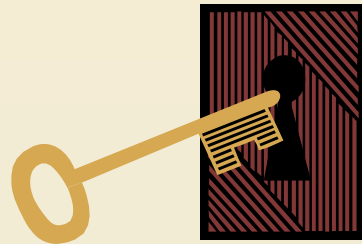


knowledge is power

Keys to Collecting Medical Revenue



Blue Cross and Blue Shield of North Carolina
Summer Provider Conferences

Presented by Effective Solutions, Inc.

Jim Fatzinger, MBA, President

Susan Moorefield, Consultant specializing in A/R

Knowledge is \$\$\$, Too!

- It is estimated that 5% – 10% of all group practice services provided to patients are never billed.¹
- 30% of the 15 billion claims filed each year are rejected on first submission.²
- 50% of these rejected claims are never resubmitted.³
- **Do the math!** 19.25% to 23.50% of collectible revenue is lost each year!
- For a primary care, single specialty practice with 3 FTE physicians, this equals \$389,770 to \$502,256 lost!⁴

¹ Sara Larch, MS, FACMPE & Deborah L. Walker, MBA, FACMPE, “Improve your Revenue Cycle: Five Key Steps,” MGMA Annual Meeting Presentation, October, 2004.

² Health Care Investment Analysts

³ Health Care Investment Analysts

⁴ Performance and Practices of Successful Medical Groups, 2007 Report, MGMA.

Five Key Phrases

🔑 “Trust but verify.”

Damon Runyon, American journalist and author

🔑 “Read my lips....”

President George H.W. Bush, 1988

🔑 “Into each life some rain must fall.”

Henry Wadsworth Longfellow, “The Rainy Day”

🔑 “Keep your eye on the ball....”

Wee Willie Keeler, 2-time batting champion, Baltimore Orioles

🔑 “You can’t get blood from a turnip.”

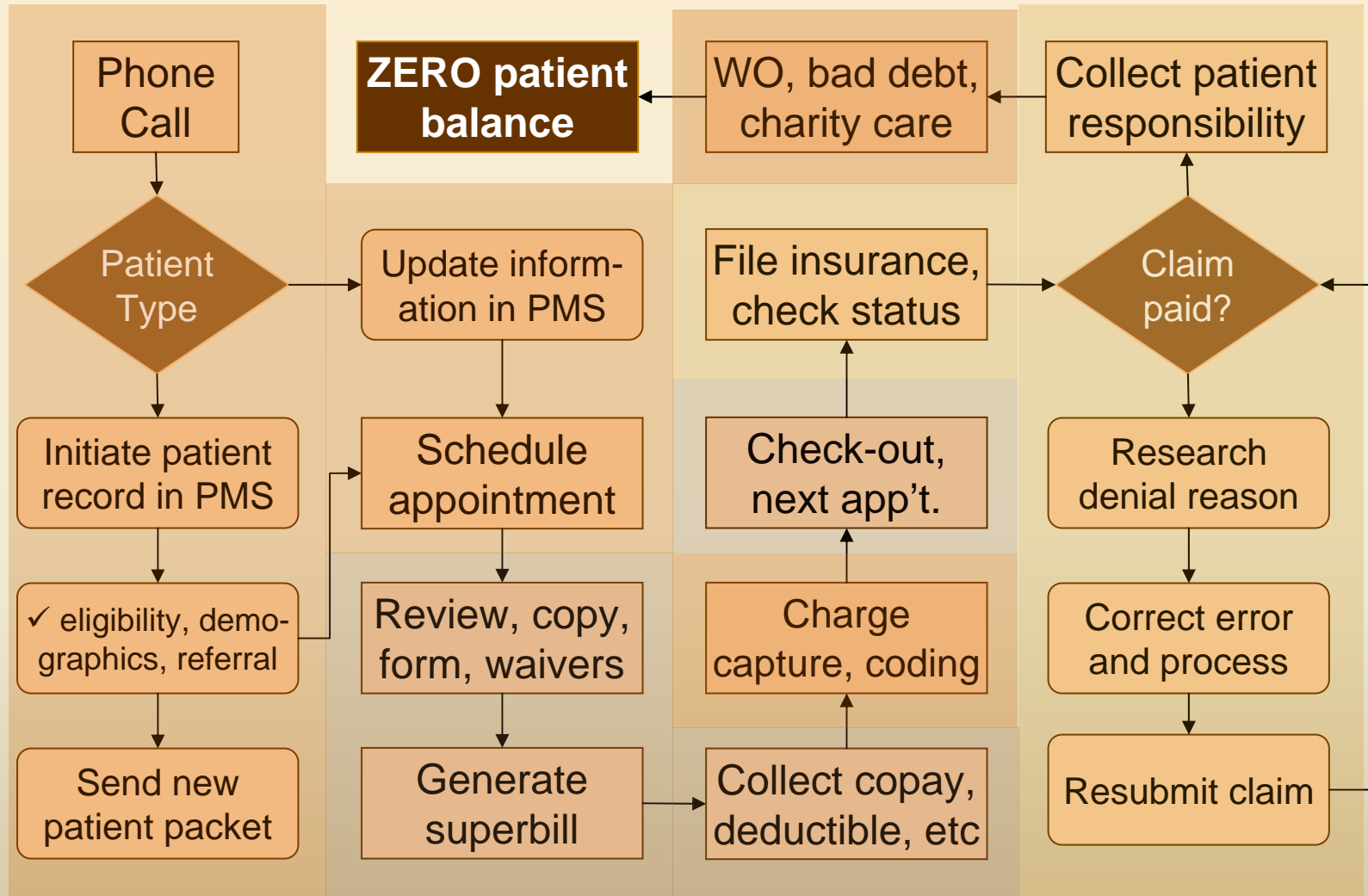
Italian Proverb

“Trust but Verify”

- “The key to successful collections is verifying insurance eligibility **before** medical services are rendered.” (NCMS)
- **Before** the patient arrives at your office:
 - Verify coverage
 - Verify amount to be collected at time of service
 - Determine whether a referral from a PCP is needed
- **When** the patient arrives for her/his appointment:
 - Copy her/his insurance card (both sides) and compare to the information previously gathered.
 - Verify a signed copy of the practice’s financial policy is in record
 - Obtained signed waivers:
 - New ABN, effective
 - Practice waivers

"Read my lips..."

