



# Teaming Up for Better Outcomes

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FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

No business can be successful without a focus on profitability. Even not-for-profit organizations must pay their bills and have operating income. The focus of a practice may be the health of the patients but the reality is that any goals to improve the health of the patients must be supported financially. So no matter your role in the practice, the financial viability of the practice is to some extent your concern.

## Making It All Count

- One encounter, two outcomes
- Hopefully both positive
- Clinical outcomes – quality care, patient satisfaction
- Financial outcomes – practice stability, patient satisfaction



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Every encounter will have two results. Some factors affecting the financial outcomes of services may be out of the practice's control (e.g., Medicare fee schedule). However, by focusing on what can be controlled most outcomes can be positive.



## Patient Satisfaction

- Most patients do not understand how insurance works or how physicians are paid
- Employers and insurance often do not provide adequate information on their benefits
- They count on your expertise to guide them and bill them correctly

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Patient's need a medical home to give them advice and directions through the complexity of receiving and paying for care.



## When they don't get it...

- Just refuse to pay – lost revenue
- Pay when their insurance would have covered – may delay seeking care, affect performance ratings
- Go elsewhere for care – lost business opportunities
- Complain to payer/others – requires time and effort to address and may lead to losses

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You may not be able to positively identify how often each of these occur. A complaint log may be a useful tool if you suspect problems.

## Complaint Log

Date	Acct. #	Issue	Action
01/01/09	123	Paid \$25 time of service, no co-pay due on preventive service	Refund issued 01/02/09, requested front desk update notes on benefits
01/15/09	265	Stated did not owe \$92 billed for out-of-network visit because Dr. X was listed as participating	Apologized pt. was not notified Dr. X non-par & discounted for hardship, scheduling has updated contracted payer list
01/19/09	369	Complaint about account turned to collections	Advised of process & missed opportunities to address account in-house, advised to phone agency

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By noting the types of calls received and actions taken to address each, practice identifies areas for improvement and complaints that do not require corrective action. Practice management systems that provide reports of note/comment fields may be used instead of manual tracking.



## Measurements

- Measure only what you want to manage
- Useful for identifying cause and effect
- Set goals that are realistic and reasonable
- Don't let time spent on measurement and analysis overcome productivity

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Time is a quantity that is always in short supply in a busy medical practice. Time spent measuring can be valuable to the practice but only if you identify a reason for measuring and are willing to take action to change when measurements indicate change is needed.

## A/R Management - Whose job is it?

- Not me, patient care is my focus
- Not me, I'm not in billing
- I don't have time for that
- The billing staff should do that



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When practice staff do not function as a team, the “not me’s” will stifle productivity. Like the person with one oar, hard work without cooperation will get you no where fast.

## Everyone's concern

- The practice has overhead
- Overhead > income = loss
- Loss =
  - reduced ability to accomplish mission
  - stress and/or low morale
  - insecurity



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Consider the how financial stress impacts a practice. Every practice should have a mission and goals (however formal or informal). Accomplishing these takes resources. Financial stability also encourages both the physicians and the staff who depend on the practice for income and employment security.

## It Takes Cast & Crew

- Producer, Directors, Stars – entrepreneurs who provide vision and leadership
- Production & Casting directors – creative decisions, cueing performers, supply procurement
- Supporting cast- set the scene & support the plot
- Cinematographers – capture the scenes & shine a light on them
- Assistant directors – dialogue coaches, track progress vs. production schedule



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Physician – entrepreneur, vision, leadership;

Managers - creative decisions, casting, cue the performers, supply procurement;

Clinical and front desk – set the scene and support the plot;

Coders – capture services and shine light on them;

Billers – dialogue coaches, assistant directors, contact insurers in their language, bill and counsel patients regarding bills, track progress vs. production schedule

## The Team Approach

- People
- Communications
- Tools
- Cross-training
- Respect
- Incentives



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People – share responsibility, open-minded and adaptive, hard-working;

Communications – verbal, written, symbolic; Tools – efficient work areas, equipment, educational and reference resources;

Cross-training – not only for coverage but for understanding of inter-related functions;

Respect – team members must feel respected and valued, concerns should be acknowledged and considerately answered,

Incentives – setting goals and celebrating progress raises spirits and encourages efforts, ice cream, donuts, small value prize drawings...

