Is 100% Collection Possible in a Medical Practice?

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Introduction:

It may sound impossible, but with physician commitment to and the enforcement of billing best practices your practice can close in on 100% collections. This white paper discusses components of a physician's reimbursement, and provides practical tips to achieving a near-100% collection rate. This article also discusses other elements of maximizing the bottom line including services offered, pricing of these services and practical tips to prevent revenue loss.

The A/R components:

Unless it is a pure cash practice, most physicians are reimbursed by third party payors. The major components of third party payments are:

i. Contracted rate payable by the primary carrier.
ii. Contracted rate payable by the secondary / tertiary payor.
iii. Patient portion of the contracted rate.

Primary carrier portion:

The primary carrier is typically 85-90% of the collectible amount. Primary carriers, including Medicare and Medicaid, have extremely complex rules that dictate payment of claims. Losses occur in the following categories:

i. Denials that arise because of deviations from technical specifications in the claim format.

> In any claim submission process, each insurance carrier has a complex set of rules dictating the claim format. Most carriers will reject a claim if the claim format does not completely comply with their rules. In addition to carriers rejecting a claim, most clearinghouses have front-end edits that will return a claim if it does not pass their filter. Most practices lose money when they do not have a control of the software configuration, and claims get lost or "slipped" in the manual process of analyzing each technical denial and correcting the format for successful resubmission of the claim. Often, carriers will technically deny claims when their systems are not configured correctly to process them, even if the physician transmits them in the required format.

ii. Claims that are not successfully transmitted and received by the carrier in a timely manner.

> Today, most carriers have instituted strict *timely filing clauses* in their contracts with the physicians - some with unreasonable limits and penalties. Claims, in their journey to the carrier's systems, pass through several human and automated processes increasing the probability of slippage.
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> Various reasons that cause the claim to be denied for *timely filing* are:
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> a. The carrier does not clearly specify the format and rejects every attempt to submit and

eventually denies the claim as beyond timely filing limit.

b. Human errors in actually uploading and transmitting the file successfully to the carrier.

c. Several carriers accept paper claims only. Even when the physician has submitted the claims via USPS or clearinghouse, claims are lost and the carrier denies they were ever received.

d. Patient's failure to provide the correct carrier information the first time. This results in the claim being sent to the wrong insurance carrier. When the claim is finally sent to the correct carrier it is denied on the basis of the *timely filing* clause of the agreement.

e. A patient's charges and demographics are captured late, e.g., when performed in a hospital or nursing home setting and are rejected for timely filing reasons.

f. Provider numbers not established correctly with the carrier.

g. Government payers create significant paperwork burdens which incur delay.

iii. Coverage issues that are connected with the patient's plan.

a. Patients do not provide correct information on their current coverage. This is the primary reason for lost revenue in most practices. It is aggravated with hospital patients where the information is not up-to-date or accessible.

b. Medicare and Medicaid HMOs – patients often switch HMOs without informing the providers, and sometimes patients are switched between plans by agents without their knowledge.

c. Coverage exclusions and pre-approval requirements – patients are not aware of their coverage clauses and do not disclose pre-existing conditions that may result in denied claims.

d. Patients ignoring request for information on their pre-existing conditions when the carrier requests it while processing the claim. This results in the claim not being adjudicated at all.

iv. Provider contract and enrollment related issues that dictate which services are covered at what rate.

a. Incorrect provider number. Claims will not be accepted by the carrier if the provider number, corresponding to the Tax ID of the practice sending the claim, is not recognized by the carrier's system
b. Provider not authorized to perform certain services. Unless the provider is clear on which codes will be paid, there are likely to be claims denied and not payable.

c. Pre-authorization not obtained. This is often related to specific patient related coverage issues and eventually leads to lost revenue.

d. Incorrect contract rate loaded in the carrier's system. **This can result in lost revenue unnoticed by the physician.**

The following are recommendations to eliminate losses in the Primary portion collection process:

i. Verify. Verify. Verify.

Eligibility checking is the single most important loss prevention step in the A/R process. Today's software has integrated and sophisticated systems in place that can help the front desk staff verify patient's coverage at each visit. Most systems can perform batch eligibility checking using the patient scheduling list prior to the patient's arrival in the office. It is important that eligibility checking is performed for each visit as the plans change without any notice. Several carriers have web and telephonic access to their eligibility verification systems. Eligibility must be specific – are the proposed services covered for the patient by the proposed provider?

Install multiple check points by different staff members in the patient flow process to ensure that eligibility checking was indeed performed.

ii. Review carrier allowed rates and participation status monthly.

This can save significant loss in terms of non-covered services and underpaid services. **Any anomaly can be detected and corrected with the provider relations representative before losses accumulate beyond a point of retrieval.**

Review of the carrier *allowed rates* monthly help in pricing the services appropriately as well as determining the economic feasibility of performing the service.

Negotiate with carriers (except Govt. carriers) at least once a year. Often the rates are left unchanged just for lack of asking. Most carriers set their reimbursement levels as a percentage of Medicare allowed rates.

iii. Review denials and their reasons monthly.

Obtain and review denial reports provided by your billing staff to identify and correct denial causes in the practice. Escalate and resolve any unwarranted denials by the carriers with their provider relations representative.

iv. Ensure that denials and rejects are handled by the billing staff.