"Collecting is everyone's job; collecting is everyone's job."



“Read my lips....”

“Clean claim, clean claim, clean claim”

- Separate appointment scheduling from check-in (reception)

Specialty	FTE Support Staff/FTE MD		TMR/FTE MD
	<u>Number</u>	<u>Payroll</u>	
Surgical, SS (BPP)	6.62	\$323,075	\$1,327,963
Surgical, SS (Others)	4.67	\$209,042	\$967,449
Difference	+1.95	+\$114,033	+\$360,514
Primary Care, SS (BPP)	4.79	\$189,333	\$666,305
Primary Care, SS (Others)	3.98	\$148,382	\$513,087
Difference	+0.81	+\$40,951	+\$153,218

- Use technology:
 - Online registration reduces errors, staff expense (95% of new patients at Northern Virginia Family Practice register online!)
 - Reception area kiosks

“Read my lips....”

“Clean claim, clean claim, clean claim” (continued)

- Clarify responsibilities:
 - **Reception/Check-in:**
 - Ask patient to verify information on superbill/encounter form
 - Collect copayment and any balance due
 - **Clinical encounter:**
 - Clinical staff use colored pens to record services on superbill
 - Complete and accurate coding by providers (chart audits)
 - If you’re not fully EHR/EMR yet, consider STAT E&M Coder (\$75 for 2 year license - <http://www.statcoder.com/eandm.htm>)
 - **Check-out:**
 - Collect patient responsibility that couldn’t be determined pre-visit
 - Schedule follow-up visits and note in patient’s computer record
- Use the collection equivalent of “spell-check”: remembers payer billing rules better than your staff possibly can.

“Into Each Life Some Rain Must Fall”

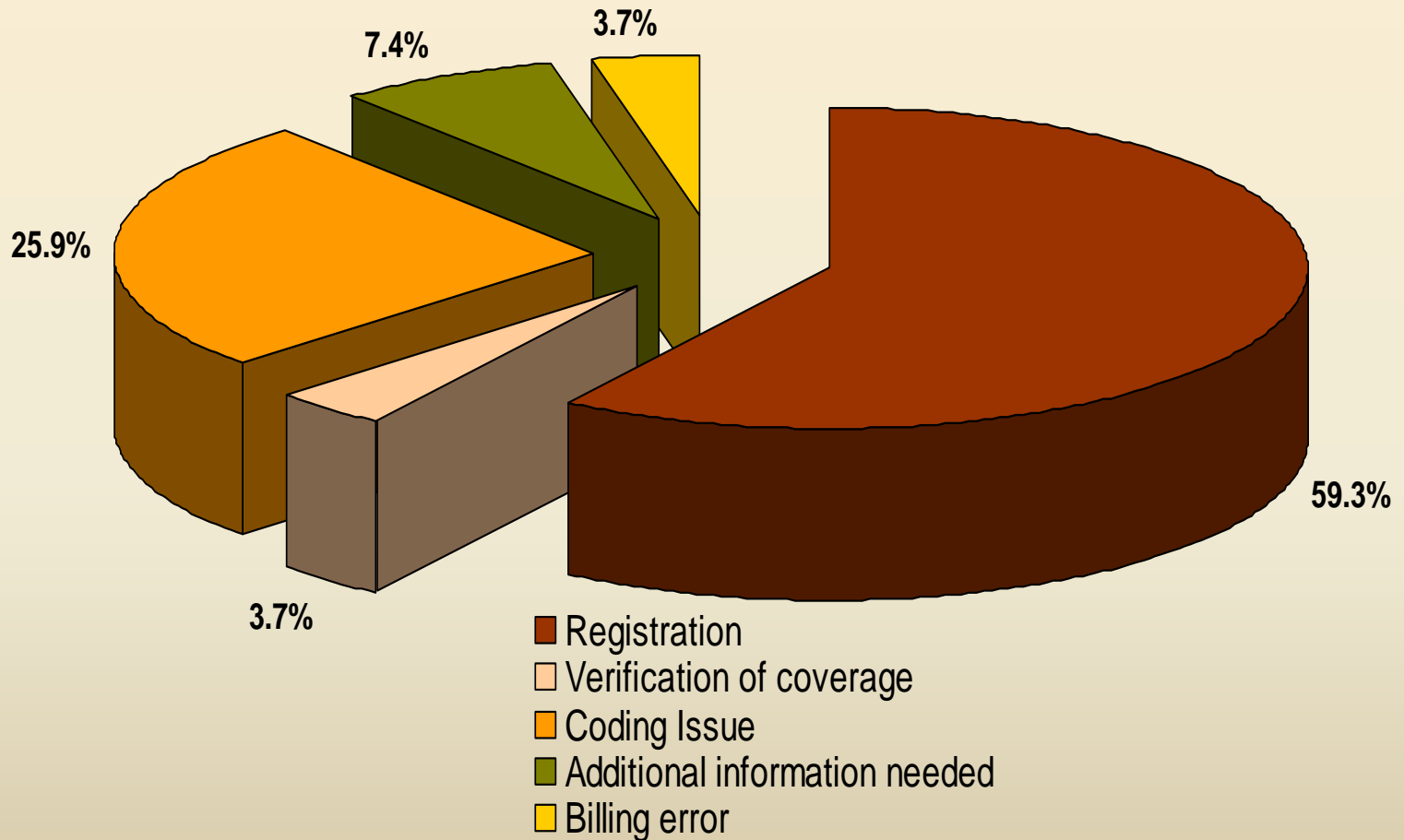
- People are human; mistakes will happen
- Establish an attainable maximum target for denied claims (5% or less is desirable)
- Track denied claims:
 - Identify causes for denied claims
 - Fix processes; don't just reprocess forms
- It costs you \$25 to rework a denied claim.
- Appeal denied claims; carriers make mistakes, too!