## To Start - Know Who's Paying

- Know what you are being paid  
<http://www.aafp.org/fpm/20041000/FeeAnalysis.xls>
- Contract with care -  
[http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/policy/private/contract-negotiation.Par.0001.File.dat/ContractNegotiation.mem.pdf](http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/private/contract-negotiation.Par.0001.File.dat/ContractNegotiation.mem.pdf)

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If unfamiliar with contract terms, see the AAFP guide to contracting with information on key clauses (requires member log-in). Keep a list of plans with which the practice has a contract and also of any plans that the practice does not accept (e.g., if you do not participate in a Medicare HMO plan, it is important that scheduling staff recognize this or the physician may be “deemed” as participating by providing the service).

## Tell Patients What to Expect

- Payment policies
  - Physicians and/or manager develop payment policies for the practice
  - Schedulers/front desk staff ensure that patients receive and agree to payment policies
  - Everyone in practice supports the use of the policies
  - Point person established for patients with questions about payment policies



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Even small practices need to have structure. Just as couples and small families function better with set expectations, a small practice must define roles and expectations. Pre-defined standards and policies reduce misunderstanding and conflict between staff and patients and between staff members.

## Payment Policies

- Business of caring but a business
- Straightforward, plain language
- Amounts due at time of service
- Respond to first statement
- Pre-payment of patient portion for planned procedures (IUD insertion)
- Discharged from practice for noncompliance

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Examples may be found on the internet or through organizations like the AAFP.

## Payment Plans

- Establish guidelines
- Realistic and expedient
- Example
  - Balances  $\leq$  \$150 paid in 3 payments
  - Balances \$151- \$500 in 5 payments
  - Balances  $>$  \$500 – 10% payments
- Designate person to consider special circumstances, allow exceptions

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Best to not get into the business of providing long-term, interest-free loans. Patients have come to expect that they can pay what they want, when they want, for medical care though they expect this of no other business.

## Financial Hardship

- Referenced in payment policy
- Based on income and assets
- Sliding scale
  - 300% poverty level – 20% discount
  - 200% poverty level – 30% discount
  - 150% poverty level – 50% discount
- [http://www.aafp.org/online/etc/medialib/aafp\\_org/documents/prac\\_mgt/codingresources/financialhardshiptemplate.Par.0001.File.tmp/FinancialHardshipTemplate.doc](http://www.aafp.org/online/etc/medialib/aafp_org/documents/prac_mgt/codingresources/financialhardshiptemplate.Par.0001.File.tmp/FinancialHardshipTemplate.doc)

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Handling patients who cannot afford to pay should not be done on the fly. By establishing criteria and a process for estimating financial need, the practice best serves those who are truly in need. The link provided above is to an example of a financial hardship form that a practice can adapt for the purpose of determining whether or at what level, patients need assistance based on practice policy.

## Suggested Reading

- *Family Practice Management*,  
Sept. / Oct. 2009
  - [What You Can Do to Help Your Uninsured Patients](#)
  - [Offering Financial Assistance to the Newly Uninsured](#)

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The direct links to these FPM articles will require a member or subscriber log-in.

## Scheduling

- Patients are informed of payment policies when appointments are scheduled
- Type of visit assessed at time of scheduling (preventive only, preventive and problem, follow-up only or new problem)
- Insurance verified & payer policies noted (e.g., preventive service covered annually) at least one day prior to visit

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Having put into place guidance for how patients collections are to be handled, it's time to address insurance verification and determining the patient's amount due. If the amount due from the patient is not determined until after the service is delivered, or worse, thirty to sixty days after the service was delivered, your chances of collecting are much lower. The expense of pre-determination is typically less than the expense of billing and collection efforts after the service is rendered.

