Maximizing Collections

Michigan Primary Care Association

The H Hotel - Midland, Michigan

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What Areas of Operations Affect How Much Cash is Generated?

- Collecting Information
- Appointment Scheduling
- Accuracy of Recording Information
- Efficiencies of Staff
- Communication with:
  - Patients (Teaching Compliance)
  - Providers and Staff
  - Community
- Patient Experience
- Management Oversight
Step 1 – Understand Your Revenue Cycle

A. Review current front office operations
B. Analyze areas where revenue can be enhanced by assuring that information is captured correctly
C. Improve processes by documenting work flows
D. Provide feedback about how staff are performing
E. Perform revenue cycle review
F. Identify bottlenecks
G. Aggressively screen all uninsured patients for eligibility
The Revenue Cycle

- Appointment Scheduling
- Registration/Certification
- Patient Reception
- Patient Clinical Visit – Service Delivery
- Documentation & Coding
- Charge Processing/Check Out
- Accounts Receivable Management and Collections
- Denied Claims Management
- Claims & Patient Payments Processing
- Patient Statement & Claim Production
- Claims & Patient Payments Processing
- Charge Processing/Check Out
Executive Management Needs Key Performance Indicators (KPI) for the Revenue Cycle Function

“If you do not measure it, you cannot manage it.”
—W. Edwards Deming

He is regarded as having had more impact upon Japanese manufacturing and business than any other individual not of Japanese heritage.
**What is a Key Performance Indicator?**

- Numerical Factor
- Used to quantitatively measure performance
  - Activities, volumes, etc.
  - Business processes
  - Financial assets
  - Functional groups
  - The revenue cycle

*Source: BearingPoint, Key Performance Indicators*
### Some Suggested Key Performance Indicators for FQHCs

#### Patient Access – Front Office Performance

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>HIMSS Measure</th>
<th>HFMA Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration Error Ratio</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Insurance Eligibility Verification Rate</td>
<td>≥ 98%</td>
<td></td>
</tr>
<tr>
<td>Point of Service Cash Collected</td>
<td>≥ 65%</td>
<td></td>
</tr>
<tr>
<td>Returned Mail Percentage</td>
<td>&lt; 5%</td>
<td></td>
</tr>
<tr>
<td>Medicaid Eligibility Screening – uninsureds</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Medicaid Eligibility Screening – Medicare Onlyys</td>
<td>100%</td>
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</tr>
</tbody>
</table>
Some Suggested Key Performance Indicators for FQHCs

**Revenue Integrity**

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
<th>HIMSS Measure</th>
<th>HFMA Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days to Posting of Charges</td>
<td>&lt;1 business day</td>
<td></td>
</tr>
<tr>
<td>Denied Claims % of Net Revenue by Payer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point of Service Cash Collected – by Site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coding Error Rate (Billing &amp;/or Provider)</td>
<td>&lt; 1%</td>
<td></td>
</tr>
<tr>
<td>Provider Coding Performance – Practice Norms</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
## Some Suggested Key Performance Indicators for FQHCs

### Claims Adjudication

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<th>Key Performance Indicator</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Top 10 Reasons for Denials Incidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Claims Filed by Payer/Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial Denial Rate</td>
<td></td>
<td>≤ 4%</td>
</tr>
<tr>
<td>Denials Re-Filed within 2 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean Claims Submission Rate</td>
<td>&gt; 85%</td>
<td></td>
</tr>
</tbody>
</table>
Some Suggested Key Performance Indicators for FQHCs

**Management**

<table>
<thead>
<tr>
<th>Key Performance Indicator</th>
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<th>HFMA Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days in AR by Insurance Payer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days in AR – Patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad Debt – % of Net Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Front Office Cash Collections % to Patient Net Revenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Mix – Net Revenue vs. Collections/Payer Type/Visit</td>
<td></td>
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</tbody>
</table>
Identifying Action Steps to Achieve Maximum Revenue & Collections

Step 2 – Clean-up Billing and Collection Efforts

A. Review current billing functions and analyze current provider documentation
B. Analyze areas where revenue can be enhanced by identifying problems with rates, bad debts, increasing A/R, etc.
C. Improve coding for quicker claims adjudication turnaround and reimbursement
D. Analyze outside collection agency and evaluate revenue implications
E. Perform denial analysis
F. Identify annual dollar amounts associated with improvements
General Standards for Patient Billing Systems

- Written Policies and Procedures with Board approval (including registration & certification)
- Annual Review and adjustment of fee schedule
- Patient Statements sent monthly
- Encounter forms entered at front desk or medical records completed daily
- Staff person to field billing questions
- Installment plan system
- Registration entry data validation on back-end
- Visit data validation on back-end
- Providers attend coding workshops
General Standards for Patient Collections Systems

- Written Policies and Procedures approved by the Board
- Dunning Notices (30, 60, 90, etc.)
- Staff person designated for collections
- Use practice information system notes on system
- Total balance requested at each visit
- Track % of collections at front desk
- Front desk and billing staff attend collections workshops
- Procedure to restrict services for chronic non-payers
Accounts Receivable “Best Practices”

- Establish expectation of payment and enforce it
- Be consistent with all payers
- Adopt a written collection policy and enforce it
- Collect amounts due from patients at time of service
- Keep accurate records on patient balances
- Send statements to patients
- Implement collection procedures
Accounts Receivable “Best Practices”

- Detailed accounts receivable aging reviewed monthly
- Use written payment agreements and implement electronic tracking
- Employ sufficient collection staff
- Resolution of denials within 10 days; written denial summary report
- Have patients sign financial policy at registration
- Involve patients in insurance collection
Establish a collections system that includes policies and procedures approved by the Board of Directors and should create knowledge within the communities served that the health center expects payment for services rendered.

