

# Maximizing Third-Party Collections: An Executive Briefing



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# Agenda

- Three common reasons for third-party claim bad debts
- The ABCs of accounts receivable management: admissions, billing and collection
- Tips for contracting with third-party payers
- More tips for improving collections



**It Is Not Unusual for Behavioral Health, Child Welfare, & Social Service Providers to Have Collection Rates of Only 80% of Net Revenues!**

**Effectively, This Is a 20% Bad Debt Ratio, Meaning That an Organization With \$1 Million in Annual Net Revenues Is Losing \$200,000 to Bad Debt Expenses!**

# Bad Debt Expenses Based on Collection Rates

Net Revenue	Collection Percentage	Bad Debt Expense
<b>\$5,000,000</b>	<b>75%</b>	<b>\$1,250,000</b>
<b>\$5,000,000</b>	<b>80%</b>	<b>\$1,000,000</b>
<b>\$5,000,000</b>	<b>85%</b>	<b>\$750,000</b>
<b>\$5,000,000</b>	<b>90%</b>	<b>\$500,000</b>
<b>\$5,000,000</b>	<b>95%</b>	<b>\$250,000</b>

# **Three Common Reasons for Third-Party Claim Bad Debts**

# Three Common Reasons for Third-Party Claim Bad Debts

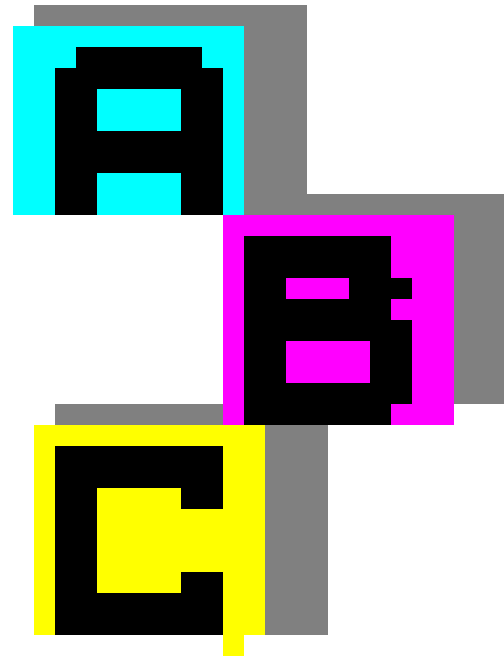
- #1 The Clinician's Services Are Not Covered by the Payer (Either Due to Credentials or Lack of Network Membership).
  
- #2 The Services Are Not Authorized.
  
- #3 The Consumer No Longer Has Benefits or Coverage by the Particular Payer Identified at the Time of Admission.