## Collecting Old Balances

- Scheduler notes balance due on patient account while scheduling new appt.
- State, “I see that you have a balance on your account of \$..., would you like to pay that now by credit card or pay this amount and your co-pay of \$... when you check-in?”

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When collecting from patients, staff should be as assertive as the person at the movie rental store. Most rental businesses will not allow a new rental until old fees are paid. Your patients know this and most abide by the rental store’s policies. However patients have become accustomed to not paying for medical care and must be reminded that the practice also expects prompt and full payment.

## Team support of scheduling

- Matrix updated by billing dept. for common payers & policies (e.g., coverage of problem-oriented service on same date as preventive)
- Set-up a protocol of short, medium, and long appointment slots
- Scripts for advising patients of need to pay co-pays or past due balances
- Cross-training w/front desk or billing

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Cheat sheets can be wonderful tools. Cheat sheets in the form of easily updated shared computer files are more wonderful. Just as each piece of medical equipment requires routine maintenance, cheat sheets and other tools used around the office must be constantly updated. Determine who is best positioned to stay up-to-date on changes in payer rules and appoint that person to update forms and tools.



## Available Information

- Most practice management systems include fields for staff notes regarding patient accounts
- Note in these fields:
  - Payment arrangements
  - Information that needs updating
  - Attempts to collect from patient
  - Follow-up with payers

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Be sure that you are using your practice management and scheduling systems to the fullest extent possible. Note fields in patient accounts can be extremely helpful in alerting schedulers and billers to missing information, past due amounts, etc. However, these should always be used in a professional manner. Notes should not contain any judgemental or otherwise inappropriate remarks.

## Information at a Glance

Payer/Phone Number	web address	CP/DD/CI	E/M w/preventive?	Notes		
Aetna -ABC PPO	<a href="http://www.aetna.com">www.aetna.com</a>	0/500/20%	Yes	LabCorp, Pre-cert. Synagis		
Aetna - ABC POS	<a href="http://www.aetna.com">www.aetna.com</a>	25/250/20%	No	LabCorp		
Anthem						
Cigna						
Empire BCBS						
Highmark						
Horizon NJ						
Independence Blue Cross						
United						

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An example of a simple way to produce a contracted/commonly accepted payer information sheet.

**Insurance Verification**

Date: \_\_\_\_\_ Patient's Name: \_\_\_\_\_

Chart/Account #: \_\_\_\_\_

Obtain from Patient and verify with Insurance Company.

<b>Primary Insurance -</b>	<b>Secondary Insurance -</b>
Insured	Insured
Relationship to Patient	Relationship to Patient
Policy/Member #	Policy/Member #
Group #	Group #
Effective date of coverage	Effective date of coverage
Mailing Address	Mailing Address
City State Zip Code	City State Zip Code
Phone Numbers	Phone Numbers
Employer Phone # Employer Address	Employer Phone # Employer Address
Co-payments	Co-payments
Deductible/Deductible met	Deductible/Deductible met
Co-insurance	Co-insurance
Benefits & Limitations Maternity care - Contraception - Preventive -	Benefits & Limitations Maternity care - Contraception - Preventive -
Out of Network Benefits	Out of Network Benefits
Notes	Notes

Insurance verified \_\_\_\_\_ (date)  
Spoke with \_\_\_\_\_ at \_\_\_\_\_ Insurance company.

Name: \_\_\_\_\_

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If information is not entered immediately into practice management system, use of a simple form to document the insurance verification and provide at-a-glance information. Many plans now offer online access to benefit verification. This saves time and frees phone lines.



## Once is Not Enough

- Employers and Insurance plans frequently change
- Verify patient coverage for each scheduled service
- Particularly important with plans that provide coverage only when working (some union plans, seasonal workers)

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For some plans, coverage is based on hours worked in a certain time period. A patient with full benefits under a plan during one eligibility period may have limited or no coverage during the next period if he/she didn't work enough hours to qualify for full benefits.

