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On the topic:

Keys to Optimizing Your Revenue Cycle
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Keys to Optimizing Your Revenue Cycle

Brought to you by
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Revenue Cycle Management

• The Healthcare Financial Management Association (HFMA) defines revenue cycle as: "All administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue." In other words, it is a term that includes the entire life of a patient account from creation to payment.

• Revenue cycle processes flow into and affect one another. When processes are executed correctly, the cycle performs predictably.

• However, problems early in the cycle can have significant ripple effects. The further an error travels through the revenue cycle, the more costly revenue recovery becomes.
What Do We Manage?

Financial Barriers in RCM that Impact Practices and Patients

- The National Health Insurer Report Card in 2013 revealed 19.3% of claims paid by commercial insurance companies are incorrect.
- In addition, patients owe larger portions of their medical bills due to increase in deductibles and cost-share of employer premiums.
- A recent report from InstaMed found that 74% of healthcare providers reported an increase in patient financial responsibility in 2015, which has prompted healthcare revenue cycle management strategies to focus more on consumers.
High-Deductible Health Plan Statistics

• The Affordable Care Act has lowered the uninsured rate in the U.S. from 15.7% in 2009 to 9.1%, according to a report from the CDC.

• Health systems used to collect a majority of healthcare reimbursements from government or commercial payers.

• Enrollment in HDHP/SO plans has increased over the last five years, from 19% of covered workers in 2012 to 28% in 2017.

• The number of Americans age 18 to 64 with a high-deductible plan increased from 26.3% in 2011 to 39.3% last year, according to a report from the CDC's National Center for Health Statistics.

• Among privately insured U.S. adults with HDHPs in 2016, 15.5% reported difficulty paying medical bills in the past 12 months. That compares to 10.3% of adults with a traditional health plan.

• Researchers found that providers only anticipate collecting 50 to 70% of a patient's balance after a visit. 70% of providers stated that it takes a month or longer to receive the payment from a patient.
• For patients whose deductibles equaled 5% or more of their annual income, 40% said they chose not to see a physician, get a medical test or visit a specialist, according to a Commonwealth Fund survey.

• When patients delay necessary or preventive medical care, they may end up in hospitals' emergency rooms for treatment. About 80% of emergency physicians said they are treating insured patients who have sacrificed, or delayed medical care due to unaffordable out-of-pocket costs, co-insurance or high-deductibles, according to a poll by the American College of Emergency Physicians.
Total Annual Costs (Premiums and Account Contributions) for Covered Workers in HDHP/SOs, for Family Coverage, by Firm Size, 2017

* Estimate is statistically different between All Small Firms and All Large Firms estimate (p < .05).

NOTE: Small Firms have 3-199 workers, and Large Firms have 200 or more workers. When these firms (that do not contribute to the HSA (47% for single coverage and 44% for family coverage) are excluded from the calculation, the average firm contribution to the HSA for covered workers is $795 for single coverage and $1,817 for family coverage. Three percent of covered workers are enrolled in a plan where the firm matches employer HSA contributions. For HDHP/HRAs, we refer to the amount that the employer commits to make available to an HRA as a contribution for ease of discussion. HRAs are notional accounts, and employers are not required to actually transfer funds to the employees’ account. Thus, employers may not spend the entire amount that they commit to make available to their employees through an HRA. Covered workers enrolled in a plan where the firm matches any employer contribution to an HSA account are not included in the average contribution (3% for single coverage and 3% for family coverage). Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages.

SOURCE: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2017

Distribution of Covered Workers with the Following General Annual Deductible Amounts for Single Coverage, HSA-Qualified HDHPs and HDHP/HRAs, By Firm Size, 2017

NOTE: In HSA-qualified HDHPs, the legal minimum deductible for 2017 is $1,300 for single coverage and $2,600 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers. Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages.

