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Welcome to PMI’s Webinar Presentation

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Meet the Presenter…

On the topic: Where Is My Money? part 2

Lisa Maciejewski-West
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Faculty
Practice Management Institute
Where Is My Money?
A practical guide to increasing collections in your practice
PART 2 – Finding Money in your Accounts Receivables
Presenter: Lisa Maciejewski-West

23% of All Commercial Insurance Claims go UNPAID

Insurer Non-payment. Physicians received no payment at all from commercial health insurers on nearly 23 percent of claims they submitted. There are many reasons a legitimate claim may go unpaid by an insurer. Claims may be denied, edited or deferred to patients. During Feb. and March of this year, the most common reason insurers didn't issue a payment was due to deductible requirements that shift payment responsibility to patients until a dollar limit is exceeded. Real-time claims processing would save time and money.

Between 20-40% of Claims are IMPROPERLY paid

“A 20 percent error rate among health insurers represents an intolerable level of inefficiency that wastes an estimated $17 billion annually,” said AMA Board Member Barbara L. McAneny, M.D. “Health insurers must put more effort into paying claims correctly the first time to save precious health care dollars and reduce unnecessary administrative tasks that take time and resources away from patient care.”

Anthem Blue Cross Blue Shield had scored the worst of those measured with an accuracy rating of 61.05 percent.

Look what happens to $1.00 when you don’t collect it TODAY!

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Accounts Receivables (AR)

- When you bill out claims, these unpaid services become part of your Accounts Receivables
- Patient Monies that are not collected become part of your AR
- Monthly AR Reports show you everything that is outstanding. Can be:
  - Broken down by Pending Insurance Claims
  - Broken down by Pending Patient Money
  - Broken down by Insurance Carrier/Case Type
  - Broken down by Age of Outstanding Balance
Make sure you know how to run AND analyze these reports!

The AR “Sweet Spot”

- When looking for INSURANCE AR that is at its MOST collectable, target unpaid claims in the 45-90 day range
- Break down AR by carrier- improves efficiency
- Look for largest balances and work your way down to smallest balance
- Working AR from A-Z may not be the most effective method, especially if you have hundreds of pages to go through.
- New AR should be run EVERY MONTH. If you don’t get through your AR in a month, generate a new report. Don’t work off the same AR for four months!
Working Old AR (over 90 days)

- Don’t work your AR from oldest to newest. The older the AR, the less likely you are to collect.
- Old AR is mostly cleanup work.
- Allocate a certain number of hours/week on old AR. STOP once you have reach that threshold
- Larger practices/clinics with multiple employee billing departments may want dedicate one or several employees to clean up old AR.
- Never put your clinic in a position of constantly chasing old AR. Divide and conquer!

ANALYZING YOUR AR

- Look for GROUPS of non payment first-this will allow you to collect on multiple accounts at once
- Look for patterns: (examples)
  - You have a bunch of claims from one particular billing date that did not get paid. (Problem at Clearinghouse, problem with the claim batch)
  - You have a carrier that has not paid in over 30 days (Credentialing issue, holding claims due to audit)
- Identify your targets and get to work
Investigations – unpaid claims

- Have a game plan/procedure for investigating unpaid claims. Many times a phone call is not necessary.
- If you have a claim that has not been paid
  1. Go to Practice Management Software
     a) Was claim billed correctly from the software (has it left the building)?
     b) Are there already notes in the account about this claim? Don’t repeat your work, take good notes and document your efforts!
  2. Go to the Clearinghouse
     a) Was claim received at Clearinghouse?
     b) Was claim rejected at Clearinghouse (Level 1)
     c) Was claim rejected back to Clearinghouse (Level 2)
     d) Is Remit waiting at Clearinghouse?
  3. If you direct bill to Carrier
     a) Check carrier sites for the same types of reports/rejects/payments as you would the clearinghouse

Investigations – unpaid claims (cont)

4. Carrier Site
   a) Go to Carrier Site and look for claim status
   b) No claim on record:
      a) Go back to clearinghouse, look for acceptance report from payer. If no acceptance report, work your way backward until you find out where the claim got hung up
      c) Claim on record:
         a) If paid, download remit
         b) If pending with anticipated pay date, follow up when indicated
         c) If pending with no explanation, CALL CARRIER
CARRIER PHONE CALLS

• Get Organized!
  • Multiple claims investigations in one call
    • Different patients, same carrier
    • Same patient, multiple DOS’
  • WHEN are you going to do this?
    • Allocate certain hours each week to do NOTHING but calls.
    • Uninterrupted time
    • Cannot be done at the front desk
    • Cannot be done if you are floating
    • DO NOT DISTURB!!

CARRIER PHONE CALLS

• Documentation system
  • Have all paperwork and documentation handy
    • AR Report
    • Clearinghouse Reports
    • Carrier Reports
    • Past EOB’s
    • Documentation previously requested by carrier
  • Write down EVERYTHING you are told
    • Time of Call
    • Name of Representative
    • REFERENCE NUMBER
  • Don’t just ask about status:
    • Where is my claim?
    • Why wasn’t it paid? (if applicable)
    • What do I need to do about it? (if applicable)
CALL GUIDELINES/ADVICE

- The person on the other end of the line has probably been having a bad day. BE NICE if you can – you will get more out of them
- Use the same conversation format for each call so you don’t miss any key information. You don’t want to have to call back!
- Call on as many patients/claims at once as possible
- Ask for immediate transfer if you don’t understand them
- Ask for supervisor if you are not getting the answers you want or representative is not being helpful
- Document conversation/results of investigation in a way AND PLACE that is easy for EVERYONE to understand. The margins of the AR report are NOT the place!
- Document TIME spent on each call

Patient AR and patient collections will be discussed in next Webinar on December 3, 2015 at 12:00p
An ounce of Prevention…..