## Never Ask...

- “Has anything changed since your last visit?” or “Is everything still the same?”
- Instead, ask for verification of key pieces of information such as address, phone, current insurance card
- “Is \_\_\_\_\_ street still your current address?”

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Updating patient demographic and insurance information is not to be taken lightly. Patients often respond to the question of whether anything has changed with a quick No even when they have moved, changed their phone number, or had a change in insurance coverage. Asking patients to review key elements of information either orally or on a written form that requires checking off each item as correct or providing corrected information can save a lot of time in the billing process as well as clinical follow-up.

## Recommended reading

- Patient Balances: Getting to the Root of the Problem – FPM March 2006 – Kristen Dillon, M.D.
- <http://www.aafp.org/fpm/20060300/48pati.html>

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Learn how one practice took steps to understand why their accounts receivable numbers were not good and put processes in place to achieve improvement.



## Scheduling teamwork

- Abide by practice policies
- Own and correct mistakes and omissions in information obtained during scheduling
- Set pleasant tone for visit - always smile when answering the phone
- Respect the contributions of other team members

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The scheduling desk can be a hectic and demanding area but using practice policies and choosing a good attitude can make the person serving in this role an invaluable starter for the team. Clearly communicate to front desk any agreements for a patient to pay a past due balance at check-in for their next appointment.



## At the Front Desk – New Patient

- Affirm patient ID, current demographic & insurance information, and reason for encounter
- Obtain patient agreement to payment policies, answer questions about payment
- Provide welcoming first impression

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Pleasant efficiency is the goal for the front desk. Relying on work completed at the time of scheduling, the tasks of the front desk staff are to provide the welcome face-to-face greeting for all visitors, provide practice information (payment, HIPAA, etc), and collect information needed for accurate and timely payment. Though practice's often prefer to collect co-pays, coinsurance, and other amounts due from the patient at check-out, the check-in should include a reminder that payment will be expected at check-out.

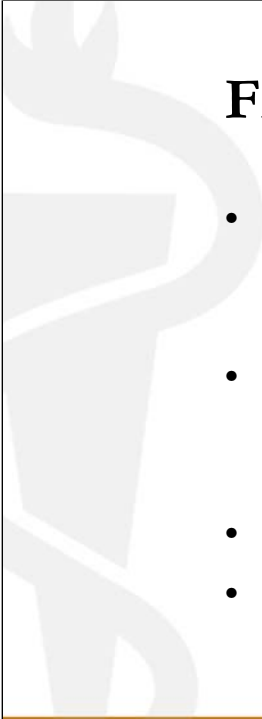


## Welcoming Established Patients

- Flag your patient list either one day prior or early the day of appt. for patients who have past due balances to pay before their service
- Compare ins. card to copies on file at least monthly (watch for # changes)
- Update patient/guarantor information
- Greet & thank patient for returning

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Try to be aware of plans that have issued new cards and recognize when patients are carrying old cards. Always verify accuracy of information on file.



## Front Desk Teamwork

- Alert clinical and/or check-out staff to any unexpected changes with patient insurance and/or reason for visit
- Give feedback and collaborate with scheduler to achieve efficient work flows
- Own mistakes and omissions
- Respect the contributions of other team members

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Like the rest of the team, front desk staff must know that they play a key role in not only making the patient's visit pleasant but also in making the services rendered profitable to the practice. A good attitude and willingness to work in a team effort are key for this position that makes the connection between the patient demographic information and the clinical care team.



## In the Exam Room

- Verify scope of visit as soon as possible
- Use of reminders for potential payment issues (need for ABN)
- Pre-authorization/Pre-certification
- Referral to preferred providers (e.g., lab contracted with payer)

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Watch out for unscheduled services. The opportunity for payment may yet be lost despite efforts by scheduling and front desk staff. Many services are subject to pre-authorization/pre-certification requirements or are covered only for certain diagnoses.

