity report

**Month/year:**

**Employee name:** Beth

**Patient type:** Medicare

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Daily audit

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Manager signature: ____________________________________________

Please make sure you write in the comment section what action was taken (e.g., collected, paid, insurance added, referral received, etc.)

**Note:** Each account must have action taken before being faxed back to the CBO and administration offices. If action was not taken at check-out it is the responsibility of the manager to resolve (e.g., get referral, enter benefits or call patient regarding balance and make payment arrangements).

Checklist for managing A/R

Specific behaviors instilled in many medical practices influence their decision-making capabilities and performance. These behaviors include establishing goals, monitoring performance and addressing A/R management problems early. Some things to consider when establishing these behaviors include the following:

**Management and culture**

☐ Provide staff training and continuing education as a job requirement.

☐ Provide physicians and staff members with updates on regulatory changes to ensure compliance and proper documentation of patient encounters.

☐ Involve the physicians in the billing process to ensure that staff members understand the importance of the process and the value of their roles.

☐ Create a policy handbook documenting all rules and procedures.

**Process**

☐ Set performance standards and expectations for billing staff.

☐ Cross-train staff on the A/R process.

☐ Define the elements of a clean claim and build training programs for billing staff.

☐ Establish a relationship with patients early to reduce patient stress caused by large payment obligations.

☐ Employ a certified coder or encourage appropriate staff members to learn more about coding.

☐ Manage payer relationships and contracts. Take action on any problems.

☐ Meet with payers regularly to form a relationship and understand their policies.

☐ Ensure that payer contracts explain what constitutes a clean claim, submission and payment requirements, the appeals process, and termination causes and methods.
Lessons for Financial Success

- Review patient account balances at scheduling time.
- Verify patient eligibility, copayments and deductibles prior to providing services.
- Confirm patient insurance status at each visit.
- Collect copayment or deductible at the time of service.
- Post charges for all office visits on the date of service.
- Follow up on outstanding claims early to reduce the need for more aggressive tactics later.
- Prioritize claims for follow up by amount and age.
- Establish structured payment in response to patient needs.


EXAMPLES

Daily billing control sheet

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</tr>
<tr>
<td>Private payer 2</td>
<td></td>
</tr>
<tr>
<td>Self pay</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>


Tips for billing efficiency

The BVA (see practice success story above) staff uses these procedures to ensure billing efficiency:

- Update each patient’s payment information at the front desk at every visit;
- Educate new patients about the practice’s financial policies and their responsibilities;
- Check the patient’s insurance benefits before check-out;
- Let the patient know at check-out if he or she needs to pay any of the cost;
Ask, in a business-like manner, if the person would prefer to pay by check or credit card; and
Send patients home with a payment envelope if they prefer not to pay that day. They can expect statements, messages and calls until they pay.

SUMMARY

This chapter featured many ideas and examples that help manage a medical practice as a business. It is clear that A/R and collections relate to the business side of a practice and that after patient care, practices share the same concerns of any business – getting paid for services, having effective billing processes, maximizing revenue, managing client payments and overdue accounts, and ensuring that employees operate in a trustworthy manner.

The success stories detailed a few approaches to managing A/R, billing and collections. You may already use some of these ideas or perhaps you can modify them to fit your practice operations. And the data tables provide a glimpse into the benchmarks you can use to measure your practice's success.

DISCUSSION TOPICS

Practice what you just learned with the discussion topics.

1. Analyze some of your practice’s A/R data and see how the numbers compare against the MGMA benchmarks, which can be found in the MGMA Cost Survey Report.
2. What does your front-office process look like? Does it have any of the steps mentioned in the text? What can you suggest to make it more effective?
3. Do you outsource your billing or is it done in-house? What steps can you suggest that would make either method more beneficial to the practice?
4. Ethical employee behavior limits theft in a practice. Does your practice have an employee handbook? Does it have detailed job descriptions and expectations of employees? What can you do to create/improve these documents?

GLOSSARY

**Bad Debts Due to Fee-For-Service (FFS) Activity** – The difference between adjusted fee-for-service charges and the amount collected.

**Collections** – The sum of FFS collections, capitation payments and other medical activity revenues; also called total medical revenue.