"Into Each Life Some Rain Must Fall"

Denial Reason	Process Error	Action Indicated
Invalid insurance information	Patient registration	Insurance verification
Demographic data errors	Patient registration	Have patient verify data
Invalid ICD-9 code	Charge entry, provider	Update PMS, cheat sheet
Duplicate claim for service	Billing process	Improve claims tracking
Lacking referral, preauthorization	Patient registration	Preregistration
Missing documentation	Provider, medical records	Chart audits, training*
Medical necessity (link ICD-9 & CPT)	Coding error	Chart audits, training*
Bundled service	Provider, billing process	Chart audits, training*
Non-covered service	Patient registration	Obtain ABN, waivers
Missing modifier	Coding omission	Chart audits training*
Secondary insurance incorrect (COB)	Patient registration	Insurance verification

*from CMS, see: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1

“Into Each Life Some Rain Must Fall”



“Keep your eye on the ball”

- 🔑 Mine and benchmark A/R reports
- 🔑 Start with “the big picture”
 - Days/Months in A/R
 - A/R aging “buckets”
- 🔑 Drill down into the details
 - Growth in A/R balance vs. net charges
 - Don’t neglect Patient A/R
- 🔑 Set goals, reward achievement

Days/Months in A/R

PRACTICE MANAGEMENT REPORT - 2007

Month	Gross Patient Charges	Contractual Discounts & Adjustments	Net Patient Charges	Write-off %	Actual Payments Received	Gross Collection Rate	Net Collection Rate	Accounts Receivable Balance	# Days in A/R	Months in A/R
JANUARY	\$58,574	\$10,199	\$48,376	17.41%	\$39,106	66.76%	80.84%	\$100,541	53.21	1.72
FEBRUARY	\$50,942	\$10,360	\$40,582	20.34%	\$36,415	71.48%	89.73%	\$104,708	56.41	1.91
MARCH	\$58,970	\$12,094	\$46,876	20.51%	\$44,884	76.11%	95.75%	\$106,700	57.00	1.90
APRIL	\$56,890	\$10,394	\$46,497	18.27%	\$36,625	64.38%	78.77%	\$116,572	62.07	2.07
MAY	\$59,158	\$6,977	\$52,180	11.79%	\$36,207	61.20%	69.39%	\$132,545	70.34	2.33
JUNE	\$50,523	\$9,652	\$40,871	19.10%	\$39,155	77.50%	95.80%	\$134,261	72.53	2.40
JULY	\$53,566	\$11,695	\$41,872	21.83%	\$50,076	93.48%	119.59%	\$126,057	68.77	2.27
AUGUST	\$61,037	\$14,022	\$47,015	22.97%	\$49,276	80.73%	104.81%	\$123,796	66.90	2.20
SEPTEMBER	\$48,012	\$14,772	\$33,240	30.77%	\$40,819	85.02%	122.80%	\$116,218	63.75	2.10
OCTOBER	\$68,179	\$25,007	\$43,171	36.68%	\$44,349	65.05%	102.73%	\$115,040	61.80	2.03
NOVEMBER	\$59,098	\$12,214	\$46,883	20.67%	\$43,432	73.49%	92.64%	\$118,491	63.33	2.09
DECEMBER	\$56,647	\$21,963	\$34,685	38.77%	\$54,903	96.92%	158.29%	\$98,273	52.63	1.73
Y-T-D TOTALS	\$681,596	\$159,349	\$522,248		\$515,247					
AVERAGE	\$56,800	\$13,279	\$43,521	23.38%	\$42,937	75.59%	98.66%	\$116,100	62.39	2.06
2005 MGMA BENCHMARKS	\$463,972/MD			28.39%	\$313,312/MD	70.57%	100.00%	\$57,368	30.63	1.01
	\$288,660 NPP			27.38%	\$182,625 NPP	69.14%	99.12%	\$71,568	38.30	1.26
	\$53,097			27.11%	\$35,241	68.83%	98.96%	\$74,976	40.03	1.32

(A)

(B)

(C)

(D1)

(D2)

(A) HOW MUCH OF EACH CHARGED DOLLAR ARE YOU **WRITING OFF**?

(B) HOW MUCH OF EACH DOLLAR **CHARGED** ARE YOU COLLECTING?

(C) HOW MUCH OF EACH DOLLAR **ALLOWABLE** ARE YOU COLLECTING?

(D) **AVERAGE TIME IT TAKES TO COLLECT** FOR SERVICES PROVIDED (D1 = Days, D2 = Months)

MGMA BENCHMARKS

Physician (All)

PA (Median)

NNP-Pediatric (Median)

Physical Therapist (Median)