## Finding Medicare LCD's

- [Medicare Coverage Database](#)
  - <http://www.cms.hhs.gov/mcd/search.asp?clickon=search>
- Review list quarterly for changes
- Use an online database like [www.aafpcodingtoday.com](http://www.aafpcodingtoday.com)

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You can create your own spreadsheets or notebooks to remind you of procedures that have local coverage decisions under your Medicare contractor or you can subscribe to an online coding program that will provide this information for each code. Physicians who do not wish to personally spend time checking for LCD requirements may choose to inform their nurse/MA that the decision to perform a procedure has been made and allow time for verifying coverage prior to performance of the procedure.

(A) Notifier(s): \_\_\_\_\_ (C) Identification Number: \_\_\_\_\_  
(B) Patient Name: \_\_\_\_\_

**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.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

**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: \_\_\_\_\_

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Experts, Clearance Officer, Baltimore, Maryland 21244-1850.

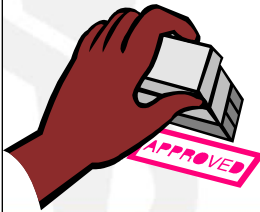
Form CMS-R-131 (03/08) Form Approved OMB No. 0938-0566

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Must use Form CMS-R-131 (03/08). Get English and Spanish versions from [www.aafp.org/codingresources](http://www.aafp.org/codingresources); look under the subheading of CMS Non-covered Services.

## Insurance Pre-auth/Pre-cert

- Inpatient admissions
- Some physician-administered drugs
- Botox
- Use payer web sites and lists of common payer's requirements for your most common services



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Some payers, like Aetna, allow for online verification of need for pre-certification and online submission of pre-certification request. Others may require special forms or phone calls. By keeping this information in a spreadsheet, you can access and update the information more easily. This may require some collaboration between billing and clinical staff to create, maintain, and keep this list available to all who may need it.

## Supporting the Bill

- Services provided & documented by all care providers
- All services captured in charges
- Systematic processes for assuring that each person providing a service, documents the service
- Codes assigned & promptly submitted for billing



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Some surveys indicate up to 15% of healthcare services rendered are never billed. This is typically due to a lack of structure in the documentation and charge capture processes. Practices have also lost money previously paid for services when an audit indicates lack of documentation for services such as injections, blood draws, or minor procedures. An important rule that may prevent lost charges/revenue is that today's work must be done today (preferably in a standardized documentation format).



## Time Standards

- Visit is not complete until record is documented
- Set policies for
  - Timely record completion
  - Submission of charges to billing office
  - Response to billing office inquiries

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When charts remain incomplete at the end of a business day, billing may be delayed and/or inaccurate. The documentation in the medical record is not only important for clinical utility but also for billing and liability risk aversion. Billing office staff cannot provide the best service if clinical staff are not cooperative in providing timely and complete documentation or do not respond promptly to inquiries from billing staff to verify correct billing or coding service.

## Lag Time Report

Clinician	0-3 days	4-7 days	8-15 days	16-30 days	30+ days	Rel Score	YTD avg
Jones	67%	33%	0	0	0	91.7	89.2
Smith	63%	22%	13%	2%	1%	86.2	85.8
Hughes	50%	33%	11%	3%	4%	80.8	73.7

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A practice may choose to periodically or on an ongoing basis track the lag time between the patient visit and the submission of completed documentation to the billing office.



## Teamwork - Front & Back Office

- Work with and give feedback to scheduling, front desk, and billing to maintain efficient work flow
- Accept your responsibility for practice financial viability
- Respect the contributions of other team members

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Direct patient care is the main focus of any medical practice but recognizing the need to support the business side of the practice and the others who play a role in the process is especially important for the clinical team.



## Before the Patient Leaves...

- Be sure that co-pays, co-ins. & deductibles have been collected or payment arrangements made
- Always provide a receipt to the patient for payments made in person & keep a copy with payment records
- Promptly post payments

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Whether collected at the time of check-in, check-out, or somewhere in between, every patient should be counseled regarding what charges were incurred in the visit and what, if any, amount is due at the time of service. The more payment options that your practice can offer (eg, credit and debit cards, auto payment agreements), the better.

