

The Nine Critical Contact Points for Cash Flow

Speaker:

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Critical Point One: Patient Demographics

The first step in the process is getting good patient demographics and insurance information. There are actually two parts to this.

1. Good patient registration forms

Types of forms

- a. Medicare
- b. Non-Medicare
- c. Minors

(Samples of these forms are found at the end of this section.)

d. Modernize your forms

Ask only for information that is required and obtain info you really need

- No SSN – insurance carriers are now using patient ID numbers
- No insurance info if you make copies of the card(s)
- Work phone – why?
- Marital status – why?
- Cell phone - yes
- E-mail - yes
- Form should state you need copy of Driver's License and ins. cards

- e. Obtain permission to:
 - Leave messages on answering machine
 - With whom you can leave info (name and relationship)
 - Marketing

f. Privacy Notices

g. Rethink your financial policy forms and pamphlets

- Are they really effective?
- Do they help your bad debt collections?
- Is the time spent worth it?
- Copayment policy is OK
- Referral policy is OK

2. Timely updates

a. Medicare

- Update annually

b. Non-Medicare

- Update at each visit unless they are in an active status (meaning they are currently receiving treatment)

c. Modernize your update policy

- Printout for patient verification
- Phone verification at time of appointment
- Obtain insurance card at every visit and don't ask pt. to fill out that info on form

d. On-line on-site (exam room updates)

Critical Point Two: The Fee Ticket

Some practices call it a Superbill; others an Encounter Form or Fee Ticket. Whatever you call it, it is a vital component of the billing process. There are five fundamental aspects to this aspect of the billing process:

1. A complete, accurate, and up-to-date, well designed form
 - a. Patient ID (Name and DOB)
 - b. Date of service
 - c. Current CPT codes (don't include codes you only do once a year)
 - d. Current ICD-9 (be sure they are to the highest degree of specificity)
 - e. Identifies location where service was performed
 - f. Identifies provider who performed service
 - g. Allows space for manual entry
 - h. Allows space for modifiers, units, charges, if needed

2. Provider accuracy

Each provider in the practice must understand how to use the form and must have intense coding knowledge. Converting what he/she did in the exam room or surgical suite and converting that into ICD-9 and CPT codes is crucial. Not billing for what is done or inaccurately representing what services were performed can be financially devastating to any practice.

3. Real-time completion

What's also crucial here is real-time completion. This means that the fee ticket should be completed at the end of the patient encounter, where possible.

4. Quality completion

- a. One diagnosis per CPT code (No need to list multiple codes on the Fee Ticket!)
- b. Make sure CPT and ICD-9 codes are compatible.

Example: Malignant diagnosis with benign excision

- c. Modifiers if needed
- d. Units are identified

5. Audit

Because it is so critical that providers complete the ticket accurately and completely, periodic audit is a must.

Critical Point Three: Referrals and Authorizations

One of the staff's biggest complaints is providers rendering services to patients who require referrals or authorizations when no appropriate referral or authorization is present.

1. Types of referrals

a. Time span of the referral.

Some referrals cover a finite, designated period of time. If the service is provided after the referral expires, it can result in an irreversible denial.

b. Covered diagnosis(es)

Some referrals are only good for a certain type of service. Acne visits or wart removal. So it's important that the provider renders only services to that patient for that designated skin condition.

c. Number of visits

Some referrals cover a certain number of visits. So again, it's important to keep track.

Some referrals are a combination of all three. Although in some cases, the staff is successful in getting after-the-fact authorizations, it's very difficult, very time-consuming and, more times than not, unsuccessful.

2. Check for new claims filing changes

Many carriers are changing to Authorization Numbers versus forms so that claims can go electronic.

Critical Point Four: Charge Entry

1. Real time entry

Once the fee ticket is completed, the charges must be entered that day. Timeliness here is an important function.