Better Performing Practices

All Practices

All Other Practices

Table 28

Table 121

Table 121

Table 121

Physician Comp. & Production Survey

Physician Comp. & Production Survey

Physician Comp. & Production Survey

Physician Comp. & Production Survey

Table 80B

Table 118

Table 118

Table 118

Physician Comp. & Production Survey

Physician Comp. & Production Survey

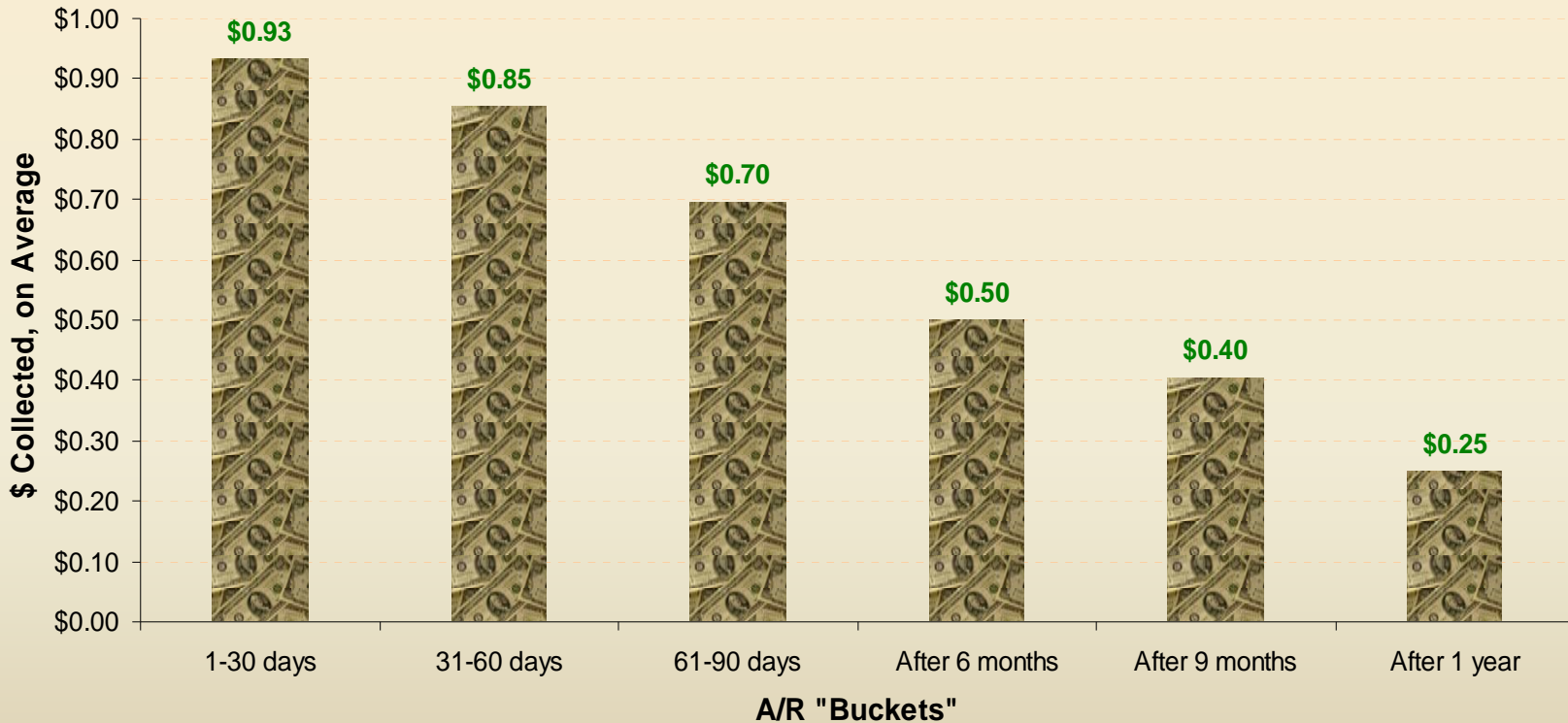
Physician Comp. & Production Survey

Physician Comp. & Production Survey

Figure V.C.6 Performance & Practices of Successful Medical Groups

Rate of Collectability

Chance of Collecting Diminishes as Accounts Get Older



Source: "Four square: Practice profitability stands on four foundations, MGMA Connexion, Volume 3, Issue 8, September, 2003.

Watch Your "Buckets"

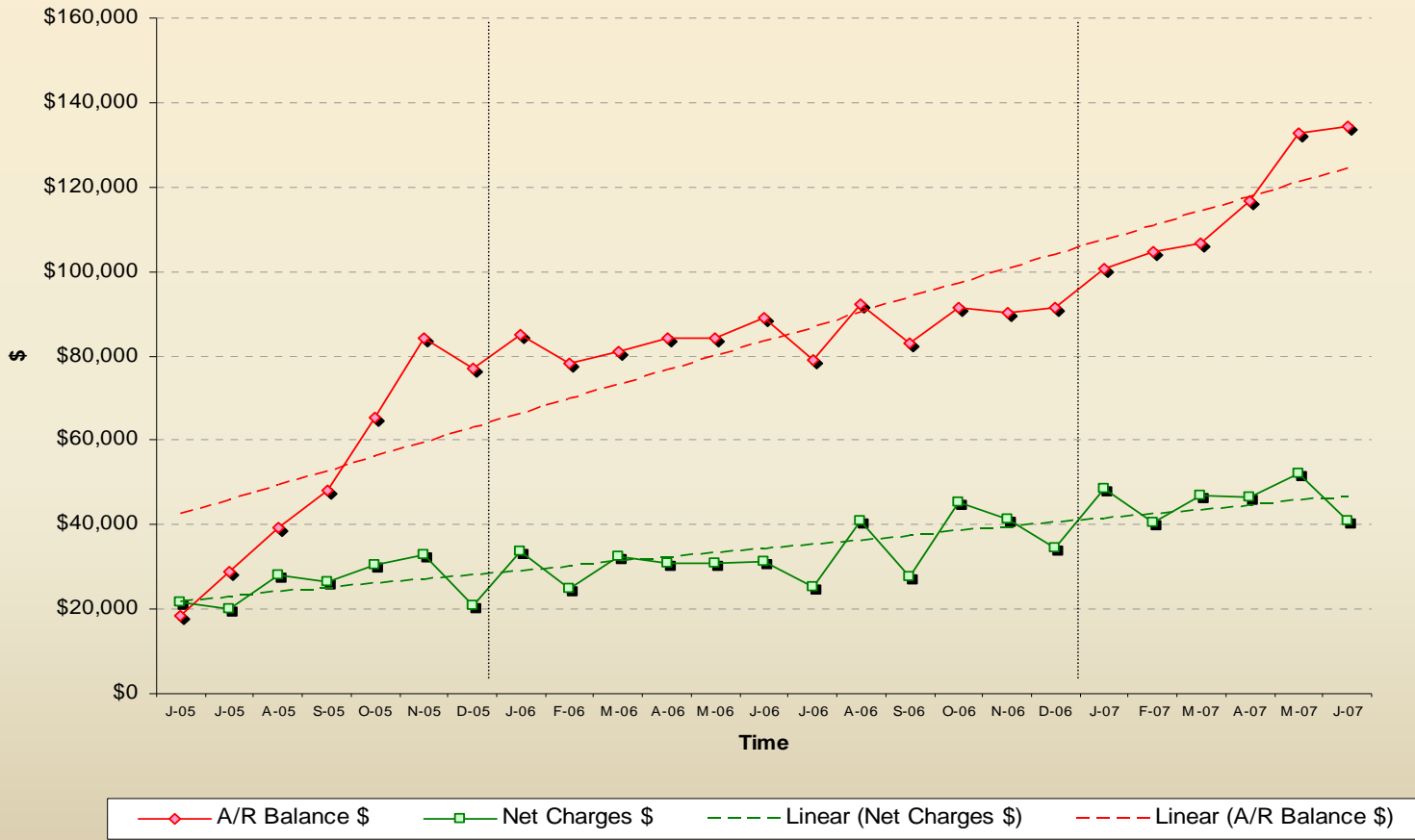
Primary Care, Single Specialty

Total A/R = \$920,522					
"Bucket"	<30 days	31-60 days	61-90 days	91-120 days	>120 days
% Collectable	93.1%	85.4%	73.1%	69.6%	63.8%
Practice X Actual %	39.0%	24.3%	11.4%	6.6%	18.7%
MGMA Benchmark %	70.3%	14.2%	6.5%	4.0%	5.0%
@ Benchmark	\$602,475	\$111,630	\$43,739	\$25,627	\$109,824
@ Actual	\$334,232	\$191,029	\$76,711	\$42,285	\$29,365
Benchmark - Actual	+\$268,243	-\$79,399	-\$32,972	-\$16,658	-\$80,459
Projected loss = \$58,755 of collectable fees; 6.4% of total A/R					

