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Welcome to PMI’s Webinar Presentation

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Meet the Presenter…

On the topic:
Getting Paid: Keeping a Pulse on Accounts Receivable

Pam Joslin
MM, CMC, CMIS
Faculty,
Practice Management Institute
OBJECTIVES

• To increase effectiveness of the entire “life” cycle of a patient’s account
• To prepare the medical practice to increase “first claims” pass
• To collect from third-party payers and patients who are “past due”
• To successfully collect from patient by increasing upfront communication
• To manage accounts receivable and collect bad debts
• To tighten internal controls for tracking denials/rejects

OVERVIEW

• Revenue Cycle Management
• Before the Patient Arrives
• When the Patient Arrives
• After the Patient Leaves
• Benchmarking – where are you and where do you want to be?
REVENUE CYCLE MANAGEMENT

PATIENT REGISTRATION/SCHEDULING
- Pre-registration
- New Patient Forms
- Registration Accuracy
- Insurance verification
- Coordination of Benefits
- Identity Theft
- Referrals, authorizations or pre-certifications
- Assignment of Benefits
- Advanced Beneficiary Notices (ABNs)
ELIGIBILITY VERIFICATION

- It has become even more important to verify benefits for each patient prior to each patient encounter.
- This allows identification of patient financial responsibility and levels of coverage prior to the patient receiving services.
- In order to maintain a healthy day-to-day cash flow you must collect the patient portion at the time services are rendered.
- Real-time electronic insurance verification at live registration makes this much easier.

BEFORE THE PATIENT ARRIVES

- Financial policies
- Collections Policy
- Insurance, Third-Party Payerrs, and Managed Care Plans
- Patient Education

We have now prepared for our initial contact with our patients via the phone, inquiry via website, and in-person or hospital treatment. The next requirement will be to have the patient fill out all of the information on the required forms.
• When the form is completed, check for completeness. This review is very important in case this form must be used later for collection purposes.
• Any previous patient with an account indicating a past due bill owed, or a serious collections status, must discuss their arrangements with the financial manager prior to their visit with the doctor.

FINANCIAL POLICIES

An effective financial policy is a basic, necessity for your health care organization.

• Maintain and maximize cash flow to the office
• Increase office staff productivity and reduce overhead by reducing time and finances spent collecting payments.
• Help to educate the patient and provide a clear understanding of his/her financial obligations.
COLLECTIONS POLICY

To be successful with your collection efforts, you must consider not only options for payment of the account, but also the working relationship between the patient and the office staff.

By offering your patients financial options, you are showing them that you are concerned not only with their personal health, but also their financial health.

ACCOUNT PAYMENT OPTIONS

- Payment at the Time of Service
- Statement (pay within 30 days or less)
- Divided payment – 4 or less
- Installment loan - more than 4 payments
- Bank loan – more than 4 payments
- Third-party plan payers (medical or dental insurance, or managed care plans)
CODING AND BILLING

• Compliance experts agree that the biggest risk is coding and billing for Medicare, Medicaid, and insurance reimbursements.
• Can significantly affect the physician-patient relationship, potentially causing even minor concerns to escalate into legal action.

DISCOUNTS AND COURTESIES

• Professional courtesy – taking care of colleagues or their families without charge or at a reduced rate.
• Discount – a reduction in the normal charge based on specific amount of money or a percentage of the charge.
According to OIG, “It is unlawful to routinely waive co-payment, deductibles, coinsurances or other patient responsibility payments.”

The discount must apply to the total bill, not just the part that is paid by the patient. For example, on a $100 service, a 20% discount to the patient would be reflected on the claim form as billed at $80.00, not $100.00.

INSURANCE FRAUD

The National Health Care Anti-fraud Association (NHCAA) conservatively estimates that 3 percent of all health care spending, or $60 billion, is lost to health care fraud. Other estimates place this number closer to $200 billion. The Federal Bureau of Investigation (FBI) has estimated fraudulent billings to health care programs, both public and private, at between 3 percent and 10 percent of total health care expenditures.
MEDICARE FRAUD

Generally refers to willfully and knowingly billing medical claims in an attempt to defraud the Medicare program for money.