## Coding

- A subject unto itself
- Three rules
  - Current coding books/software
  - Code what was provided and documented
  - Always let compliance overrule payment concerns
- [www.aafp.org/codingresources](http://www.aafp.org/codingresources)

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An integral part of the billing process, coding is too detailed and complex to fully discuss in this presentation. Please see additional AAFP resources for more information.

## Coding Resources

- <http://www.cms.hhs.gov/NationalCorrectCodingInitEd/>
- [\*Family Practice Management\*](#)
- [Medicare Manuals](#) – Claims Processing (12), Benefit Policy(15)
- [Physician](#) and [Laboratory Fee Schedules](#)

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Most AAFP billing and coding resources are free and available online for both members and non-members. Every person involved in coding and billing should have at least basic knowledge of the National Correct Coding Initiative Edits produced for Medicare claims and used by many private payers also. The Medicare manuals noted are those most pertinent to family medicine. The Medicare physician and laboratory fee schedules may also be found on your local Medicare contractors web site. The physician fee schedule includes the global periods for procedures and relative value unit information.



## In the Billing Office

- Final checkpoint for accuracy and completeness
- Must use all of the information from the encounter to create billing
- Learn constantly – read payer bulletins & web sites
- Handle the practice accounts with professionalism, confidentiality, & integrity

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The term “billing office professional” is a valid description of what those hired to manage medical accounts should be. The confidential nature of information handled and the importance of consistent and accurate work should not be overlooked. While some positions do not require extensive formal education or training, someone must take accountability for the overall management of the billing processes including the continuous monitoring of reports and updating of payment rules and practice resources.

## Charge Entry

- Establish routines for verifying charges are complete & all diagnoses & services are coded
- Pay careful attention to patient demographics and date insurance information was last updated/verified
- Aim for completing today's work today

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Rather than mere data entry, charge entry should be a process devoted to completeness and accuracy of information. Organization and attention to detail are key characteristics of efficient charge entry.



## Claims Submission

- Run billing or claim scrubber reports before submitting claims to check for obvious errors
- Immediately correct errors and re-batch if necessary
- Review electronic claims reports, correct errors, resubmit daily

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All claims data should be scrubbed or reviewed for potential errors prior to submission. Electronic claims acknowledgment and acceptance reports should be carefully reviewed noting any errors and promptly making corrections to resubmit the claims.

## Some numbers that matter

- 81% of clean claims are paid within 14 days (AHIP data)
- 29% of charges are 30 days old before a claim is sent
- 20-30% are rejected
- Approx. 50% of those never re-billed
- Average practice cost to process claims \$7.92

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The first bullet point tells you that most of your claims sent electronically should be paid within 14 days. If this isn't the case, an investigation is in order. It is actually possible to lose money in getting paid when the time spent correcting errors and resubmitting costs more than the amount paid.

<http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf>

## Working the Accounts

- Unpaid insurance claims are aging daily, they must be worked daily
- Timely filing denials should be few
- Denied claims must be corrected & resubmitted or submitted for review to meet payer time limits
- Every area has at least one payer that is difficult to work with, that's no excuse for not trying

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Often billing staff would rather enter and send claims for new charges than work on unpaid insurance balances. While the new claims work is generally easier and feels more productive, every day that passes without follow-up on an unpaid balance costs the practice money. With today's time limitations on refiling and appealing insurance claims, claims follow-up must be a constant process. Likewise, the older a patient's balance due, the less likely that it will be paid.



## Patient Balances

- It costs anywhere from \$2 -\$10 to send a statement depending on practice overhead costs
- Does it make financial sense to bill amounts not due from the patient?
- If you are willing to use a collection agency, don't delay too long, if internal collections know the laws

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Though there are many schools of thought regarding patient statements, I see little value in sending statements saying a claim has been filed to insurance and no payment is expected at this time. Patients should expect that a statement represents a balance due now. Sending statements daily is more effective and efficient than monthly. If the statement is sent immediately following posting of the insurance payment, the patient likely has just received an explanation of benefits and is aware of their balance. If the statement were sent a month later, the patient may no longer have the explanation of benefits.