A/R Balance & Net Charges

Family Practice

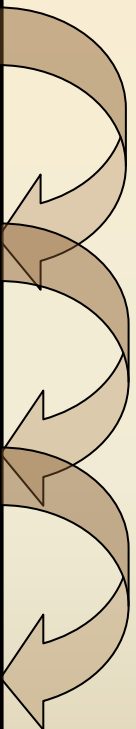
Growth in A/R Balance Compared to Net Charges, 2005-07



knowledge is power

Don't Neglect Patient A/R!

Date	Type A/R	Current	31-60	61-90	91-120	>120
6/30	Total	\$26,440	\$14,644	\$12,334	\$10,290	\$76,802
	Insurance	25,327	12,459	10,879	7,999	71,067
	Patient	\$1,113	\$2,185	\$1,455	\$2,291	\$5,735
9/30	Total	\$26,662	\$8,617	\$5,745	\$4,564	\$64,041
	Insurance	24,010	6,164	3,390	3,069	54,092
	Patient	\$2,652	\$2,453	\$2,355	\$1,495	\$9,949
12/31	Total	\$28,519	\$15,488	\$9,745	\$3,784	\$42,186
	Insurance	26,088	12,793	7,110	1,939	30,302
	Patient	\$2,431	\$2,695	\$2,635	\$1,845	\$11,884
3/31	Total	\$32,603	\$6,798	\$4,701	\$2,189	\$12,062
	Insurance	30,207	4,551	2,407	938	6,672
	Patient	\$2,396	\$2,247	\$2,294	\$1,251	\$5,390



“Blood from a Turnip”

- % of uninsured grew from 12.9% of the United States population in 1987 (31.0 million) to 15.8% in 2006 (47.0 million)¹
- Another 24% of the United States population (71.4 million) is underinsured²
- Consumer-directed health plans, which transfer first dollar responsibility to the insured, effectively increase the number of self-pay patients.
- Current estimates are that, between increased co-pays, higher deductibles, the patient/insurance split is 35%/65%
- Once a self-pay patient leaves your office, your chance of getting paid can be cut in half.

¹ U.S. Census Bureau, Income, Poverty and Health Insurance Coverage in the U.S., 2006

² Consumer Reports, August, 2007

Consider this scenario...

- Your practice has 3 providers.
- Each provider sees 24/patients/day.
- Each patient has a \$30 co-pay.
- Your overworked, understaffed front desk forgets to collect co-pays half the time.
- It costs you, on average \$8.33 to bill a patient.
- That's \$259,200 in co-pays that walk out your door!
- It will cost you \$71,971 to try and collect money you could already have in the bank!
- Avoid paying for rework at all costs!

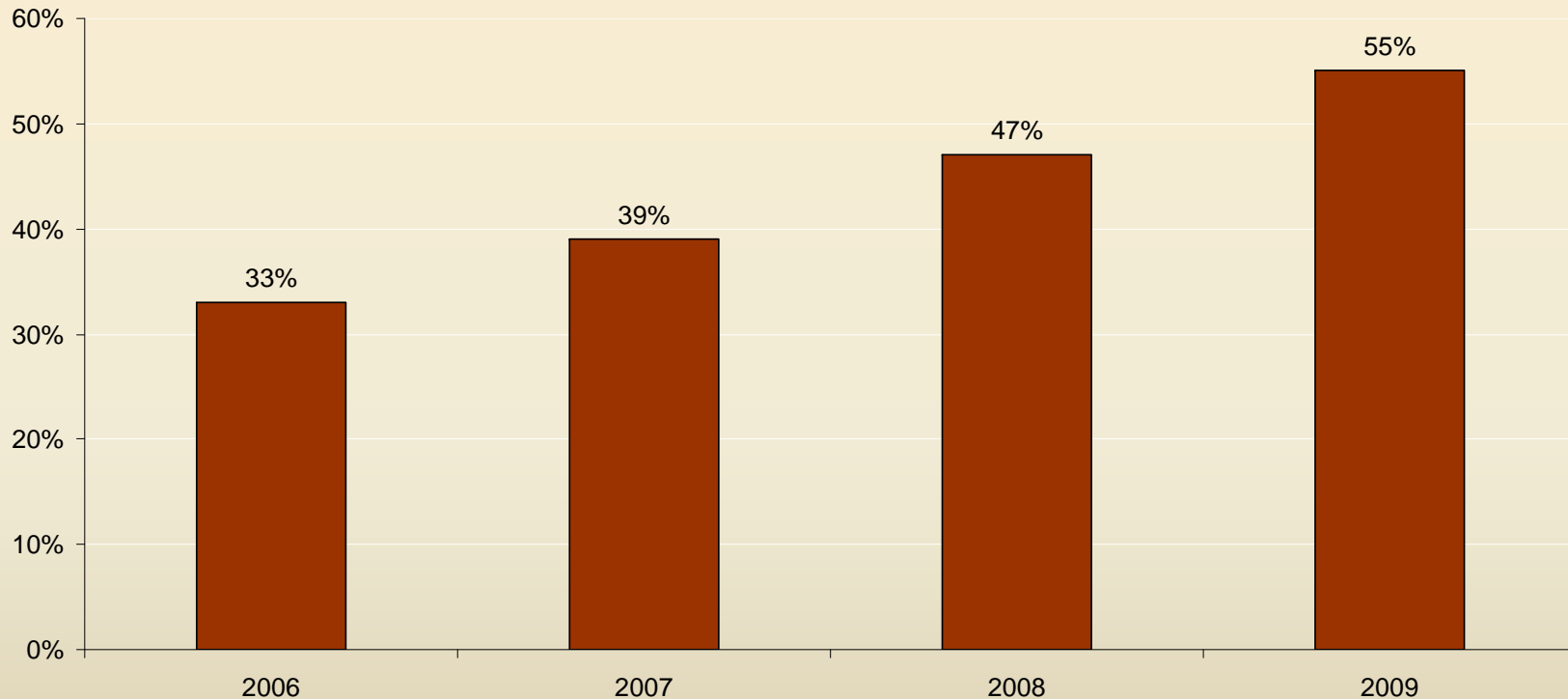
“And the Survey Says...”