- Billing for services, procedures, and/or supplies that were not provided.
- Misrepresentation of what was provided, when it was provided; the condition or diagnosis; the charges involved; and/or the identity of the provider recipient.
- Providing unnecessary services or ordering unnecessary tests.

COMMON INDICATORS IN DETECTING MEDICARE FRAUD

- Routinely waiving copayments and deductibles for Medicare patients without checking for their ability to pay?
- Charging higher rates to Medicare patients compared to other persons for similar services?
- Missing treatment documentation such as physician or other provider notes?
WHEN THE PATIENT ARRIVES

• Provide a proper environment for the patient
• Obtaining patient information
• Educating the patient
• Liability statements
• Provider involvement
• Accountability and control of collections
• Payment at the time of service
• Federal Fair Credit Billing Act

OBTAINING PATIENT INFORMATION

• The key to collections is to get all of the additional necessary information up front.

Includes:
– New patient forms
– Established patient data
– General data for all patients
EDUCATING THE PATIENT

• Billing and collections in the medical field are confusing for even those who have worked in the field for years.

      Education methods:
      • Phone Patient Information Sheet
      • Welcome letter Review of information
      • Patient brochure Superbill/Routing Slip
      • Website Waivers
      • Signage

LIABILITY STATEMENTS

• When patient is liable for physician fees, necessary for patient to sign liability forms.
• Medicare has strong regulations regarding patients’ awareness of their liability.
• Patient needs to be educated on what is covered and what is not considered “medically necessary.”
PROVIDER INVOLVEMENT

• Using proper diagnosis on ALL chart entries
• Using proper CPT/HCPCS for procedures and E/M codes
• Reviewing the new CPT codes and guidelines annually
• Using modifiers and special service codes
• Reviewing the types of services for new patients and established patients
• Helping to review and revise the office encounter form and fees annually.

• Reading and understanding consultation codes and usage
• Reviewing past due balances monthly and deciding the process (collections, etc.)
• Communicating with other providers doing concurrent care
• Obtaining necessary reports needed for receiving payment for services rendered
• Utilizing the AMA/CMS Documentation Guidelines for E/M Services
ACCOUNTABILITY AND CONTROL OF COLLECTIONS

• Superbill/receipt system for all payments
• Document number on each form
• Balance at end of each day
• Adjustment Report with reason codes and amounts
• Patients get receipt for ALL transactions
• Lock money drawer

INFORMATION GATHERING AND CLAIMS FILING

• **HMO** – Primary care physicians provides referral/authorization. Patient is responsible only for co-payment and non-covered services.
• **PPO** – Patient chooses physician from contracted provider list. Patient responsible for any deductibles, copay or percentage. Patient portion can and should be collected at time of service.
• **PPO – OUT OF NETWORK** – Patient chooses any physician. Benefits paid at lower percentage and will possibly have yearly deductible.
FEDERAL FAIR CREDIT BILLING ACT

• October 28, 1975, the Federal Fair Credit Billing Act was implemented as part of Public Law 93-495. This Act is an amendment to the previously-enacted Truth-in-Lending Law.

• “…to protect the consume against inaccurate and unfair credit billing…” as well as to “…ensure that the various financial institutions and other firms engaged in the extensions of credit, exercise their responsibility to make credit available with fairness, impartiality, and without discrimination on the bias of sex or marital status…”

• 1) Practice must acknowledge receipt from the debtor of a notification regarding an error in billing within 30 days after receiving the notification.

• 2) If not within the 30-day period, then no later than two complete billing cycles but not later than 90 days after the receipt of the notice.