## Messaging

- If staff send statements from the office, messaging can be effective
- Hand-written with name of billing staff to contact
- Delivers message that staff are aware of this account and can provide reminder to patient of payment policy

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A simple statement such as, “Your insurance plan recently paid benefits due on this charge and we have adjusted your balance accordingly. This \$100 represents the amount applied toward your annual deductible. Your prompt payment is appreciated.”, sends a clear message to the patient that the practice is aware of the balance due and expects payment in full now. If no payment is received within your statement cycle time, a second message might read, “Please send full payment of this past due balance now to avoid collection proceedings. If you have any questions regarding this charge, please contact Sallie at 555-5555 or [Salliebilling@practice.com](mailto:Salliebilling@practice.com) today.” If necessary to send a third statement, the message should indicate the practice’s bad debt collection policies such as “We have sent two prior statements requesting payment of this balance. If you disagree that you owe this balance, please contact us immediately. Otherwise, in accordance with the payment policies previously provided to you, we will turn your account to our collection agency in 28 days.”

## Payment Posting

- First opportunity to recognize payer issues (e.g., downcoding, payment less than contractual agreement)
- Must recognize patient responsibilities such as deductibles
- Careful attention to account detail (correct person & date of service)

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Payment posting is detailed work. Though speed of data entry is helpful, it is posting the correct amounts to the correct accounts and fields that probably matters most. Revenue can be lost and patient's upset if a payment for one charge is posted to a charge for another patient's account. If payments are posted automatically in the system, be sure that explanation of benefits are carefully reviewed for denials.

## Suggested Reading

- <http://www.elizabethwoodcock.com/resources/TOOLS%20+%20patient%20collections%20fact%20sheet.pdf>

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Patient Collections Fact Sheet

*Patient Collections Fact Sheet Prepared by Elizabeth W. Woodcock, MBA, FACMPE, CPC*

## Nevers for Billing Staff

- Never move a balance to patient responsibility based solely on aging
- Never write off a balance to avoid follow-up work or to make reports look better
- Never assume that your practice is unique, others are fighting the same fight and may have tips

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Working aged accounts and trying to get claims information from payers can be frustrating work. Billing staff must be tenacious and not ignore or write-off balances that might be received. Sometimes it is necessary to enlist the assistance of the patient, their employer, or a provider representative for a payer to resolve claims.

## Never Stop Learning

- Constant education – payer newsletters, etc.
- [http://www.anthem.com/ca/provider/f0/s0/t0/pw\\_b133757.pdf](http://www.anthem.com/ca/provider/f0/s0/t0/pw_b133757.pdf)
- [http://www.humana.com/providers/tools/provider\\_tools/publications.asp](http://www.humana.com/providers/tools/provider_tools/publications.asp)
- <http://www.triwest.com/provider/default.aspx>

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Use all available resources to stay abreast of payer policy changes.

## Always

- Get approval for write-offs above a set limit
- Follow practice protocol for write-off of small balances
- Post payments promptly so that follow-up work is not wasted
- Refund overpayments promptly

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Some balances are too small to collect. It doesn't make sense to send a statement for \$1.50 if it costs \$3.00 in supplies, postage, and staff time to process the statement. Holding small balances for a short time to see if further charges are incurred may allow for collecting in a more cost-effective manor.



## Teamwork in the Billing Office

- Use tracking to determine causes of billing/claims errors & collaborate to prevent further errors
- Own mistakes & respectfully approach others regarding theirs
- Treat patients and payer representatives with firm courtesy

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Billing staff will typically see mistakes and omissions that occur from scheduling through documentation and billing. The right perspective and attitude must be used in addressing errors. Is the error a recurring one or likely a one-time occurrence? Can billing staff determine a cause and recommend a solution? Staff may frequently speak with the same representatives of a payer. Establishing a professional and friendly contact can lead to easier resolution of payment issues.