SOURCE: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2017
Why We Manage RCM

- The average out-of-pocket cost for patients has increased by 230%.
- More than 90% of persons enrolled in an Exchange Plan through the Affordable Care Act are in high-deductible health plans.
- The average cost of working denials/rejects can be $25/claim.
Revenue Cycle Management

- Payor contracts
- Registration/Pre-registration
- Eligibility Verification
- EMR Creation/Documentation
- Coding
- Capturing Charges/Claims Submission
- Processing payments
- Patient Billing
- Denial Management
- Managing Accounts Receivable/Collections via Patient/Payer Follow-up

Payor Contracts

- The revenue cycle begins with defining the terms of the relationship with the insurer.
- The patient makes contact with your office.
- The cycle begins with stating the practice policies, knowing the terms of insurance contracts, and establishing an appropriate, but enforceable policy for patients without insurance.
• Everyone in the practice needs to be involved in the revenue cycle: clinicians, administrative staff
  ➢ not just billing office staff
  ➢ THE TEAM APPROACH
• The process of getting paid starts before the patient walks in the door.

Registration/Pre-registration
Eligibility Verification
• Gather accurate patient information before and during registration.
• Collect patient demographics and insurance information during the scheduling initial phone call with patient.
• Obtain authorization for any procedure that requires it.
• Describe the practice’s payment expectations to patients at the time they make appointments.
• Provide Financial Policy to patient.
• Communicate appointment reminders phone calls, text, electronic.
• When patient checks in, front desk should always verify demographics.
• Mandate that time-of-service collection is a core function of front-office staff.
• Easier to collect from patients prior to service being rendered.
• This reduces the number of patient accounts that end up in bad debt or collections status.

Scripts for Requesting Payment or Informing about Payment Responsibilities

Prior to Day of Service
• When a new patient with insurance makes an appointment
  – “Payment is due at the time of service, unless you bring your current insurance card, in which case only the co-payment and deductible amount will be due.”
• When a new patient without insurance makes an appointment
  – “Payment in full is due at the time of service”
• When a patient with a previous balance makes an appointment
  – “Both your payment (or co-pay) for this visit and your prior balance of $75 will be due at the time of service.”
• Informing patient of expected financial responsibility ahead of time
  – “Mr. Brown, I contacted your insurance company and according to your insurance the procedure the doctor has ordered for you is a benefit under your plan......(pause)......I also want to let you know that according to your insurance you have a co-pay of 30% after deductible. I calculated what you would have to pay. You will be responsible for approximately $120. We do require payment on the day of the appointment. We accept MasterCard, Visa, Checks and Cash. ...Do you have any questions?”
Sample Financial Policy

The providers and staff at the _______ Group feel that we can better serve your healthcare needs if you are familiar with the following policies and procedures of the group:

**OFFICE HOURS:** The _______ Group is open Monday through Friday from 8:00 a.m. to 5:00 p.m. Providers are available on an emergency basis at any time.

**APPOINTMENTS:** Appointments may be made by calling (555) 555-5454 during our office hours. Appointments may be requested with the provider of your choice. Every effort will be made to provide the earliest possible attention for the convenience of the patient. Due to the unscheduled nature of emergencies imposed upon the providers, occasional delays do occur. We hope that you will understand that these delays are unavoidable. If you are unable to keep your appointment, please cancel as far in advance as possible. Some other patient who can be booked into the open time will be grateful for your thoughtfulness. **If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee.**

**PAYMENT FOR SERVICES:** Patients are requested to pay at the time the service is rendered. In our contract with insurance carriers, we are required to collect a co-pay for your visit with the provider, therefore, we will be collecting your co-pay prior to your visit. We will accept cash, check, or credit card. Returned checks will incur a $30.00 service charge. **In order to participate in protecting your medical identify, we do ask for a copy of a health insurance card, Driver's License (ID card) upon check-in.**

Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit.
However, if this is not possible, a copy of your account charges will be provided the day of your visit. Payment of your account is expected within 10 days of receipt of charges. In the event that timely payment cannot be made, special and specific arrangements may be made by calling our Patient Accounts Department at (555) 555-2455. We will be most understanding and willing to accommodate unusual circumstances.

You are directly responsible for any unpaid balance on your account with us. You will receive a statement each month, even if insurance payment is pending. The medical information necessary for insurance claim forms is provided as a courtesy to you.