**Current Procedural Terminology® (CPT®)** – A standard system of codes and descriptive terms, developed by the American Medical Association, for the reporting of medical procedures and services provided by physicians and other health care providers.
**Health Savings Account (HSA)** – Health insurance that combines a low-cost, high-deductible insurance policy with a tax-free savings account to pay for qualified medical expenses. An HSA is an individually funded plan that shifts more financial responsibility to individuals for health care management. Patients can withdraw or carry forward any funds in an HSA at the end of the year.

**Payer** – An insurance company that arranges for the delivery of health care services on behalf of insured beneficiaries.

**Receivables** – All money claims against individuals, organizations or other debtors.

**Self Pay** – Fee-for-service gross charges, at the practice’s undiscounted rates, for all services provided to patients who pay the medical practice directly.

**BENCHMARKING DATA FROM MGMA SURVEY REPORTS**

Better-performing practices take steps to improve their processes. Data below shows results from the MGMA *Performance and Practices of Successful Medical Groups: 2008 Report Based on 2007 Data*.

<table>
<thead>
<tr>
<th>Business operations and financial management – survey results</th>
<th>Better-performing practices</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Used dashboards to benchmark and track practice performance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly financial reports</td>
<td>94.48%</td>
<td>85.10%</td>
</tr>
<tr>
<td>A/R summary reports</td>
<td>81.38%</td>
<td>65.87%</td>
</tr>
<tr>
<td>A/R detail reports that included data such as charges, collections and coding</td>
<td>64.14%</td>
<td>61.84%</td>
</tr>
<tr>
<td><strong>Percentage of copayments collected at time of service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 – 100%</td>
<td>47.15%</td>
<td>36.63%</td>
</tr>
<tr>
<td>75 – 89%</td>
<td>32.52%</td>
<td>29.07%</td>
</tr>
<tr>
<td>50 – 74%</td>
<td>9.76%</td>
<td>15.12%</td>
</tr>
<tr>
<td>0 – 49%</td>
<td>10.57%</td>
<td>19.19%</td>
</tr>
<tr>
<td><strong>Practice’s billing function structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centralized – all claims are forwarded to a central location</td>
<td>73.33%</td>
<td>75.53%</td>
</tr>
<tr>
<td>Decentralized – each branch/office enters its own charges</td>
<td>6.67%</td>
<td>7.98%</td>
</tr>
<tr>
<td>Both/hybrid</td>
<td>13.33%</td>
<td>7.45%</td>
</tr>
<tr>
<td>Outsourced this function</td>
<td>6.67%</td>
<td>7.45%</td>
</tr>
</tbody>
</table>
Use the following financial measurements against those of your practice to help improve revenue and manage costs. The data table below presents median, better-performing practices data and median MGMA *Cost Survey Report* data for a subset of specialties\(^1,2,3\).

<table>
<thead>
<tr>
<th></th>
<th>Multispecialty</th>
<th>Cardiology</th>
<th>Orthopedic Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BP*</td>
<td>Cost Survey</td>
<td>BP*</td>
</tr>
<tr>
<td>Percent of total A/R 120+ days</td>
<td>8.04%</td>
<td>16.84%</td>
<td>8.66%</td>
</tr>
<tr>
<td>Months gross FFS charges in A/R</td>
<td>1.05</td>
<td>1.38</td>
<td>.92</td>
</tr>
<tr>
<td>Adjusted FFS collection percentage</td>
<td>100%</td>
<td>98.05%</td>
<td>99.58%</td>
</tr>
<tr>
<td>Bad debts due to FFS activity per FTE physician</td>
<td>$7,647</td>
<td>$18,893</td>
<td>$33,174</td>
</tr>
<tr>
<td>Total medical revenue per FTE physician</td>
<td>$725,814</td>
<td>$690,032</td>
<td>$1,082,890</td>
</tr>
<tr>
<td>Total medical revenue after operating cost per FTE physician</td>
<td>$273,425</td>
<td>$272,460</td>
<td>$553,079</td>
</tr>
<tr>
<td>Total medical revenue after operating and nonphysician provider cost per FTE physician</td>
<td>$262,706</td>
<td>$255,064</td>
<td>$512,602</td>
</tr>
</tbody>
</table>

*Better–performing practice

APPENDIX

Visit www.mgma.com/lessons for interactive tools that will help you practice the concepts presented in this chapter.

Special recognition goes to our advisory board members who reviewed and approved the content:

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