# What Can We Do About It?

**Learn Our ABCs of Billing &  
Collection!**

# ABC's of Accounts Receivable Management

- Admissions
- Billing
- Collection

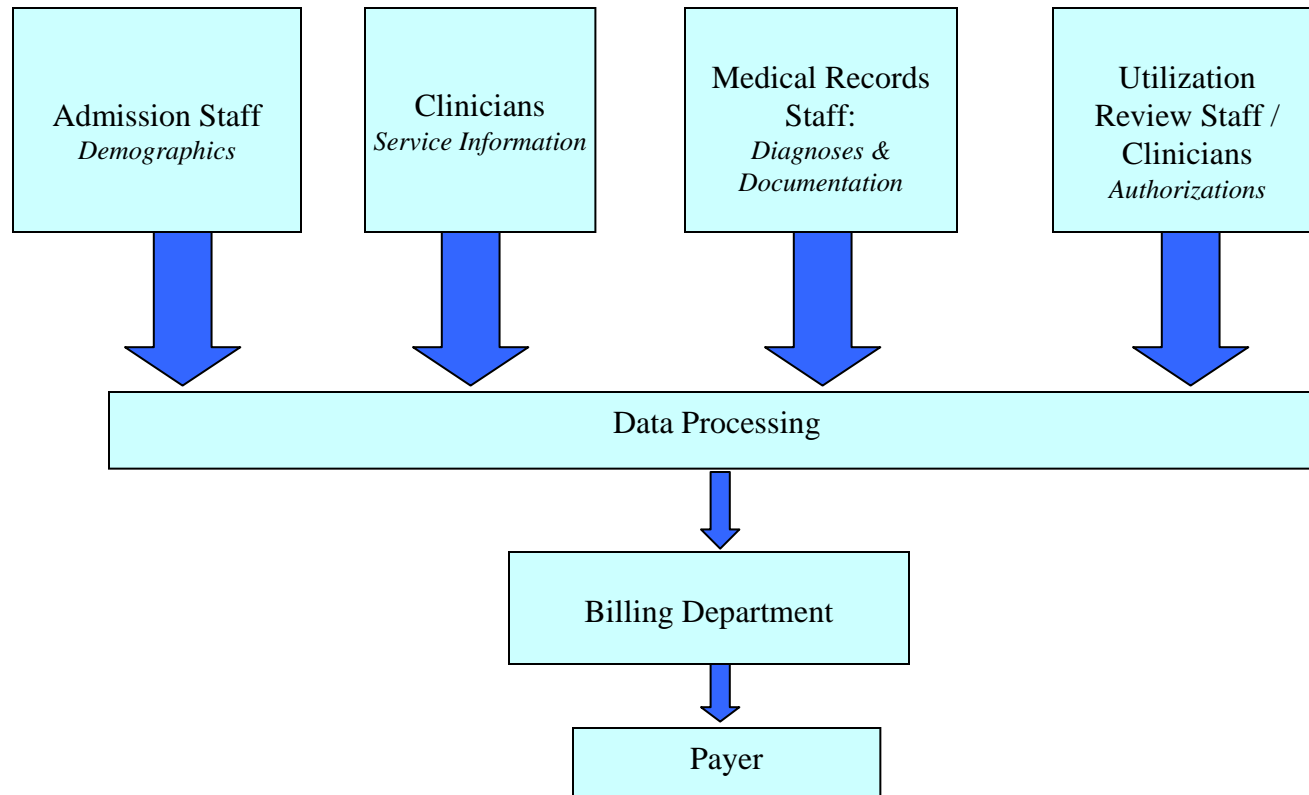


# Admissions



**Getting the “Front End” Right Is Probably the Most Important Step in Improving Your Agency’s Collection Rate**

# The Flow Of Billing Information



# Admissions

- Centralize Accountability for Accuracy & Completeness of Client Demographic Information
  - ✓ Benefits Verification
  - ✓ Authorization
  - ✓ Required Clinician Credentials
  - ✓ Coordination of Benefits
- Establish Required Data Fields for Client Registration & Perform QA on Data Entry for 100% of Client Registrations

# Admissions

- Set-up Reports for Common Admission's Related Billing Problems:
  - ✓ Missing Data Fields
  - ✓ Missing Service Authorizations
  - ✓ Missing Diagnoses
- Use Your MIS' Edit Capabilities Regarding Payer Benefits Rules to the Maximum Extent Possible

# Admissions

- Establish Very Tight Security Controls for Which Staff Members Can Add New Records to the Payer Table File

# Key Questions for Verifying Commercial Insurance Coverage

- Benefit Questions
  - ✓ Is the Insurance Policy Active?
  - ✓ What Was the Effective Date of the Policy?
  - ✓ How Do You Define the Waiting Period?
  - ✓ Is There a Waiting Period?
  - ✓ For Certain Benefits, All Benefits?

# Key Questions for Verifying Commercial Insurance Coverage

- Benefit Questions
  - ✓ Is the Client Subject to This Waiting Period?
  - ✓ Are There Any Pre-existing Conditions?
  - ✓ What Are the Mental Health Benefits Under This Policy?
  - ✓ Are Benefits for Substance Abuse Any Different?
  - ✓ Are There Any Riders to the Contract? Is There a Deductible and Has Any of It Been Met?

# Key Questions for Verifying Commercial Insurance Coverage

- More Benefit Questions
  - ✓ Is There a Co-payment for Services?
  - ✓ Is There a Cap for Mental Health Coverage?
  - ✓ Is the Cap Based Upon a Calendar Year or a Benefit Year?
  - ✓ Has Any of the Cap/deductible Amount Been Used?
  - ✓ Is There a Lifetime Cap on Services?
  - ✓ What is the Amount?

# Key Questions for Verifying Commercial Insurance Coverage

- More Benefit Questions
  - ✓ Is the Cap / Deductible Separate From Medical Services?
  - ✓ Are There Mental Health Services That Are Not Covered?
  - ✓ Are There Diagnoses Not Covered?

# Key Questions for Verifying Commercial Insurance Coverage

- Service Authorization Questions
  - ✓ Do Services Need to Be Pre-authorized?
  - ✓ How Is That Done?
- Clinician Credential Questions
  - ✓ What Type of Clinicians Are Covered for Services?
  - ✓ Do They Need a Specific License or Provider Number?
  - ✓ Can We Get Authorization for Other Clinicians or “Out of Network” Providers to Render Services?

# Key Questions for Verifying Commercial Insurance Coverage

- Claim Submission Questions
  - ✓ What Is the Address for Claim Submission?
  - ✓ Is a Standard HCFA 1500 Form Used?
  - ✓ Does the Subscriber Have to Sign a Claim Form?
  - ✓ Is There Anything That Needs to Accompany the Claim Form?
  - ✓ Is There a Time Limit to Submit the Claim?
  - ✓ What Is the Phone Number for Claim Inquiry?