The _______ Group cannot accept responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract.

Any special arrangements between patient and provider for payment of your account must be presented directly to the patient Accounts Department.

After 90 days, if no payments have been received and no extended payment arrangements have been made, necessary collection proceedings will begin.

It is important that you notify us of any changes of address promptly since undeliverable statements are turned over to collection agencies immediately.

In accidents, legal cases, etc. in which an insurance company or other party is presumed liable for your expenses incurred as a result of your accident or illness, the _______ Group looks to the party receiving the services for payment and cannot be expected to wait for the conclusion of long-term court cases or the settlement of disputed insurance claims before being paid. The party receiving such services is normally expected to take care of his/her account in line with the above credit guidelines.
INSURANCE CLAIMS: If you have indemnity insurance, which will pay for services rendered at the _______ Group, it is our policy to provide to you, without charge, a statement with all the information needed by your insurance company. You should forward this statement together with your insurance claim form, filling out the patient part only, directly to your insurance company. It must be understood, however, that financial responsibility for the account rests with the patient. Insurance claims on services performed must be requested by the patient. You will be responsible for any deductible at time of service.

*Caution: If your insurance covers services rendered in the _______ Group, it is your responsibility to request an itemized statement from our insurance department covering these services. If you have filed an insurance claim and no payment or rejection notice has been received within 60 days from the date of filing, we encourage you to:

A. contact your insurance company as to the reason for delay.

B. make regular payments on your account to keep it in good standing. Any overpayment will be refunded in the event that the insurance pays directly to the _______ Group.

DIVORCED PARENTS OF PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

FORM FEES: There will be a $10.00 fee charged to complete forms. The following list includes, but is not limited to: disability, FMLA, loan, cancer policy, supplemental insurance policy & daycare forms. Payments must be made prior to the completion of the forms. The office will have 10 business days in which to complete forms before making them available for patient to pick up.
EMERGENCIES: Call our phone number, (555) 555-5454, at any time. A provider is available on call to meet emergency needs. New patients making their first visit to the group are requested to arrive 15 minutes before their scheduled appointment for the purpose of registration.

COMPLAINTS: It is our sincerest desire that you will have no occasion to register a concern, but if that occasion should arise, please call any of the providers or the clinic administrator at (555) 555-5454. Your constructive criticism is encouraged at all times to assist us in improving service to our patients.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor, if applicable) ____________________________ Date __________________________

Please print name of patient

Front Desk

• When patient checks in, front desk should always verify demographics.
• Mandate that time-of-service collection is a core function of front-office staff.
• Easier to collect from patients prior to service being rendered.
• This reduces the number of patient accounts that end up in bad debt or collections status.
EHR Creation/Documentation

• In May 2014, a report from the Office of Inspector General (OIG) found that 55% of claims for E&M services were coded incorrectly and/or lacked documentation, which resulted in $6.7 billion in improper payments.

• According to the same report, 26% of all claims for E&M services were overcoded, which means that the documentation supported a lower level than what was billed.

• It also showed the following:
  - 15% of all E&M services were undercoded
  - 19% were lacking sufficient documentation or billed under the wrong category of code (i.e., inpatient vs. outpatient). Some claims were both incorrectly coded and insufficiently documented.

• The study also looked at the problem of cloned notes. Authenticity counts as much as completeness in supporting medical necessity and appropriateness of payment.

• Use of EHR systems present risks when providers overuse the copy/paste functions and auto-fill templates to create cloned notes.

• Each element of the review of systems (ROS) and physical exam must be supported by the history of present illness (HPI), which is documented personally by a provider for each visit.

• Using templates that automatically fill in a complete ROS with preselected content or physical examination with prepopulated normal findings does not support medical necessity.

  If it wasn’t documented, it wasn’t done. If you didn’t do it, don’t document it.
Medical Necessity

• According to Medicare.gov, “medically necessary” is defined as “health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."

• For a service to be considered medically necessary, it must be reasonable and necessary to diagnosis or treat a patient’s medical condition.