2007: AMA surveyed members about the impact of consumer-driven health plans:

- ❑ 65% believe increased collections efforts will be necessary.
- ❑ 61% believe CDHPs will make verification of benefits, patient responsibility even more important.
- ❑ 61% believe CDHPs will necessitate additional staff training.

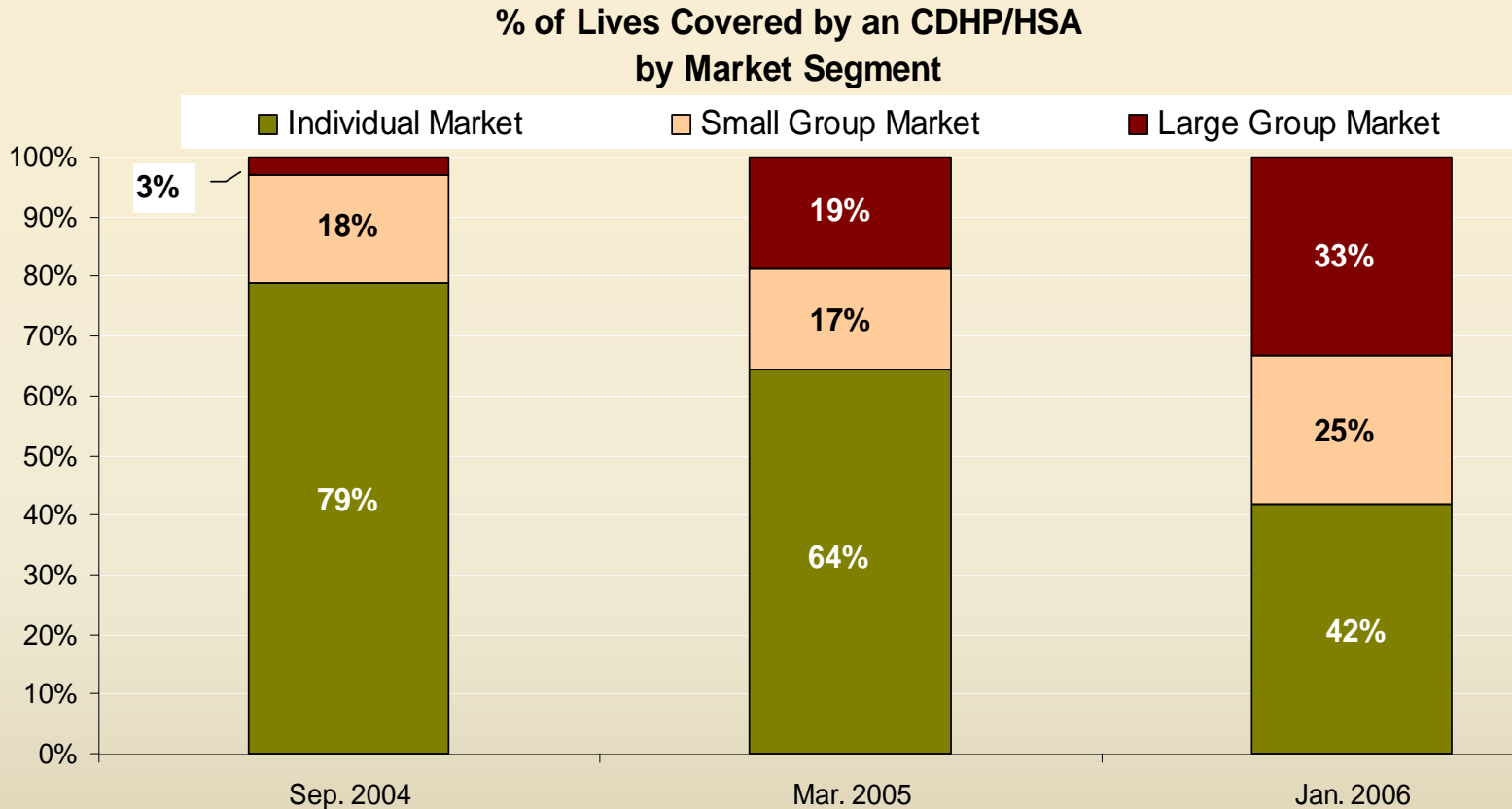
Growth of CDHPs (A)

Percent U.S. Corporations Offering HDHP/HSAs



Source: Bridgeford, Lydell C., reporting on the Watson Wyatt/National Business Group on Health study in Employee Benefit News, March 13, 2008.

Growth of CDHPs (D)



Source: Center for Policy and Research, America's Health Insurance Plans, January, 2006, <http://www.ahip.org/content/default.aspx?docid=15302> .

