RANAC

Optimizing Performance & Profit For Healthcare Professionals

How to Use Your Practice Management Effectively to Collect More Money

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Table of Contents

Overview

To say the least healthcare reimbursement is a challenge.

Everyone, including insurance companies and patients, hold on to their money more tightly.

Insurance companies and other payers have developed an increasingly complex and often confusing set of rules and processes that lead to more denials and lost or unpaid claims. Long story short: It's becoming harder for doctors to get paid for the work they perform.

At the same time, medical practices are under increased pressure to collect more money and cut their operating expenses in an inflationary environment – while continuing to provide top-quality care to their patients.

On top of all that, with new regulatory challenges, such as the Patient Protection and Affordable Care Act and the forthcoming implementation of ICD-10 effective October 2014, the healthcare landscape has become more uncertain. This will cause the collection process to become increasingly more complex. The financial impact on medical practices could be significant, making it even more important for practices to collect all the money owed.

How much money is being left on the table?

Unfortunately, most medical practices are currently not collecting everything they have earned. Here are some alarming figures:

Only 70% of claims are paid the first time they are submitted, according to research by the Centers for Medicare and Medicaid Services (CMS).

The other 30% of claims are either denied (20%) or lost or unpaid(10%). Consequently, 60% of them are never resubmitted to payers. That means medical practices never collect on 18% of claims.

Claims submitted past the timely filing limit account for a significant amount of revenue lost each year.

How do we prevent these problems?

1 Sending Claims Successfully

As you can see from the statistics above, when a claim is not paid the first time it is submitted, the likelihood the practice will ever receive money for that work drops significantly.

Therefore, one of the best ways for practices to improve their billing efficiency is to catch potential denials before the claims are submitted to payers so more claims are paid the first time. With a claims scrubber practices can automatically identify claims that are likely to be denied.

Using a claims scrubber that updates and adapts its rules, practices can stay on top of the latest claim denials to continually improve their collection rates.

The impact of billing software that provides a claims scrubber:

1. Higher claims acceptance on first submission – Since potential denials are caught before the claims are submitted, practices have much better odds of being paid on the first submission. Our claims scrubber helps practices improve their collections right out of the box. Since many denied claims never end up being paid, improving the claims acceptance the first time keeps practices from leaving money on the table.
2. Less work for practice staff – Having claims paid the first time submitted minimizes the time-consuming task of reviewing denials and resubmitting claims with payers to resolve issues. That makes practices more efficient overall and provides staff more time to take care of what is important – helping patients.
3. Ability to follow your claims – It is imperative to follow your claims all the way to the payer. Claims can be dropped going from your system to the clearinghouse and ultimately to the payer.

2 Payer Contract Management

In addition to denials, another problem keeping medical practices from collecting the full amount of money they have earned is failure to collect co-pays and patient balances.

Knowing your contracts will help ensure a practice will:

1. Collect the payments owed – checking contract for underpayments can allow practices to raise their net collection rates
2. Increase efficiency and organization – Keeping contracts in an electronic system eliminates a lot of the manual work required when staff members need to look up contract details.

3 Accounts Receivable Aging

Traditionally, receivables are tracked based on 30-day increments – different actions are scheduled depending on whether a receivable is 30, 60, 90 days old, etc.

But each payer operates on its own schedule, so two receivables that are 30 days old could require completely different actions if they're from different payers.

For example, Medicare typically issues payments in 14 days, whereas they may wait 45 days for other carriers to pay. A practice's best bet is to act on claims based on each payer's individual schedule.

Simplifying collections as much as possible – for example generating a letter, resubmitting a claim, or creating a collection follow-up and sending it to the collector's queue for outstanding claims, helps assure that the practice is taking the right action at the right time.

That gives practices several tangible benefits:

1. Increase collections – Billing staff members can easily check when claims have passed pre-set claim filing limits.
2. Faster collections – Practices will improve their average collection period because they can follow-up based upon the payer's average days to pay. The sooner the practice follows up on unpaid claims, the lower the likelihood it will become lost or ignored.
3. Less money left on the table – Tracking outstanding claims ensures that no lost or ignored claims slip through the cracks and that the appropriate action is taken for all of them.

4 Keys to Improve Collections

The physician revenue cycle from scheduling patients to collecting final reimbursement involves many steps. There are 5 basic areas that can cause a decrease in revenue.

Eligibility – make sure the insurance information for the patient is correct. Failure to make sure you have the proper carrier information can result in a delay or even a denial in payment.

Authorizations – more and more procedures are requiring a prior authorization. Failure to precert procedures can result in no payment. Many carriers will not do a retro certification.

Co-pays – this is money the patient owes at the time of service. Be sure to collect this. This can be as much as 25% to the bottom line of a practice.

Deductibles – know the patient's deductible. Many plans now have large deductibles, how are they going to pay the balance. If it is for an elective procedure have the patient pay prior to the procedure or at minimum have a 50% prepayment and a payment plan established.

Payment plans – this has become a necessity for many patients who have large deductibles or are responsible for a percentage of the approved amount. Practices need to set up payment plans and monitor for payment. Have the patient sign a payment arrangement form listing the arrangements.

5 Reporting, Analytics and Business Intelligence Tools

Managing a medical practice requires access to complete, easy-to-understand reports.

It is important to be able to have reports for billing and collection trends to determine how the practice can improve.

Strong reporting capabilities offer several benefits to practices.

1. Better decision making – Allowing key reports to be easily created – as well as understood – helps make sure all the necessary data is reviewed before important decisions are made.
2. Higher productivity – Generating and sharing reports automatically means practice staff members no longer have to spend time gathering data, printing reports, and distributing them by hand.

6 Electronic Remittance and Automated Denial

One method is accepting electronic remittance advice (ERAs) from insurance companies. An ERA is a standard report that can be read by a computer system detailing payments made.

With the ability to post denials it makes it easier to track, measure, and manage them – that helps make sure more denials are resolved and makes it easier to gather data to prevent denials in the future.

These features impact practices by:

1. Increasing collections – Automatically posts denials to help keep better track of unpaid claims.
2. Improving efficiency – Automating these parts of the revenue cycle eliminates manual work and decreases the likelihood of data entry errors, which can add even more hassles to the process.
3. Getting practices paid faster – Converting more parts of the payment cycle into automated electronic process helps practices improve their A/R. By receiving payments from primary insurance companies, it will reduce the payment cycle from secondaries.

7 Advanced Collections Application

Your A/R management applications provide advanced tools to greatly improve a practice's efficiency and workflow. The features that will benefit you the most are:

1. Work queue for collectors – Sending information and assignments to collectors and queue up an automated list so they can work quickly.
2. Collection Notes – Easy documentation of collection efforts including follow-up dates.
3. Advanced tracking – Tracking all denials, underpayments, and lost or unpaid claims.
4. Standardized denial types – Categorize denials based on their type – e.g., authorizations, no coverage, medical necessity, and others. These denial types should be able to be standardized into the same category across different payers. This provides practices the criteria to analyze when trying to minimize denials.

Conclusion

The revenue cycle for medical practices is complex and tough to manage. That's why it is more important than ever to get a handle on the process and efficiently collect the money your practice is owed.

By using the capabilities described above it will lead to better billing and collections not only saving practices money and adding to their revenue, but it also allows medical practices to focus more time on what they do best – caring for patients.