# Billing



**How Can We Streamline & Improve  
Our Billing Processes?**

# Billing

- Billing Starts With Service Entry! Enter All Services Into MIS With 24 Hours
  - ✓ Set Up Report to Track “Late Service Entry” to Identify Clinicians & Locations Whose Services Are Entered More Than Sevens Days From Date of Service
- Do QA Checks for Data Entry Accuracy
- Most Payers Should Be Billed on a Weekly Basis to Improve Cash Flow

# Billing

- Set-Up Electronic Billing for All Possible Payers
  - ✓ Tip: Confirm Receipt of Electronic Billing Files!
- Use “Pre-Billing Edit” Reports Prior to Billing to Find & Fix All Identifiable Claim Problems
- Print & Mail All Paper Claims Within 48 Hours

# Sample Billing Edit Summary Report

Billing Edit	# of Claims	Dollar Amount
<b>Missing Diagnosis</b>	<b>32</b>	<b>\$3,200</b>
<b>No Authorization</b>	<b>10</b>	<b>\$1,000</b>
<b>Clinician Not Credentialed</b>	<b>3</b>	<b>\$300</b>
<b>Missing DOB</b>	<b>5</b>	<b>\$500</b>
<b>Missing Policy Number</b>	<b>1</b>	<b>\$100</b>
<b>Total</b>	<b>51</b>	<b>\$5,100</b>

# Collection



**Does Anyone Actually Do Collection & Follow-up on Unpaid Claims?**

# Collection

- Fact: Accounts Receivable Follow-Up & Collection Is the Biggest Problem for Most Organizations
- The Standard You Should Seek to Achieve Is That Your Staff Can Account for the Status of All Claims That Have Aged 60 Days Since the Last Bill Date

# Collection

- Start by Ensuring All A/R Payments Are Posted in a Timely Manner
  - ✓ What's the Point of Running an Open A/R Report if Is Inaccurate Because You Haven't Posted Payments?
  
- Things To Do:
  - ✓ Batch Control Systems for Deposits & All Correspondence
  - ✓ All Deposits Entered Within 24 Hours of Receipt
  - ✓ All Payments Distributed Within 48 Hours of Receipt
  - ✓ Data Entry QA for Payment Distribution

# Collection

- Set-Up a Daily “Undistributed Receipts” Report to Monitor Deposits That Have Not Yet Been Applied to A/R
- Use Electronic Payment & Remittance Posting Whenever Possible to Save Time & Money
  - ✓ Lobby Payers to Set-Up This Capability
- All Payer Correspondence Should Be Batched With Deposits & Handled Within the Same Time Frame

# Collection

- All Payer Correspondence Should Be Batched With Deposits & Handled Within the Same Time Frame
  - ✓ Balance Billing & Denial Processing Should Occur at the Same Time Payments Are Posted.
  - ✓ Other Correspondence From Payers Should Be Processed Within Two Business Days

# Collection

- Ideally MIS Allows You to Post A/R Follow-Up Notes on Individual Client Accounts & Claims
- Bad Debts Should Be Approved & Written Off the A/R as Soon as the Claim Has Been Identified as Un-collectable

# Improving Self Pay Account Collection

- Use Sliding Fee Capabilities In MIS Effectively
  - ✓ Establish Clear Self Pay Fee Policies
- Collect Self Pay Fees at the Time of Service Whenever Possible
  - ✓ Use On-Screen Self Pay Balance Alerts or Reports at the Front Desk
  - ✓ All Clinicians Should Know Client Balances at the Time of Services

# Improving Self Pay Account Collection

- Self Pay Statements Should Be Sent out on a Monthly Basis
- “Customize” the Self Pay Statement as Much as Possible in the MIS to Make It Clear & Understandable
- Self Pay Statements Can Only Be Accurate if Sliding Scale Fees, Services, & Payments Are Entered Accurately

# Billing & A/R Management Policies & Procedures

- Client Registration Policy and Checklist (Including Insurance Verification Requirements)
- Daily Insurance Verification Policy (for Verification of Continued Insurance Coverage)
- Client Demographic and Insurance Change Policy
- Billing Diagnosis Policy
- Self-pay Fee Assessment and Collection Policy

# Billing & A/R Management Policies & Procedures

- Service Authorization Policy (Initial and Ongoing)
- No-Show/Late Cancellation Policy
- Appointment Scheduling Policy
- Service Tracking Policy
- Billing Process Policies
- Mail Batch Control Policy
- Deposit and Payment Posting Policy
- Correspondence Processing Policy

# Billing & A/R Management Policies & Procedures

- Credit Balance and Refund Policy
- Collection and Follow-up Policy
- Bad Debt Write-off Policy
- Self Pay Collection Policy
- Month-End Procedure Policy
- Table Maintenance Policies for New Insurances, Clinicians, and Service Code Files

