On one hand, healthcare practices have reason to be optimistic. The challenges of the past few years, including economic turmoil and the adoption of electronic medical record (EMR) systems, are slowly easing. On the other, providers still confront trends that will likely have a material effect on their financial performance. For one, they continue to receive little, if any, reimbursement increases from commercial insurance payers, hurting their cash flow and access to capital. And Medicare has not been any more generous, eschewing rate increases in favor of offering incentives to physicians who deploy an EMR and conduct efficiency-enhancing activities such as ePrescribing, enabling them to meet the Meaningful Use requirements.

Meanwhile, insurance payers continue to shift a greater percentage of costs to patients in the form of higher deductibles and co-pays, leading to higher self-pay balances. According to data from the Centers for Medicare and Medicaid Services (CMS), the amount for which the consumer is responsible rose nearly 50 percent between 2000 and 2010 to an all-time high of $299.7 billion.¹ This trend is likely to continue as insurance payers look to offset their own financial pressures, including increasing competition and rising costs for medical care.

When facing future revenue challenges, physician practices are left with two options to keep their practice in the black: decrease expenses or increase revenue. It turns out that medical practices have realized some success with the former, but it’s often the result of drastic measures such as staff layoffs, even as providers struggle to cope with their workloads. These cost cutting activities are often a detriment to office operations, according to the Medical Group Management Association’s (MGMA) “Cost Survey for Multispecialty Practices: 2011 Report Based on 2010 Data,” which noted that practices trimmed general operating expenditures an average of 2.2 percent in 2010.²

“In an effort to reinforce themselves against a draconian proposed cut to Medicare payments, as well as other factors, they have worked to reduce operating expenses, and renegotiate rates with vendors, supply companies and insurance carriers,” said William F. Jessee, MD, FACMPE, MGMA president and CEO, when explaining the trend. “This means medical practices are not spending as much money as they were last year, which isn’t necessarily a good thing. There is only so much more practices can do to cut expenditures without inhibiting their ability to run a successful, innovative practice.”³

This fact leads the practices to the second option: increasing revenue by collecting a higher percentage of money for services they are performing. This whitepaper will provide tips for improving payment collections by:

- Automating eligibility verification processes,
- Increasing time-of-service collections, and
- Benchmarking current activities to incite future improvements.

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¹Time-Tested and Practice Proven:
Top Tips for Collecting Payments

An Emdeon
White Paper
TIME-TESTED & PRACTICE-PROVEN

OPTIMIZING PATIENT BILLING ACTIVITIES

CONSUMER RESPONSIBILITY FOR HEALTHCARE PAYMENTS ROSE NEARLY 50% BETWEEN 2000-2010

ACCORDING TO DATA FROM CMS

REDUCING UNCOMPENSATED CARE/BAD DEBT

IMPROVING OPERATIONAL EFFICIENCY

72% of respondents rated these issues as “very important” or “critically important,” second only to “improving patient care.”

MINIMIZE THE IMPACT OF “PATIENT RESPONSIBLE” BALANCES

DECREASE expenses

INCREASE revenue

HOW CAN YOU DO THIS?

Optimize Payment Collections with Technology 79% of respondents surveyed have not fully implemented a system to accept patient payments online.

USE STAFF RESOURCES MORE EFFECTIVELY

ONLY 44% of respondents have a system to receive and record insurance payments electronically.

WHAT’S THE STRATEGY FOR SUCCESS?

INCREASE TIME-OF-SERVICE COLLECTIONS

BENCHMARK CURRENT PERFORMANCE TO ENCOURAGE FUTURE IMPROVEMENTS

THREE MORE TOP TIPS

1. GET COMPLETE REGISTRATION INFORMATION BEFORE THE VISIT

2. USE A CLAIMS ESTIMATOR

3. OFFER ONLINE PAYMENT OPTIONS

HIGH-PERFORMING PHYSICIAN PRACTICES CARRY ABOUT $6,900-$14,000 LESS IN BAD DEBT THAN COMPARABLE GROUPS, WITH ONLY 7-10% TOTAL A/R IN THE 120-DAYS CATEGORY.