Obviously, there are cases where there may be a delay in completion contingent upon the results of the pathology report; but the charges should still be entered as "charges pending" or some other method used to track such delays. For all other instances, it is vital that the staff enter the charges by the end of the day. This is the critical point!

2. Verification of data (Assure provider has properly completed the form)

3. Allows for TOS collection

- a. Copayments
- b. Deductibles
- c. Cosmetic

Critical Point Five: Claims Processing

1. Types of claims processing

a. Paper claims

If claims are sent on paper, make sure they are folded, put into envelopes and mailed the day they are printed. No piling up of claims because no one has time to fold them, mail them, or because you're out of stamps!

b. Electronic submission

It is vital that practices file claims electronically even though this can, at times, add a layer of complication to the claims processing mechanism.

- Check transmission reports immediately

If claims are rejected, the basis for the rejection must be fixed. This must be a timely function. The day the claims are sent is the day the transmission's success must be monitored and the rejected claims must be corrected.

If there are errors, determine the nature of the error and fix it!

- Keep transmission log
- Do phone spot-checking
- Keep up with ongoing HIPAA changes

2. Timeliness

- a. Send out claims on a predetermined schedule

It can be that claims are sent out daily, twice a week (if that's the case, exactly which days must be identified), or once a week (that's the absolute minimum).

Some practices still have short filing limits. It is, therefore, crucial that claims are sent out clean and quick.

3. Quality control

Monitoring the quality of the claim is a must (whether paper or electronic). Check the claim for accuracy, modifiers, truncated or invalid ICD-9 codes, UPIN information for consultations and laboratory services, correct POS (place of service), and CLIA information, when needed.

Critical Point Six: Payment Posting

1. Timeliness is vital

As the checks from both patients and insurance companies come flooding in, they must be posted to the accounts on a prescheduled, predetermined, no-exception basis. Merely tearing off the check and throwing the EOMBs into a pile, for posting at some nebulous date in the future, is not acceptable. It's suicide!

2. Affects other cash flow functions

a. Secondaries

b. Reviews and appeals can't be performed. Many carriers have time limits.

c. Patient statements can't be sent.

3 Accuracy

a. Patient statements quality

Accuracy here is also an important factor. If the payment posting is sloppy, then the snowball starts growing and rolling. Up on the top of the list of problems is the production of incorrect patient statements. The cost of sending out patient statements is high. When incorrect statements go out, the phone calls implode the practice and many patients leave the practice due to dissatisfaction. And along the way, money is lost. Lots of money!

b. Charges are written off that should be appealed

c. Filing limits may be missed

Critical Point Seven: Filing Secondary Claims

1. Timeliness
 - a. Payment posting and generating secondary should be done simultaneously so that you can attach the EOMB right then a there.

2. Get the patient involved

Many of the plans send the check to the patient; not to the provider's office. Here's a little suggestion. If the secondary has not made a payment within 60 days, send a standardized letter to the patient indicating that their secondary has not paid and that they will be getting a statement in the mail. (See copy of this letter at the end of this section.)

This letter accomplishes several functions:

- a. It eliminates your staff having to spend their time calling insurance carriers for small balance claims.
- b. It assures that patients, who have received and cashed the secondary check, pay you.
- c. For secondary carriers that haven't paid, it gets patients involved in contacting the carrier for you; in essence helping your practice to get paid. It reduces your staff time and increases the response. Patient's can get the insurance carrier to be more responsive since they are the covered entity.
- d. For contracted secondaries, if patients call about the balance, ask them to help you get the claim paid by calling their insurance carriers for you.

Critical Point Eight: Working the Accounts Receivables

1. Functions of the A/R staff

a. Working the denials or incorrectly paid claims.

These are identified by the payment posters. These include improperly bundled services, denied services due to missing modifiers, and postoperative denials, just to name a few.

b. Correspondence

This is answering the many letters sent by insurance carriers asking for additional information before the claim can be paid. Most of the correspondence is easy to answer. It just requires someone's attention. If the correspondence pile keeps growing and growing; it becomes an insurmountable task that no one ever wants to tackle. Again, lost money. Enough to buy a car or two!

c. The 45-day report

In our billing service we run a report every month for every practice that lists all the claims that have been "in the system" for 45 days (from the date of service...not the date of filing) that have not been paid.