• When submitting claims for payment, the diagnosis codes reported with the service tells the payer "why" a service was performed. The diagnosis reported helps support the medical necessity of the procedure.

• For example, a patient presents to the office with chest pain and the physician orders an electrocardiogram (ECG).

• A 12-lead ECG performed in the office and interpreted by a physician is reported with CPT® code 93000.

• The reason the physician orders the ECG is because the patient is complaining of chest pain. The diagnosis code for unspecified chest pain is R07.9.
• In this case, the provider should be queried why the chest X-ray was ordered so the proper diagnosis can be reported.

• The provider may have wanted a knee X-ray and made a mistake when writing his orders. By asking the provider for clarification, you have prevented the performance of an unnecessary test because the provider really intended to order a knee X-ray.

• In this case, the knee pain would support the order of the knee X-ray. If the provider intended to order a chest X-ray, by asking for clarification you can report the service with a more appropriate ICD-10-CM code and eliminate a claim denial.

• The provider must document the diagnosis for all procedures that are performed. The provider also must include the diagnosis for each diagnostic test ordered.

• A common error seen when reviewing medical documentation is that the provider will document a diagnosis and indicate tests ordered, but it is unclear that all the tests ordered are for the diagnosis documented in the assessment.

• For example, the patient presents with right knee pain and the physician performs an arthrocentesis. He also orders a chest X-ray. The only diagnosis documented is knee pain. The knee pain supports the medical necessity for performing the arthrocentesis, but it does not support the medical necessity for the chest X-ray.
Advance Beneficiary Notice

The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied.

Guidelines for mandatory and voluntary use of the ABN are published in the Medicare Claims Processing Manual, Chapter 30, Section 50.

ABN Form

A. Notifier:
B. Patient Name:  
C. Identification Number:  

**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn’t pay for D. below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. below.

<table>
<thead>
<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**WHAT YOU NEED TO DO NOW:**
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.
G. OPTIONS:  Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D. listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D. listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don’t want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:  J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

On Day of Service at Registration or Check-out

• Apply discount if applicable but always, always let the patient know what the total charges were, what the discount is, and what their portion is….Start off by saying:
  
  – “The total charge is $___ but after I apply your discount of $___ your portion is $____.
  
  – “Mrs. Jones, the charges for today’s visit is $120. After I apply your discount of $80 your payment is $40. Would you like to pay with cash, write a check or with a credit card?”

• Persuade to pay any past due balances in addition to today’s fees
  
  – “Mr. Smith, the charge for today was $10 due to your copay responsibility according to your insurance. You also have a previous balance of $320, so the amount due to today is $330. Will you be paying by cash, check or credit card?”

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• If patient cannot pay in full, obtain date they will return to pay for today’s visit in full. Check your policy on how much time can give. It is important to develop urgency…explain that the health center needs to be paid so it can continue to provide care.
  – “Ms. Jones, if you are not able to pay today when will you come back within the next week to take care of this payment? Your payment is very important to help us keep our services going….”
  – “Ms. Jones, what day of next week should I schedule a call from our billers to obtain your payment over the phone? Your payment is very important to help us keep our services going…."

Capturing Charges/Claims Submission

• Establish a written policy for timely completion of patient records, full and accurate documentation of all services rendered.

• Policy should clarify the roles of clinicians regarding waivers and pre-authorization for services.
• Clean claims and statements translate directly into faster cash flow. Optimal staffing means having enough employees to allow billers the time to ensure charges are accurate before posting them.

• A practice can prevent many of the denials that hold up cash flow by submitting claims that get paid on first submission.

• Send claims to payors as soon as they are ready.

• Use software or clearinghouse services to help identify problems in any denied claims so that corrected claims can be resubmitted as soon as possible,

• Send billing statements promptly to patients who don’t have insurance or who are covered by an insurer with which the practice does not participate.
Payment Posting

- When posting payments in a practice management system the need for accuracy is essential. Inaccurate postings can result in serious downstream financial affects for your practice.
- Though the importance and possible negative ramifications of posting payments inaccurately are seemingly obvious, mistakes can easily occur with a simple typo.