1 Better-performing medical practices focus on cost management, productivity, and patient satisfaction. 2, MGMA, Jan. 2012.


3 Ibid.

4 MGMA, Jan. 2012.
**Tip 1: Conduct Full Registration Prior to the Appointment**

When office staff members schedule an appointment, they often record only the patient’s name, phone number and brief explanation for the visit. Unfortunately, they are missing an excellent opportunity to improve cash flow by not fully registering the patient over the phone. The reality is that many rejected claims result from lackluster insurance eligibility verification efforts prior to the medical service. When practices preregister patients, they should give themselves an appropriate amount of time to verify whether or not the individual currently has insurance, the extent of the benefits and whether or not a referral or authorization is necessary. In fact, practices should conduct verifications at least 48 hours prior to patients’ scheduled visits to ensure they receive eligibility details from a health plan well ahead of time.

Preregistration also allows practices to conduct batch verifications with individual insurance payers rather than one-off eligibility screenings as patients arrive at the office, saving precious time and eliminating manual processes for administrative staff. And it affords employees an excellent opportunity to review practice policies with the individual and set expectations, including those related to their financial responsibilities, prior to the visit.

**Tip 2: Use a Claim Estimator**

Practices can collect more money faster simply by using a claims estimation tool. Critically important for surgical practices in particular, claims estimators built into practice management (PM) systems or a claims submission technology can calculate with a relatively high degree of accuracy what the charges will be for the services rendered. By comparing the total cost of a medical procedure against the patient’s insurance coverage, the practice gains insight into the individual’s financial responsibility, including co-payment or deductible amounts.

While a claims estimator may not be spot-on for all payers and procedures (namely those that are particularly complicated), the details it provides create context for a conversation with the patient on what their financial responsibilities will likely entail. Practices should use this information to inform the patient as to what they should expect to pay at the time of service, as well as options for settling post-surgery balances. Discussing these details early in a frank yet tactful manner, and perhaps referring to the practice’s financial policies, can help prevent patient-due amounts from going to collections.
Tip 3: Collect a Portion of the Bill at Time of Service

Healthcare providers can also become more sophisticated in methods to secure patient payments upfront. At a minimum, practices should collect past-due balances and co-pays when a patient presents themselves for their appointment. To improve their chances of securing a co-payment, many practices will impose an additional fee if the patient cannot settle at the time of service.

Some practices also charge patients for missed appointments. While it may be difficult to collect a no-show charge, it should nonetheless be included in the practice’s financial policies. Of course, patients must be advised of the potential for additional fees if they skip their appointment without a formal cancellation. A good opportunity to do so is when the practice reminds a patient of their upcoming visit via email, or manual or automated phone call. The practice must have a system for recording the no-show so they can inform the patient of the fee if and when the patient schedules another visit.

To make it easier on patients when collecting payment upfront, practices should consider using a credit card reader. Credit cards are now standard payment options for patients, and practices can reap the efficiency and convenience benefits of using a credit card reader in which an individual simply swipes the card. This technology is more accurate and quicker than manually keying in patient credit card information. The device should be linked with a computer terminal with transactions sent via a high-speed Internet connection, ensuring the process doesn’t tie up a telephone line.
Tip 4: Optimize Payment Collections with Technology

The longer patients owe their physicians money, the less chance a practice has to collect the balance. Medical offices can improve cash flow by enabling patients to pay for services online. This is an increasingly attractive proposition for a younger generation that pays most, if not all, of their bills online. Very affordable Internet-enabled payment capabilities can be established directly on the provider’s website with credit card transactions or checking account withdrawals automatically routed to the practice’s bank account. These online tools are available to providers regardless of whether or not they maintain a website.

Providers should also use an online system to schedule recurring payments whenever possible. This enables practices to work with patients to establish a certain payment amount that is automatically charged to their credit card on a monthly basis until they reach a zero balance.
Tip 5: Benchmark Measures of Success

Perhaps the most important, but often overlooked, way to improve payment and collections efforts is to establish financial quality-control processes. To implement this course of action, practices should designate someone to review clearinghouse reports and develop a system for following up on insurance balances from claims that are awaiting payment. Even more critical is to make sure an individual within the practice is reviewing denied claims to determine if there was an error made, if the claim was denied due to a clearinghouse edit or if the insurance payer made a mistake. Armed with this information, providers can use this knowledge to improve future submissions.