We print the report and require that staff call the carrier or verify claims status on line. We absolutely forbid refiling the claim without a call or electronic status check. We find out early why the claim is unpaid. Not on file, can't identify the patient, no authorization, terminated coverage are all examples of what the staff finds out. Once we are armed with this information, we can take the appropriate steps so that we can reprocess the claim, within the filing limits established by the carrier, or balance bill the patient.

Using this methodology, we have been able to keep our average A/R over 90 days to 7.5% and below!

2. Types of A/R (Always separate the two!)

- a. Insurance balances
 - Unpaid claims
 - Open items
 - Claims in appeal or review
 - b. Patient balances
3. Categories of A/R
- a. Current (services provided in the past 30 days)
 - b. 31 to 60 days
 - c. 61 to 90 days
 - d. 91 days and older (no need to subdivide further)
4. Scheduling A/R activity
- a. Must be assigned to someone
 - b. There must be a schedule... Not something you do when you have time
 - c. Work each report each month. If this is impossible, you need to hire more staff!
5. Generate quality reports
- a. By date of service not date of last filing
 - b. By carrier
 - c. By large to small balances (No alphabetical)
 - d. Call first then refile if necessary

6. Write off balances regularly (Your A/R needs to reflect realistic data)
 - a. Claims appealed twice
 - b. Bankrupt plans
 - c. Patient bad debt

Critical Point Nine: Patient Statements

Although it's a relatively simple and uncomplicated task, it's astonishing how many offices don't send out patient statements on a regular, predictable schedule. Sending out monthly or cyclic patient statements like clockwork is a must.

1. Send out statements on a regular schedule
 - a. Same day each month!
 - b. For smaller practices, once a month may be enough.
 - c. For larger practices, you may want to break the sending out of patient statements into cycles to cut down the volume of phone calls.

2. Review statements for quality

Three to five days prior to the send-out date, certain staff should be assigned to review each patient's account to assure accuracy of the patient balance. It's a quick scan of the account to make sure that all contractual adjustments were made, deductibles and copayments were correctly reflected, etc.

3. Outsource the statements

- Once the review is complete, send the bills via an outsourced electronic patient statement service.
- This is a cost-effective quality alternative and significantly reduces time and money.

4. Establish a dummy patient account for tracking

Established an account in the name of the office manager with a \$50.00 balance. Staff should know that this is a fake account and should not be touched. When the statements go out, the office manager gets his/her monthly statement. Stamp the date the statement is received and put it into a folder.

Why do this?

a. Monitor the outsourced statement service or your staff

This assures that they are sending out quality statements, with the return mailer, on the date they are scheduled to do the mailings.

b. Patient excuses

Use it as a tool for patients who complain stating that they never got any statements.

5. BIT-WIO-TIO

a. Bill it twice (BIT)

Send out only *two* consecutive statements. (Statistics show that the chances of getting paid after three or more statements are the same as sending out only two. So why incur the expense?)

b. Write it off (WIO)

Write off the balance of the patient's balance if no response after two billings.

c. Turn it over (TIO)

The physician can decide whether or not he/she wants the patient turned over to a national collection agency and/or credit bureau.

d. Consider legally dismissing patient from the practice

Note: Many practices dismiss any and all patients who do not pay their bills; whether they are turned over to a collection agency or not. See sample discharge form at the end of this section.

6. Phone coverage

It's important to have adequate phone lines and staff available when statements go out as the phone call load increases significantly for several days after the statements go out. That's why many practices send out cyclic bills several times during the month; rather than all at once.

Add Patient Reg Form

Add Medicare Patient Reg Form

Add Minor Patient Reg Form

Add Sample Discharge Form