**Denial Tracking Worksheet**

**Instructions:**

Complete one row for each denial received by an insurance company.

Record the amount of the denial under the appropriate category; if the error occurred at registration, for example, record the amount under that column

Use your judgement about the categories -- and the reasons that fall under each; the key is not to place blame, but to allow you to identify root causes

Write the specific reason for the denial under "REASON".

NOTE: We'd suggest one page per day or week, depending on volume. Review each month to identify problem areas and trends.

Account No.	Insurance Co.	Coding	Front Desk		Billing Office	Insurance Company	REASON:
			Registration	Referral/Auth			
1123-04	United		\$240				Subscriber not enrolled on DOS

[Have a question? Go to www.physicianspractice.com](http://www.physicianspractice.com) and Ask an Expert.

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<http://www.physicianspractice.com/index/fuseaction/tools.details/activityType/calculators/tool/32.htm>, accessed 07/15/09



## Minding the Shop

- Charges turned in promptly
- Days outstanding < 90
- Monitor claims follow-up notes
- Adjustments match contracted discounts
- Write-offs appropriate
- Refunds made
- Deposits match receipts

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Those in management positions should always be mindful of the practice's accounts payable and accounts receivable. Though I did not address accounts payable in this presentation, cross-referencing things such as cost of drugs including procurement time and storage to average payment for drugs provides a basis for determining whether services provided and processes to provide them are cost-effective. Continuous monitoring is the best defense against unexpected fluctuations in revenue.

## How's it working?

- Aging by patient/guarantor responsibility – Are there balances that should have been collected at time of service?
- Aging by payer – Is a payer consistently slow? Suddenly slow?
- Aging by payer by CPT code- any services not being paid?

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The Aged Trial Balance has been referred to as the Mack Daddy of reports. Reviewing twelve months of aging reports will provide a historical review of the practices cash flow by payer and/or by service (by physician also if desired). Monitoring this data monthly will allow for early management of problems and adjustments to account for any changes in cash flow.

## Benchmarks for Aging

Aging	Top 10%	Median
< 30 days	42.68	61.55
31-60 days	9.15	14.46
61-90 days	4.71	6.89
91 – 120 days	2.79	4.77
Over 120 days	3.68	11.21

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The table above is based on data from the “MGMA Cost Survey for Single Specialty Practices: 2007 Report Based on 2006 Data” and represents survey data from family medicine practices that were not hospital or IDS owned

## Periodic Reviews

- What was written off today and why?
- What was the lag time between date of service and date charge entered this quarter?
- Do our reports show we bill vaccine and vaccine administration codes for each service?

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There's only so much time that can be spent reviewing reports but by staggering when you focus on key indicators, you can keep track of them. Other examples for consideration, are we billing out lab charges for all of the test kits that we purchased (CPT codes billed vs. supplies purchased) and are we seeing as many Medicare patients as we used to (number of Medicare patients with charges entered by month for the last year).

## Suggested Reading

- <http://www.physicianspractice.com/index/fuseaction/articles.details/articleID/1064/page/1.htm>

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### **Billing & Collections: Mine Your A/R Reports**

***Billing & Collections: Mine Your A/R Reports, Use reports to understand business and set staff priorities***

By Pamela Moore



## Checks & Balances

- Set limitations on who can make adjustments to accounts and for what amounts
- Make sure that payments from patients are not collected, posted, and deposited by one person (other than owner)
- Use receipt books that are numbered and marked

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Every business is vulnerable to theft from external and internal sources. Many practices have suffered ongoing losses to internal theft for years before discovering the practices that were ongoing. Often, theft has been conducted in a manner to cast blame on an employee who was innocent. Checks and balances in handling of accounts are a protection for the practice and for staff.



## Got Questions?

We hope this has been helpful to you. AAFP members and their staff may contact [chughes@aafp.org](mailto:chughes@aafp.org) with any questions.

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