• 3) If the debtor alleges that the patient bill does not reflect services provided, the practice may have to provide statement of services rendered.
AFTER THE PATIENT LEAVES

- Patient Account Management
  - The Statements
  - Insurance Follow-Up
- Patient Refunds
- Billing Services
- Patient Collection Sequence/Debt Resolution
- Sequence of Statements & Procedures

PATIENT ACCOUNT MANAGEMENT

- Now, all proper forms are signed, the patient is educated and aware of the charges, we can not take a look at account receivables and take proper action.

- Statements
- Insurance Follow-up
PATIENT REFUNDS

• Review patient account to verify refund:
• Check payable to patient
• Attach printout to check for signing
• Make appropriate adjustment in system
• Do refunds weekly or at least monthly
• Public relations impact is negative if patient’s money is held.

• NOTE: Medicare or Medicare patient refunds should be submitted within 30 days.

COLLECTION CALLS

1. Start your objectives
2. Speak only to the responsible individual
3. Identify yourself
4. Pinpoint the responsibility
5. Obtain a firm commitment
6. Tell them you are going to send a confirmation letter
7. Always make your calls in private
TELEPHONE CHECKLIST

Standards of Conduct/Phone Collections

NOTE: Remember, not one technique works on everyone. Just like with collection letters, a graduated approach to phone collections is appropriate.

PHONE RESPONSES

When you call, be polite, introduce yourself, and ask if this is a good time to call. If debtors say, “no,” ask them when you can call back to discuss their account.

If the time is right, then discuss the balance and ask, “Is there a problem with clearing up the balance on your account?”
Collection Letters
Level 1

Dear Patient:

We have not received payment on your bill of $_________. If you have any questions about the bill or the individual charges, please call or write immediately. If there are no questions, please mail your payment today.

Sincerely,

________________
(Name of provider)

Collection Letters
Level 2

Dear Patient:

Please call our business office at XXX-XXX-XXXX as soon as possible regarding your account. We appreciate your prompt action in this matter.

Sincerely,

________________
(Name of provider)
Collection Letters
Level 3 (Final)

FINAL NOTICE
Date of Service:__________
Amount:____________

Dear Patient:

Your account remains unpaid, and we regret your lack of response. This account is now delinquent and will be removed from our current files.

We will turn this account over to a collection agency if we do not receive payment within fifteen (15) days.

Sincerely,

(Name of provider)

HERE’S HOW IT WORKS:

• NOTICE #1 - Send to any patient with a 90-day unpaid balance.
• NOTICE #2 – Mailed ten days later if still no response has been received.
• NOTICE #3 – 30 days have elapsed since the first reminder notice was sent. Letter of dismissal from practice. Account placed with collection agency.
Letter of Dismissal

Mrs. Gloria Smith
1234 First St.
Nowhere, DL 12345

Dear Mrs. Smith:

In view of the fact that we have failed to maintain a satisfactory patient-physician relationship, I feel it is necessary to inform you that you will no longer be treated under my care.

I urge you to call your local hospital or medical society, look through the yellow pages under “Physicians and Surgeons, Osteopathic,” or search online to secure another doctor to address your medical needs. If you incur problems in finding another doctor, please contact my office staff, and they will assist you in finding a physician.

In the event you are in need of emergency services in the next 30 days, I will be available to treat you. However, after that time period has elapsed, I urge you to place yourself under the care of another physician. Your new physician will be able to write and obtain your records from my office with your written permission. This will assure your continuous care. May you have good health and good fortune.

Sincerely,

Dr. Bill Jones III

NOTE: Be certain to certify the letter and notify the person in charge of your appointment scheduling of this action.

SUMMARY

• When a new patient calls for an appointment, the person making the appointment will inform the patient that he visit is to be paid for at the time of the appointment.

• When the new patient arrives, the receptionist will give the patient a copy of the patient information booklet and a new patient information form to be completed while waiting.
At the completion of the visit, the patient will be given an amount due. DO NOT ASK IF THEY WANT TO PAY!!! Assume that they will pay.

Ask, “Will that be cash, check, or credit card today?”