- The most successful AR program is not to have one…..
- GARBAGE IN…..GARBAGE OUT
  - Patient data/demographics keyed in correctly
  - Correct coding (Webinar #1 – in Archives)
  - Collect from Patient at TOS (Webinar #3 Dec 3rd)
  - Catch Billing errors BEFORE they go out
  - Monitor progress of claims continually
  - Jump on improperly paid claims as soon as you receive them

Vetting your Bills/Claims

- CODERS/DOCTORS
  - Before claims are sent to billing department for transmission, make sure you’ve coded properly
    - CORRECT PROCEDURE CODES
    - CORRECT NUMBER OF UNITS
    - CORRECT MODIFIERS
    - CORRECT ICD10 CODES
- BILLERS
  - Print/view a pre-billing report. Look for coding and claims errors…scour your claims first! Common errors
    - Missing patient information
    - Incorrect CPT/HCPCS Codes/modifiers
    - Missing CPT codes
    - INCORRECT ICD codes
Vetting your Bills/Claims

- BILLERS
  - VERIFY that the claim batch MATCHES the number of claims billed
  - VERIFY that the claims were all accepted by the clearinghouse. Correct Level 1 rejections immediately
  - VERIFY that the claims were all accepted by the carrier Correct Level 2 rejections immediately
    - It is important to go to the clearinghouse DAILY to find these reports. They don’t all come in at once.
  - Check for claims that need to be filed on paper (secondary, non crossover claims, auto/work comp claims, union policies, etc)

When a claim is not paid properly..

- Prepare for Battle…
  - Find similar claims that were paid properly, use for comparison
  - Call carrier and find out why claim was processed incorrectly (if you can’t tell from the EOB)
  - Find out what needs to be done to rectify the situation
  - Don’t just REBILL the claim, unless you know the rules – may need a telephone reopening/appeal, may need additional documentation. If you rebill, find out how the carrier wants it done, so the claim does not flag as a duplicate
  - Track that claim! Have a tickler system to follow up on claims that are under appeal or need to be resubmitted
CONSEQUENCES OF BAD BILLING PROCEDURES

- Once you have to touch an improperly paid/processed claim more than once, you will have to touch it at least FOUR times, maybe more. Your goal is to end the process at #2
  - 1. Bill It
  - 2. Post Payment/correct denial – IF NOT PAID/DENIED PROPERLY, then
  - 3. Investigate
  - 4. Rebill/Appeal
  - 5. Possible Second level appeal
  - 6. Post payment/denial
  - 7. Notify patient/provider

FOLLOW UP SYSTEM-Old School

- Create Billed Claims File
  - Billed claims Reports, E-Claims Transmissions or Copies of CMS 1500 Forms
- Create Disputed/Unpaid Claims Binder (Suspense File Format) (31 Tabs for Days of Month and 12 Tabs Jan-Dec)
- Create Priority (72 Hour) Follow Up Folder
- Date Received Stamp for EOB’s
- Insurance Communication Logs
- As office gets larger, create separate dispute binders by billing profile (Medicare/BCBS/PI/WC etc)
FOLLOW UP SYSTEM - Old School

- Once claims are filed and/or transmitted:
  - Print Billed Claims Report, file in Billed Claims Folder
  - Print Transmission Reports, check to see all claims accepted, file in Billed Claims Folder
  - (Your PROOF Claim was submitted)

FOLLOW UP SYSTEM - Old School

- When an EOB/PAYMENT is received:
  - Electronic EOB’s - Print remit notice (from clearinghouse – for 835 files/auto posting)
  - Electronic EOB’s – Print remit (for manual posting)
  - Paper EOB’s - Stamp EOB on DATE RECEIVED
  - Check EOB CAREFULLY.
  - Make sure DOS and Amount Billed = the Billed Claims Report/Insurance Log
  - Make sure payment/denial in accordance with patient’s insurance verification info
  - Post Payment/Denial to Software
  - Apply Payments CORRECTLY
  - Apply ZERO payments so amount remaining is kicked over to the patient’s responsibility
FOLLOW UP SYSTEM-Old School

- When a Claim is Paid CORRECTLY
  - File EOB in Paid Claims Binders or Folders (By carrier, most recent on top) Do not file in patient charts
  - PAPERLESS OPTION: Scan EOB to shared folder on computer (Desktop, cloud based, etc) and shred paper EOB.
  - Highlight Claim, or Mark Off from the Billed Claims Report

- When a Claim is NOT Paid Correctly
  - Attach Insurance Communication Log to EOB
  - Place in Priority Follow Up Folder
  - Make a note in the patient’s account that claim is delayed or denied and why.
  - CALL Insurance Co within 72 hours (3 Business Days of Receipt)

FOLLOW UP SYSTEM-Office Manager

- Daily: Check suspense file for follow up calls and/or activities that are due. Any unfinished business is forwarded to the next day/next follow up day
- Weekly: Make sure billing has been done, and all issues in clearinghouse have been resolved
- Weekly: Make sure patient accounts, including insurance demographics, dx codes, etc are current
- Weekly: Go to clearinghouse and carrier websites to pull all EOB’s delivered electronically
- Weekly: Print/View Unpaid claims reports, look for claims that should have been paid by now
- Monthly: Print AR each month and look for claims with NO activity that have aged over 30 days.
Next Time….

- How to efficiently, correctly and compassionately collect patient money
  - Importance of TOS collections
  - Importance of Accurate VOB’s
  - Importance of Good Customer Service
  - When all that’s left is patient money
    - Statements, and how many times do you send them before it becomes TOO MANY.
  - When is it appropriate to write off old AR
  - Use of collection agencies, billing agencies (pros and cons)
  - Analyzing your collections through statistical data vs. emotions