All clearinghouse and carrier rejects must be resolved and resubmitted immediately to prevent *timely filing* loss. All denials must be resubmitted / appealed after correction.

v. Do not participate with carriers that unreasonably deny / underpay claims.

It is important to the financial health of the practice that the carrier contracts be reasonable and provide adequate compensation for the services performed. All carrier contracts must be reviewed before acceptance. *Rates for the commonly provided services* and *timely filing clauses* deserve special attention to prevent reimbursement losses.

Secondary carrier portion:

This typically accounts for 5- 10% of the collectible amount in a Medicare heavy practice. It is extremely difficult to achieve 100% collection rate on this component. Reasons being:

i. Patients secondary coverage information is not correct.

ii. Secondary carriers pay the patient for the secondary portion of the bill.

iii. Medicare automatically forwards the secondary carrier on file. In several instances the secondary carrier does not map the Medicare provider number and the carrier's own provider number resulting in claims being dropped. Also, Medicare may not have the correct and current secondary carrier information on file.

iv. Since secondary carriers require a claim with a copy of primary explanation of benefit by paper, claims get lost in the process.

v. The physician may not be a listed provider in the secondary carrier's system leading to ignored claims.

To maximize revenue and minimize losses, the following recommendations can be considered:

i. It is preferable not to accept assignment on secondary claims. Accepting assignment on secondary claims is more of a courtesy than a requirement, except when a provider contract with a carrier specifically covers secondary claims. The courtesy of accepting assigment on secondary insurance with a patient can be made on case by case basis – to patients with good credit history with the practice.

ii. Collect secondary balances if possible at the time of the visit. Elgibility checking in conjunction with a secondary balance reference sheet using the office superbill can help determine exactly how much to collect. **It is legal to collect secondary portion of the visit (based on the Medicare allowed rates) during the time of the visit.**

iii. Start the patient statement cycle within 60 days of sending the secondary claim. Patients will often respond to statements with correct information or a with a call to their secondary carrier.

iv. Communicate the secondary insurance policy to the patients clearly and make sure they understand it. This will avoid common complaints regarding their assumption – "I have secondary card and it is the physician's responsibility to obtain payment".

v. When performing a service to patients in a hospital or the nursing home, ensure that their secondary carrier information is correct and verified by the hospital / nursing

home.

Patient portion:

Patient balance is the most sensitive and difficult portion to collect. It accounts for approximately 10 – 20 % of the typical practice revenue. The collection rates vary based on several factors:

i. Patient demographics & the economy. Financial ability of the patient determines their ability to pay co-insurances, deductibles and co-pays. As the carriers increase the patient portion of the coverage, it is a challenging task to ensure patient compliance with the physician's bills.
ii. Mismatch between patients expectations with respect to their bill and reality. Patients are quite shocked to discover that their insurance requires them to pay a significant portion of the physician's bills.
iii. Difficult patients. These patients will find a reason to avoid payment like "I did not receive a bill", "The doctor did not spend any time with me", "I received the statement late", "You should fight with the insurance to pay for the bill. I was told that I do not have to pay anything" etc.,

Success rate on collecting patient balance largely determines the success rate on overall collections. An effective and consistent policy regarding the patient balance can contribute significantly to a 100% collection rate of an office based practice.

i. Patient balance policy should be clearly communicated to the patient and understanding of the same should be acknowledged by the patient.
ii. Patient portion should be correctly estimated and collected at the time of the visit. Eligibility checking helps the office to accurately estimate the patient portion.
iii. A backup credit card authorization form (with a limit) should be obtained and kept on file, in the event of patient defaulting on their payment.
iv. Front desk staff should collect any patient balance upfront before checking in the patient for the current visit. **Front desk staff's performance should be rated and incentivized based on their ability to collect 100% of the patient balances during the patient's visit.**
v. Compromise on patient balance collection policy should be an exception approved by the billing physician. Compromise due to fear of losing the patient will end up with an A/R that is not collectible.

Conclusion:

The billing process is a complex and troublesome process that involves numerous entities and individuals. To succeed in revenue realization, it is important to clearly understand the various elements of the process, establish policies, communicate the policies clearly, assign responsibilities for the various elements, and enforce compliance and accountability to the assigned.

While it is difficult to achieve a 100% collection rate, an office base practice can come very close to it, if the process is handled effectively and with involvement and oversight of the physician.

Ron Flormann is Chief Commercial Officer at Glenwood Systems, LLC. Glenwood Systems LLC, a privately held company based in Waterbury, Conn., is a market leader in electronic administrative solutions for health care providers. Founded in 1998 as a technology solution consulting services, Glenwood today emerges as a leading EMR and billing service provider with its innovative product, GlaceEMR, a CCHIT-certified (http://www.cchit.org/) Internet-based medical documentation and workflow solution. Its flagship product, GlaceComplete - a billing and AR management software combined with GlaceEMR manages the entire practice and customer experience from scheduling and clinical documentation to accounts receivable cycle, cuts costs and enhances efficiency for providers. For more information or to learn more about GlaceEMR and GlaceComplete visit http://www.glacecomplete.com