False Credits
When transactions are posting in excess of their true amounts it will leave a credit on a patient's account. If left uncorrected or unnoticed this credit may be carried over to subsequent balances due.

Deflated Accounts Receivable
Credit balances within the practice management system result in a deflated accounts receivable (AR). Credit balances are subtracted from the practice’s account receivables and may provide reporting that suggests the practice is more financially stable than it actually is.

Incorrect Patient Statements
When financial transactions are posted incorrectly it results in inaccurate information on the patient’s account. This information is often shown on the statements the patients receive for balances due.
How To Prevent Errors

• The most effective way to prevent these errors is through attention to detail. Each transaction posted should be reviewed for three key balancing factors:

1. Does the payment amount entered match the monies received?
2. Does the adjustment amount entered match the contractual adjustment amount listed on the remittance advice received?
3. Does the remaining balance match the amount designated as patient responsibility?

• Following these 3 verification steps prior to finalizing any financial transaction posted to the practice management system will ensure accuracy and prevent the financial losses associated with these errors.

Patient Billing/Collections

• Give the patient a bill upon rendering service if it is agreed the patient will pay for services after leaving the office and if their insurance company doesn’t cover the full amount of the bill.

• After insurance has paid their portion and an explanation of benefits (EOB) has been received, immediately send the first mailed statement.

• If no payment is received within 30 days, a letter and second mailed statement should be sent with a handwritten note on the statement.

• If no payment is received within 15 days, the first phone call should be made and documented in the patient’s file. Note: the most successful times for reaching patients are 8:00 a.m. to 10:00 a.m., 5:00 p.m. to 9:00 p.m. and on Saturdays.
• If no payment is received within 30 days after sending the last statement, a letter and third mailed statement needs to be sent to the patient requesting payment.

• If no payment is received within 15 days after sending the letter requesting payment, a second phone call should be made.

• Finally, if no payment is received within 30 days after sending the last letter, send a letter and final, fourth mailed statement noting that payment is due within ten days or the matter will be forwarded to a collections agency.

• Stay professional yet firm when attempting to collect on patient bills. If it makes you or your staff uncomfortable to call patients about unpaid bills, you can hire a professional collector.

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**After Day of Service**

• If calling to collect on an unpaid balance, say who you are and why you are calling:
  - “This is ___________ and I’m calling about your balance of $1000 which has been outstanding over 75 days.”
  - “Mr. Rivera, your account has been given to me for special attention, I’m here to help in any way I can.”

• When working with patient on a payment plan, establish exact amounts and time frame for payments to be made, establish how payments will be made, and confirm agreement.
Follow up with phone calls immediately if payment not received on time:

- “So let’s review, you will pay $50 every month for 6 months, to pay your $300 amount due. I’m very pleased we were able to work out a payment plan that will get your account up to date. I will expect your first payment of $50 on January 1st, and then every first of the month through June 1st.”

On payment plans, follow up with a phone call immediately if payment not received on time:

- “I’m calling about the check you said you would mail by January 1st. I see there have been no payments posted to your account and I wanted to be sure it wasn’t lost or posted to the wrong account. When did you mail the check?”

Optimize Patient Payments with Technology

- The longer patients owe their physicians money, the less chance a practice has to collect the balance. Medical offices can improve cash flow by enabling patients to pay for services online.

- This is an attractive proposition for a younger generation that pays most, if not all, of their bills online. Very affordable Internet enabled payment capabilities can be established directly on the provider’s website with credit card transactions or checking account withdrawals automatically routed to the practice’s bank account for current payments and payment plans.

- These online tools are available to providers regardless of whether or not they maintain a website.
• Providers should also use an online system to schedule recurring payments whenever possible.
• This enables practices to work with patients to establish a certain payment amount that is automatically charged to their credit card on a monthly basis until they reach a zero balance.