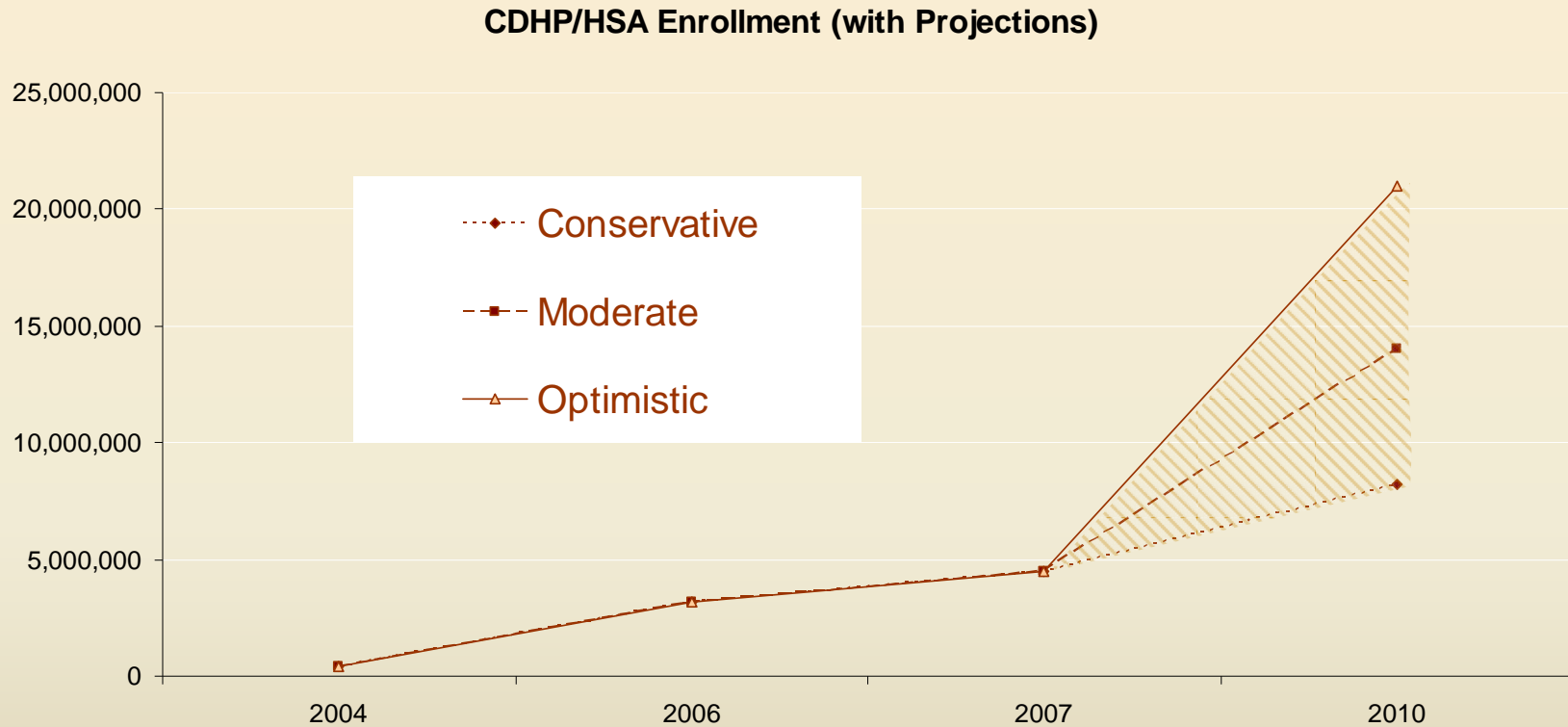
Growth of CDHPs (B)

Growth of CDHP/HSA Enrollment in Just 16 Months
from September, 2004 to January, 2006



Source: Center for Policy and Research, America's Health Insurance Plans, January, 2006, <http://www.ahip.org/content/default.aspx?docid=15302> .

Growth of HDHPs (C)



Sources: U.S. Department of the Treasury, "Dramatic Growth of Health Savings Accounts" <http://www.ustreas.gov/offices/public-affairs/hsa/pdf/fact-sheet-dramatic-growth.pdf> and "Collecting Just Got Harder," Medical Economics, May 20, 2005.

CDHP Collection Challenges

- Contract language may require you to bill the carrier first although the patient actually has 1st dollar responsibility. Even though you'll be paid by the carrier, this presents:
 - a cash flow problem and
 - remember, the more time there is between providing service and patient billing, the less you're likely to collect.
- Employers are not required to contribute to employees' HSAs.
- Generous employers may "seed" employees' accounts but nothing stops the employee from using the funds:
 - for any eligible health expense or
 - for ineligible expenses (penalty essentially employer-paid).
- The IRS Code authorizing HSAs actually provides an unintended incentive not to use these funds.

Collecting from CDHP Patients

- “Knowledge is power”
 - “The answer...is preregistration, plain and simple.”¹
 - Know the deductible and how much has been met
 - Learn the collection rules for each plan
- Negotiate for the right to collect the deductible at the time of service
 - Some practices are “requiring” a “deposit”
- Encourage patients to authorize automatic debiting
- Get the patient’s HSA debit card number on file
- Submit claims within 24 hours
- Collect past due amounts at time of service
- Reschedule elective app’ts. until past due \$ is paid