Online tools are available to help practice administrators review reports indicating rejected claims from the clearinghouse or insurance payer. Whether part of the PM system or clearinghouse technology, the analytics must include capabilities that allow users to review claims by batch and allow users to search for denied claims. The application can also provide a reason as to why a claim was denied, allowing the provider to more easily resolve the problem and institute processes and procedures to prevent similar denials in the future.

Another IT tool, dashboards, can be incredibly useful for practice administrators. Those included in PM and clearinghouse systems will allow staff to look at a variety of data points that measure income, productivity and collection success. Key productivity metrics that physician practices today should monitor include:

- Gross charges with information by individual provider, location and type of service
- Collections details by insurance payer
- Gross collection ratio
- Adjustments
- Adjusted collection ratio

Collection success metrics to watch monthly or on a rolling three-month average include:

- Adjusted gross charges
- Days in receivables outstanding
- Aging of claims and patient due balances
- Credit balance reports
Other important collection and billing metrics include:

- Denial percentage by insurance payer, by line item or claim
- Number of claims suspended by the clearinghouse
- Percentage of co-pays collected at the time of service
- Volume and dollar value of denials based on timely filing limits
- Posting lag time between the service and posting dates

MGMA regularly surveys members to learn how well they are using financial tools to improve practice performance. They found that denial tracking and monitoring activities can help practices learn from their mistakes, improve processes and systems in the office, and make sure that they are using technology thoroughly and correctly. In 2011, top-performing medical practices reported less bad debt due to fee-for-service activity per physician. These groups realized approximately $6,900 to $14,000 less in bad debt than other practices.4

High-performing practices were also collecting receivables more quickly than their peers, having only seven to 10 percent of their total accounts receivable (A/R) in the 120+ days category. In contrast, the other groups had 19 to 35 percent of their total A/R in the 120+ day category, an indication that strong cash flow is crucial to the success of any practice. Additionally, 50 percent of better-performers reported collecting 90 to 100 percent of co-payments at the time of service.5
Striving for Improvement

Group practices, specialists and independent physicians alike are feeling the pinch of increased costs and lower reimbursements, coupled with higher patient balances that are slowly being converted to cash, if at all. Always critical to a practice’s viability as a quality healthcare provider, payment collections have taken on a new meaning for offices not only stricken with fiscal uncertainty, but also facing increased regulatory, competitive and operational demands. The best-performing practices are successfully automating eligibility verification processes whenever possible, increasing time-of-service collections and benchmarking current payment collections activities with an eye toward future improvements.

For additional information on how small practices can improve the revenue cycle through enhanced billing and collections, please view the Emdeon-sponsored webinar, titled “Time-Tested and Practice-Proven: Top Tips for Payment & Collections Efforts,” at www.emdeon.com/paymentswebinar.

Emdeon is a leading provider of intelligent revenue cycle solutions that help physician practices maximize revenue and profitability. With growing bad debt and increasing pressure on reimbursement rates, Emdeon’s full suite of solutions, technologies and services can help healthcare businesses succeed in a difficult environment. To learn more about how Emdeon’s complete line of technology and services can help practices optimize payment collections for improved financial health, visit www.emdeon.com/physicians or call 866.349.1607.

A Website’s Role in Collection Improvement

Before scheduling an appointment, many patients will visit a practice’s website. A good first impression for patients is an informational website that strikes a healthy balance between functionality and design, offering patients directions to the office, outlining the practice’s policies and reviewing payment expectations at the time of service.

Providing this information in a clear, sensible manner can cut down on the number of phone calls office staff must field prior to the patient visit. Some providers even offer a patient portal that allows the individual to register with the website, which will enable them to receive automated appointment reminders or access lab results, for example. Patients can also download and complete any necessary patient forms prior to their visit. Finally, the site should contain a personal message welcoming patients to the practice with information about what makes the business and its individual clinicians unique.

The personalities of physicians and office staff can make a huge impact on customer satisfaction, and a practice’s website can set a great first impression.


4. Ibid.