Coding

• For a service to be considered medically necessary, it must be reasonable and necessary to diagnosis or treat a patient’s medical condition.
• When submitting claims for payment, the diagnosis codes reported with the service tells the payer "why" a service was performed. The diagnosis reported helps support the medical necessity of the procedure.
Denied/Rejected Claims

- According to Medical Group Management Association (MGMA), even the best-performing medical practices:
  - 4 percent of their claims denied.
  - 65 percent of denied claims are never resubmitted,
  - and, it costs approximately $25 to resubmit a denied claim.
- In addition, if the denied claim is not researched correctly and resubmitted within the time frame required by each individual payer, you may not get paid.
- Typically 85 – 95% percent, either get paid on the first pass or prompt an action to redirect the collection to another party (secondary payor or the patient). The remaining 5% to 15% of claims are opportunities to improve the revenue cycle.

Patient Collection Reporting (Key Indicators)

- High-performing practices were also collecting receivables more quickly than their peers, having only seven to 10 percent of their total accounts receivable (A/R) in the 120+ days category.
- In contrast, the other groups had 19 to 35 percent of their total A/R in the 120+ day category, an indication that strong cash flow is crucial to the success of any practice.
- Concentrate on highest and oldest patient balances when running collections reports.
- Additionally, 50 percent of better performers reported collecting 90 to 100 percent of co-payments at the time of service.
It is important to take into consideration the following:

- The key indicators for measuring collection rates are:
  - Ratio of months in A/R
  - Gross charges in A/R
  - Percentage of days in A/R
- Each of these key indicators have statistical variations:
  - Type of specialty
  - Insurance contracts
  - Geographical locations
  - System capabilities

Patient/Payer Follow-up Accounts Receivable Key Indicators

**Gross Collection Percentage:**

The GCP indicates the percentage of gross original charges (before any adjustments/contractual write-offs) that has been collected and can be expected to be collected on an ongoing basis.

This percentage is calculated by dividing dollar Collections by dollar Gross Charges \([\text{Collections} / \text{Gross Charges}]\).
Net Collection Percentage:

The NCP isolates the percentage of collections to a more realistic collectible amount.

This percentage is calculated by dividing dollar Collections by dollar Net Adjusted Charges \[ \frac{\text{Collections}}{(\text{Charges} - \text{Contractual Adjustments} - \text{Patient adjustments})} \].

Accounts Receivable to Receipts Ratio:

The AR to Receipts Ratio indicates how quickly the average account is being paid. High ratios may indicate that some balances should be deemed uncollectible and turned over to a collection agency or written off as bad debt.

This ratio is calculated by dividing the ending Accounts Receivable Balance by Collections \[ \frac{\text{AR Balance}}{\text{Collections}} \].
**Accounts Receivable to Charges Ratio:**

The benefit of the AR to Charges Ratio is to review the consistency of the calculation over a period of months. If there is good Accounts Receivable management then this number will be fairly consistent from month to month. It should also be somewhat similar to the AR to Receipts Ratio (above). If numbers vary dramatically, it may indicate that the practice is highly influenced by seasonal changes.

This ratio is calculated by dividing the ending Accounts Receivable Balance by Charges for the month \( \frac{AR\ Balance}{Charges} \). Any number above 5.0 justifies a serious look at the practice’s economic health.

**Average Days Outstanding:**

The results of the ADO calculation indicate how long it takes to collect on a charge, i.e., the turnover rate. The greater this number, the longer it takes insurance plans and patients to pay you. The turnover rate depends not only on insurance carrier payment practices but also how well the AR is being managed with prudent medical billing and patient collection practices.

This ratio is calculated by multiplying AR to Receipts ratio by the number of days in that month, except that in this calculation the average AR is used \( \frac{(Beginning\ AR + Ending\ AR)}{2} \). The full formula is \( \left( \frac{Average\ AR\ Balance}{Collections} \right) \times number\ of\ days\ in\ period \).
Tools, Tips, and Techniques

• Have policies in place that reflect your practice goals
• Train staff to communicate effectively with patients
• Educate patients on their financial responsibilities
• Choose key financial indicators to benchmark for practice success

Resources

• http://www.medigain.com/
Contact Information

• Thank you!

• Get your questions answered on PMI's Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp

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