Finally, every time a patient calls, you should bring up the account and quickly review past due amounts, and other significant information – this may be your only opportunity to discuss the account.

HOW TO USE AN A/R REPORT

First, look at the greatest amounts of money owed by all insurance carriers and/or guarantors.

Working on the 80/20 principle, working on the highest balances that have been due for the long time

Italian economist, Vifredo Pareto created a mathematical formula to describe the unequal distribution of wealth in his country, observing that 20 percent of the people owned 80 percent of the wealth. This rule is used today in debt collection.
ACCOUNTS RECEIVABLE

• The AR report is based on aging claims form 0 to over 120 days, depending on how your report is set up.

• They can be set to begin the aging process from the original date of service or the date submitted to the insurance company.

• These reports give you an overview of how long it takes to get paid from various carriers as well as guarantor or patient responsibility.
## FINANCIAL CALCULATIONS

**Assumptions:**
- Balance in A/R: $50,000
- Collection/year: $216,000
- Billed for month: $20,000
- Expenses: $250,000
- Adjustments: $1,000
- Total salary: $200,000

### Gross Collection Ratio:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Collection</td>
<td>$18,000</td>
</tr>
<tr>
<td>Total Billing</td>
<td>$20,000</td>
</tr>
<tr>
<td>Length in A/R</td>
<td>2.5 months</td>
</tr>
<tr>
<td>Collected</td>
<td>$18,000</td>
</tr>
<tr>
<td>Monthly Billing</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

### Net Collection Ratio:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Billings</td>
<td>$20,000</td>
</tr>
<tr>
<td>Total Collections</td>
<td>$18,000</td>
</tr>
<tr>
<td>Length in A/R</td>
<td>2.5 months</td>
</tr>
<tr>
<td>Net Collections</td>
<td>$18,000</td>
</tr>
<tr>
<td>Monthly Billing</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

### Billing Per Patient:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Billing (Mo. or Yr.)</td>
<td>$20,000</td>
</tr>
<tr>
<td>Revenue per Patient (Mo. or Yr.)</td>
<td>$45 each</td>
</tr>
<tr>
<td>Total # of patients (Mo. or Yr.)</td>
<td>4,800</td>
</tr>
</tbody>
</table>

### Expense Per Patient:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Expenses (Mo. or Yr.)</td>
<td>$250,000</td>
</tr>
<tr>
<td>Expense per Patient (Mo. or Yr.)</td>
<td>$52.08 per patient</td>
</tr>
<tr>
<td>Total # of patients (Mo. or Yr.)</td>
<td>4,800</td>
</tr>
</tbody>
</table>

### Salary Rate:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Salary (with or without benefits)</td>
<td>$200,000</td>
</tr>
<tr>
<td>Salary Rate (per patient)</td>
<td>$41.67 per patient</td>
</tr>
<tr>
<td>Total Patients</td>
<td>4,800</td>
</tr>
</tbody>
</table>

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**Accounts Receivable Summary**

For Month Ending: [Month]

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Billing</td>
<td></td>
</tr>
<tr>
<td>To be billed (1 to 30 days)</td>
<td></td>
</tr>
<tr>
<td>Aging balances (31 to 90 days)</td>
<td></td>
</tr>
<tr>
<td>Overdue balances (91 to 120 days)</td>
<td></td>
</tr>
<tr>
<td>Past due accounts (91 to 120 days)</td>
<td></td>
</tr>
<tr>
<td>Delinquent accounts (over 121 days)</td>
<td></td>
</tr>
<tr>
<td>In collection</td>
<td></td>
</tr>
<tr>
<td>To be written off (less than $100)</td>
<td></td>
</tr>
<tr>
<td>Credit balances</td>
<td></td>
</tr>
<tr>
<td>Special accounts (written down)</td>
<td></td>
</tr>
<tr>
<td>(SUBTOTAL)</td>
<td></td>
</tr>
<tr>
<td>Third party payables</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
</tr>
<tr>
<td>Private insurance</td>
<td></td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>(SUBTOTAL)</td>
<td></td>
</tr>
<tr>
<td>GRAND TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