# Tips for Contracting With Third-Party Payers



# Don't Just Sign the Contract Without Reading It!



# Review Draft Contract

- Examine the Contract Carefully
  - ✓ Read Every Word!
  - ✓ Determine What You Do and Do Not Understand
  - ✓ Don't Just "Assume" Anything!
  - ✓ Use Legal Council as Needed

# Review Draft Contract

- Key Definitions

- ✓ “Provider”

- ✓ “Covered Services”

- ✓ “Medically Necessary”

# Typical Contract Provisions

- Your Agency's Obligations
  - ✓ Services to Be Provided
  - ✓ "Timely Filing" Language
  - ✓ Right to Subcontract
  - ✓ Medical Records

# Typical Contract Provisions

- The Payer's Obligations:
  - ✓ Obligation to Pay
  - ✓ Obligations Regarding Authorization
  - ✓ Information About the Client's Benefit Plan

# The Provider Manual

- Items for Intense Review
  - ✓ Authorization Process
  - ✓ Quality Management Program
  - ✓ Appeal Rights and Mechanisms
  - ✓ Provider Sanction Process
  - ✓ Claims Payment Information
  - ✓ Benefit Plan, by Contract

# Clinical Criteria Manual

- Outlines Medical Necessity, Usually by Level of Care

# Make An Informed Business Decision

- The Bottom Line:
  - ✓ Does Your Contract With the Payer Protect Your Agency?
  - ✓ Is the Draft Contract One-Sided?
  - ✓ Can You Live With the Rates and the Provisions?

# Recommended A/R Management Reports



# Aged Trial Balance Reports

- Aged Trial Balance by Payer in 30-Day Buckets
  - ✓ Aging by Date of Service Shows Allows Overall A/R Analysis
  - ✓ Aging by Most Recent Bill Date Allows You to Find Claims With No Activity
- Aged Trial Balance Detail
  - ✓ Run by Payer or Payer Category for All Claims Over 60 Days From Date of Service
  - ✓ Goal Should Be to Follow-Up On ALL of These Claims (Get Claim Status, Fix Any Problems, Re-bill, or Balance Bill)

# Billing & Collection Performance Measurement

- Over 180 A/R
- Collection Performance
- Days In A/R

# Over 180 Days Accounts Receivable

- It Is the Percentage of the Total Dollar Amount of the Accounts Receivables That Is Over 180 Days From Service Date, I.E., the A/R Over Six Months Old
- With Clean Admissions, Billing, and Collection Operations, the Standard for This Should Be About 5%

# Collection Percentage Reports

- Simply the Percentage of the “Net” A/R Collected in a Given Time Period
- Routinely Run Sorted by Service Month & Payer Category So You Can Track Collection Success Over Time
- Target Should Be 95% for Ambulatory Services & 98% for I/P

# Days in A/R Report by Payer

$$\text{Days In A/R} = \frac{\text{Gross Accounts Receivable}}{\text{Current Month's Gross Revenue} / \text{\# of Days In Current Month}}$$

- Essentially Is a Measure of the Average Numbers of Days From Service to Payment for A/R Claims

# Sample Days in A/R Report: July 2003

- If Gross A/R Was \$1,350,078 & You Generated \$176,000 Of Revenue in July, Here's The Math:

$$\text{Days In A/R} = \frac{\$1,350,078}{\$ 176,000 / 31} = 237.8 \text{ Days!}$$

# Sample A/R Performance Indicators

	Jan	Feb	Mar	Apr	May	Jun
<b>Over 180 A/R</b>	<b>12%</b>	<b>13%</b>	<b>9%</b>	<b>9%</b>	<b>8%</b>	<b>8%</b>
<b>Collection Performance</b>	<b>87%</b>	<b>83%</b>	<b>71%</b>	<b>62%</b>	<b>43%</b>	<b>0%</b>
<b>Days In A/R</b>	<b>97</b>	<b>92</b>	<b>81</b>	<b>79</b>	<b>77</b>	<b>75</b>

*What Does It Mean?*

# More Tips For Improving Collections



# Ten Tips For Improving Collections

Tip #1: Maximize the Billing Edit Capabilities of Your Management Information System

Tip #2: Tighten Up the Clinician Credentialing & Case Assignment Process

Tip #3: Verify & Re-Verify Insurance Coverage

# Ten Tips For Improving Collections

Tip #4: Keep on Top of Service Authorizations

Tip #5: Set up Charity Care as a Managed Care Payer

Tip #6: Tightly Manage Self Pay Accounts & Collection

# Ten Tips For Improving Collections

Tip #7: Manage the Paper in the Billing Department!

Tip #8: Follow Up, Follow-Up, Follow-Up!

Tip #9: Institute Data Entry Quality Assurance Checks

Tip #10: Incentivize Staff to Improve Collection



# Questions & Discussion



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