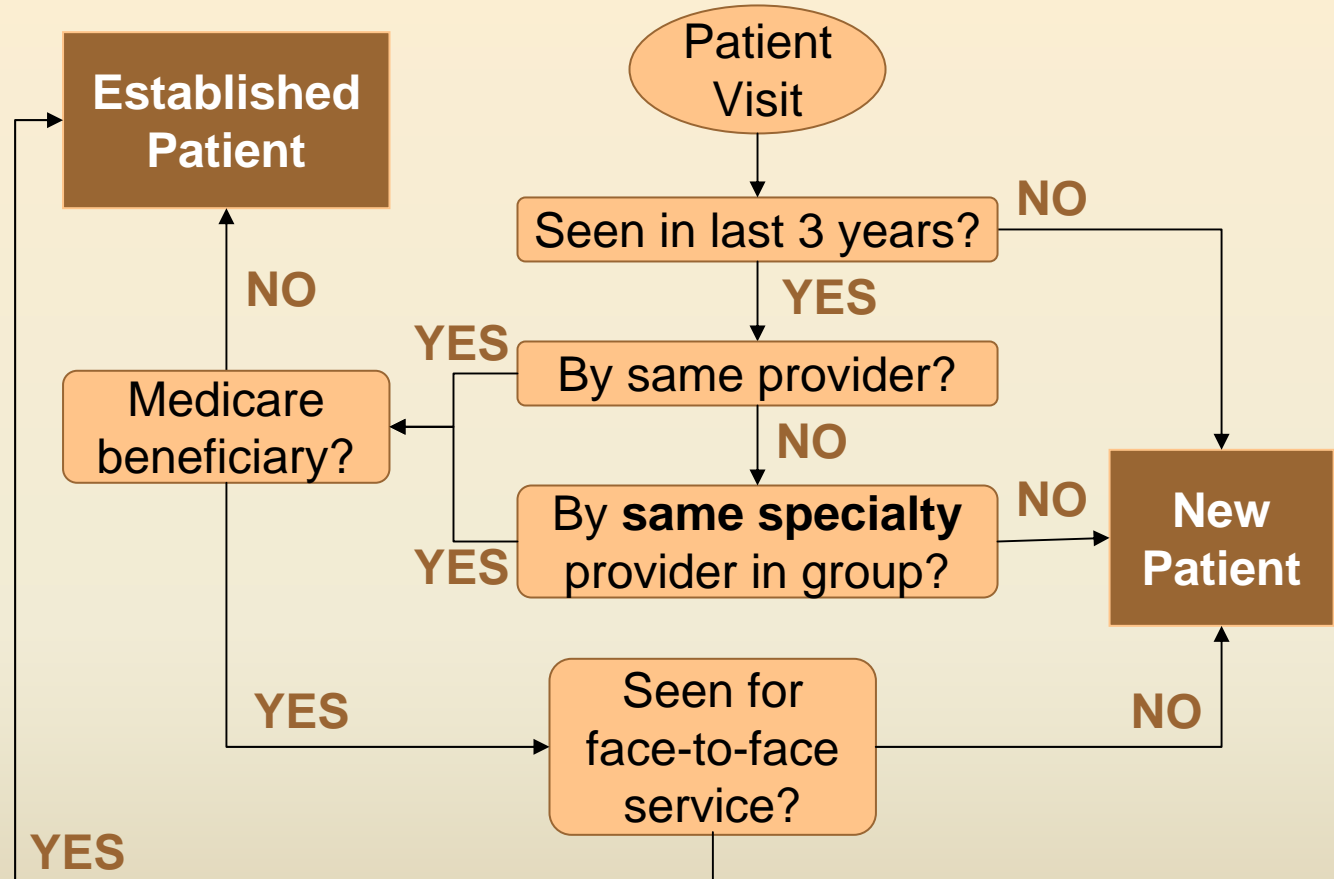
¹ Cynthia Dunn, Senior Consultant, Medical Group Management Association, Cocoa Beach, FL

knowledge is power

Thank You!

**Thank you
for your
attention!**

Established or New?



“Many practices fall into the bad habit of counting every patient with a chart as an established patient. **Those practices lose money.**” (citing coding expert Emily Hill from Wilmington, NC in “Discover the Power of Positive Coding”, 2002)

Yearly Difference/Provider

If <u>just 5%</u> of New Pt. Visits Are Miscoded as Established Pts.			
<u>E&M Code</u>	<u>Established</u> ¹	<u>New</u> ¹	<u>Difference</u> ²
Level 1 (992*1)	\$18.81	\$34.24	\$810.26
Level 2 (992*2)	\$35.29	\$59.01	\$614.82
Level 3 (992*3)	\$57.24	\$86.48	\$4,126.35
Level 4 (992*4)	\$86.08	\$132.59	\$4,152.41
Level 5 (992*5)	\$116.42	\$166.73	\$289.79
per provider =			\$9,588.50
for a practice with 3 FTE MDs =			\$28,765.50

Note: Any undercoding would make this amount even LARGER!

- ¹ 2008 North Carolina Medicare Physician Fee Schedule, <http://www.cignagovernmentservices.com/partb/coverage/fees/index.html>
- ² Based on distribution of E&M codes by Douglas E. Henley, M.D., EVP of AAFM; served on the CPT Editorial Panel from 1991 to 2000.

“Blood from a Turnip”

Communication Tips

Situation	Script
New patient makes appointment:	“Payment is due at time of service, unless you bring your current insurance card and benefits booklet, in which case only your copayment and any deductible will be due.”
Established patient with a balance makes appointment	“Both your copayment (or payment, if self-pay) for this visit and your prior balance of \$___ will be due at the time of service.”
Asking for payment (practice accepts insurance)	“Your copayment for today's visit is \$___. Would you like to pay that today with cash, check, credit, or debit card?”
Asking for payment (practice does not accept insurance)	“The fee for today's services is \$___. As we explained, we don't accept your insurance. Would you like to take care of your responsibility today with cash, check, credit, or debit card?”

“Blood from a Turnip”

Communication Tips

Situation	Script
Patient with previous balance checks in for appointment	“The amount for today’s visit is \$____, plus your previous balance of \$____, for a total due today of \$____.”
Patient says s/he can’t pay	<ul style="list-style-type: none">▪ “Do you have a credit card to which we can charge your responsibility today?”▪ “ATMs are conveniently located nearby at ____.” (give directions or have a map handy)
Patient says, “I forgot my checkbook (or credit card).”	“Please remember that payment is due at time of service for future visits. I can offer you are 2 options today: You can call us with your credit card number when you get home or you can mail your payment using this stamped, addressed envelope. I’ll write the amount you owe inside the envelope flap. If you send it today, we should receive it by [date + 3]. Let me make a note of that.”

“Blood from a Turnip”

Communication Tips

Situation	Script
Patient says, “Bill me.”	<ul style="list-style-type: none">▪ “Your copayment is due at the time of your visit. Your insurance requires us to collect this amount each time you see a doctor.”▪ (if provider approves rescheduling) “I would be happy to reschedule your visit for a time when you will have the cash or you can pay today using a check, credit or debit card. Which would you prefer?”
Patient says, “My insurance company will take care of this.” (practice accepts insurance)	<ul style="list-style-type: none">▪ “We certainly will be billing your insurance for the amount they have contracted to pay for the doctor's services. However, your coverage requires you to pay your copayment at the time of service.”▪ Your only responsibility today is \$____. You will be billed for any balance after the insurance company pays its portion.”

“Blood from a Turnip”

Communication Tips

Situation	Script
<p>Patient says, “My insurance company will take care of this.” (practice doesn’t accept insurance)</p>	<p>“We will be happy to help you file a claim with your carrier. However, as we explained, since we don’t accept your insurance, you are responsible for paying for your visit. Would you like to pay that today with cash, check, credit, or debit card?”</p>
<p>Patient asks you to waive a copayment</p>	<p>“I’m unable to waive (or discount) your payment. The insurance rules for this are explained in your benefits booklet). If you’d like, I could get (name of person responsible for meeting privately with patients who escalate) to explain this further. However, we still will require you to pay \$___ for your services today.”</p>