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[Note: The image contains a table with columns for description, amount, and notes, but the specific amounts are not filled in. The totals for each segment are not calculated.]
SEVEN STEPS IN THE APPEALS PROCESS

Step 1 Examine the EOB:
- Determine why the claim was paid incorrectly or denied.
- Contact the insurance carrier for a detailed explanation for a detailed explanation for the reason of the denial.
- Request information on the re-consideration or appeal process.
- Ask for re-consideration of the claim by phone if possible.
- Request and understand any additional information that needs to be included in the re-consideration or appeal documentation.
- Ask if there is a specific person to whom the appeal is to be sent. Ask for their name, telephone number and extension of the individual.
- Determine if the appeal can be faxed. Make sure to keep additional copies of all correspondence on file.
- Understand how long the appeal process will take and when payment can be expected, make sure to follow up to ensure the process is adhered to by the carrier.

Step 2 – Make sure to review the EOB, plan benefits, contract provisions, carrier policies and medical records.

- When an appeal is initiated, include a cover letter with a detailed explanation as why the claim was denied incorrectly or inaccurate payment. Include the EOB, and any supporting information as well as my authorizations, pre-certification or referrals.
• **Step 3** – Contact if Human Resources Department assists with employee benefits. They will definitely be interested if you are having any issues with clean claims being paid. This impact could determine if that particular carrier will be utilized when time for renewal of the policy.

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**Step 4** – Understand your state laws and the allowances for carriers to respond to claims. Go to your local Department of Insurance’s website for detailed information.

**NOTE:** Some plans may not fall under the jurisdiction of the State Insurance Commissioner.
Step 5 – Document who you spoke with and when for ALL contact in regards to a claim.

Step 6 – If the carrier continually asks for additional information that has been repeatedly sent, state the practice’s policy on “administrative fees for additional information.”

Step 7 – If all our previous efforts fail, file a complaint with the State Insurance Commissioner.

Make sure before filing the complaint all information is reviewed from the above steps.
BENCHMARKING YOUR ACCOUNTS RECEIVABLE FOR SUCCESS

Measurements & Monitoring Outcomes – Setting Goals!!

- **Specific**: Be clear and unambiguous when setting your goal. Don’t leave room for guessing.
- **M – Measurable**: Set a goal that allows you measurement toward your goals progress.
- **A – Attainable**: Ask yourself, “Is this realistic and attainable?” If not, back to the drawing board.
- **R – Relevant**: Create a goal with importance and meaning. Make sure the effort is worth it to you.
- **T – Time-bound**: Commit to a deadline. Open-ended goals tend to go forgotten.

http://www.movemequotes.com/top-15-goal-setting-quotes/
Multispecialty A/R Dashboard

Days in AR

Ar/To30: 55.56%
Ar/91To120: 13.84%
Ar/31To60: 13.84%
Ar/61To90: 7.17%
Ar/91To120: 5.40%
Ar/121Over: 17.98%

http://www.mgma.com/industry-data/all-data-resources/benchmarking-tools-from-mgma-surveys

Primary Care A/R Dashboard

Days in AR

Ar/To30: 54.06%
Ar/61To90: 6.90%
Ar/91To120: 4.67%
Ar/121Over: 21.72%
Ar/31To60: 12.78%

http://www.mgma.com/industry-data/all-data-resources/benchmarking-tools-from-mgma-surveys
**Tips, Tools, Techniques**

- Have a consistent policy for ALL patients and effectively communicate your financial policies with them.
- Select the RIGHT PERSON to do the job in all cycles of reimbursement billing.
- Don’t spend a lot of time on smaller accounts. Hit the large ones first.
- Be acquainted with carrier specific rules for appeals, refunds and recoupments.
- Have monitoring systems in place to track success.

**Questions**

- Thank you for your attendance!


- Contact information: pjoslin@pmimd.com