This system should be managed by in-house staff and not rely on outside agencies.

An important component of successful collections systems in health centers is to adopt the policy that if patients ignore all requests for payment or ignore making arrangements for payment, that the health center will restrict services until such time as the patient makes arrangements for payment.

It should also be noted that by certifying and placing a patient on the sliding fee scale, they have been given a payment status that is based on their ability to pay, and they should pay their part.
Process for Collecting Patient Accounts

- **Must send statements monthly** to all patients. Statements should be somewhat easily understood by the reader and have the current month’s new charges and any old balances, showing a total amount due the health center.

- **Dunning notices** should be sent for past due amounts each month. The theme throughout the aging of the account is the request that patients contact the center’s financial department and make arrangements for payment.

- If at 120 days past due, the patient hasn’t made any effort towards payment or arrangements for payment, a letter should be sent informing the patient that if they do not contact the center’s financial department and make arrangements for payment within the next 30 days, their account will be placed on restriction and they’ll be asked to find another doctor. A list of these patients should be shared with providers and providers can determine that there are certain patients with chronic conditions that should not have any restrictions placed on their account.

- At 150 days if those patients contacted at 120 days still make no effort to contact the financial department and no effort to make payment arrangements, they should be sent a letter stating that until they make such arrangements, their account will be placed on “**restricted status**” and they cannot receive services from the health center.
Process for Collecting Patient Accounts

- Restricted accounts’ balances should be written off as bad debts at the 150-day mark. Lists or computer flags should be shared with front office personnel and instructions issued to the effect that if a restricted account patient calls for an appointment or presents as a walk-in, they must be told that their status is restricted and that until they receive clearance from the financial department, they cannot be seen at the health center.

- An installment plan system must be established by the health center that allows patients to make payments on at least a monthly basis. There must be a staff person to manage this system and assure that payment plan statements are mailed monthly and notices and phone calls are made for those missing payment due dates.

- Collections staff person could be hired, easily justified by monies now paid to the collection agency.

- Policies and procedures for this system should be in writing, approved by the entire Board of Directors, and the policy should be shared with patients during registration and re-certification of the sliding fee scale, and at visits if needed.
Step 3 – Reimbursement/Revenue Optimization

A. Analyze revenue versus cost of payer categories – a health center will have a difficult time surviving if it’s losing money on Medicaid. Compare cost per visit vs. your PPS rate. If cost is more than 5% higher, determine what factors trigger a successful rate appeal in your state

B. Monitor managed care wraparound payments – compare managed care payments plus wraparound payments vs. PPS rate times managed care visits

C. Maximize Medicare Reimbursement

D. Maximize Medicaid Reimbursement

E. Management needs to take control
Reimbursement Optimization

**Medicare**
- Are you over the cap? Look at ways to increase visits enough to get your rate below the cap
- Will DSMT or MNT services result in getting costs below the cap?
- Increase your market share of Medicare patients.
- Are you billing wraparound for contracted MA plans?
- How about the PFFS MA plans; billing should result in 80% of cost rate, 20% of charges minus any co-pay.
Reimbursement Optimization

Medicaid
- Are there services reimbursable under PPS that could improve revenue stream?
- Opportunities for applying for a change in scope of services, (i.e., increased costs, new services, intensity of services etc.)
- Do you get your PPS rate for crossover claims?
- PPS rate appeals, due to increased costs...not enough revenue.
Executive Management Must Take Control of the Revenue Cycle and Billing Operations
Management Responsibilities

- Management must establish billing and collections direction for staff that result in maximization of revenue from all sources
- Management needs Board “sign-off” on Policy
- Management sets the tone, so all (CEO with final say-so) must agree on approach
- Management must monitor and oversee activities to assure staff is executing based on the planned approach
Management Responsibilities

Management should:

- Develop and maintain a detailed billing and collections policies and procedures manual that delineates procedural differences for each payer
  - Revise job descriptions, as appropriate
  - Assign responsibility and include a timeframe for completion of each defined task
  - Educate ALL staff about newly defined policies, procedures, job functions, and regulatory changes
  - Monitor staff adherence to newly defined policies and procedures
Management Responsibilities

Management should:

- Establish a liaison with each third-party payer
- Establish periodic (e.g., quarterly) meetings with a provider representative from each major payer to resolve problem bills and payment issues, and clarify regulatory and claims adjudication changes
- Define the content, format, and production frequency and distribution points of accounts receivable (A/R) management reports (e.g., days in A/R, dollars in A/R)
Management Responsibilities

Management should:

- Periodically (e.g., semi-annually) engage a certified coder to audit sample health records to ensure adequate documentation and appropriate coding practices
  - This is particularly important because of the potential of coding audits in health centers.
  - Educate providers during orientation and on an ongoing basis about coding and productivity expectations
  - Consider incentive-based compensation program for providers and other support staff.
Management Responsibilities

Management should:

- Periodically review the physical flow of patients to ensure that registration, financial counseling, and collections activities can be easily and confidentially performed.
- Periodically observe waiting room operations to see how established policies and procedures are carried out and can be improved.
- Work with registration, financial counseling, care, and collections staff to improve your organization’s physical layout.
Questions???
Contact Information

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