# 7 Best Practices for Physician Accounts Receivable Management

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OVERVIEW

Let’s face it – the healthcare reimbursement system is brutal.

The rough economy has led everyone, including insurance companies and patients, to 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, underpayments, and lost or ignored 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 – all while continuing to provide top-quality care to their patients.

On top of all that, new regulatory challenges have appeared recently, such as the Patient Protection and Affordable Care Act and the federal incentives for doctors to adopt electronic health records contained in the American Recovery and Reinvestment Act. Those changes in the legal environment have made the healthcare landscape more uncertain. The financial impact on medical practices could be significant, making it even more important for practices to collect more of the money they’re owed.
A lot of money left on the table

Unfortunately, most medical practices aren’t currently collecting everything they’ve earned. Here are some scary figures:

Only 70% of claims are paid the first time they’re 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 ignored (10%). And of those claims, 60% of them are never resubmitted to payers. That means medical practices never collect on a full 18% of claims.

But that’s not all. Even when practices are paid, they aren’t necessarily being paid in full according to their payer contracts.

The Medical Group Management Association (MGMA) estimates that payers underpay practices in the U.S. by an average of 7% - 11%.

So if you add a 7% underpayment to the 18% of claims that aren’t paid at all, that means medical practices are failing to collect, on average, at least 25% of the money they’ve earned by treating patients.

That translates to a total of $125 billion left on the table every year by American medical practices.

Getting your piece of the pie

How can practices reclaim those missing funds? One major way is by simplifying and automating their revenue cycle management. New technologies such as electronic health records, patient portals, and practice management systems have created new opportunities for practices to cut operating costs and provide better care.
But those advances have also led to several new challenges and decisions practices must make about the best ways to use new technology.

Practices that want to increase their collections and reduce denials, underpayments, and lost and ignored claims must make sure they choose a practice management system with robust capabilities to manage their accounts receivables.

This white paper will describe seven must-have features of practice management systems that allow practices to effectively track, measure, manage, and, most importantly, collect all of their receivables.

**RULES ENGINE**

As you can see from the statistics above, when a claim isn’t paid the first time it’s 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 that more claims are paid the first time around.

Software can help practices accomplish that with a robust rules engine that can automatically identify claims that are likely to be denied.

It’s not enough to set the rules and then forget about them – the top available software solutions use an intelligent engine that constantly updates and adapts its rules so practices can stay on top of the latest claim denial trends and continually improve their collection rates.

The software collects data about claims and denials from not just your practice, but every practice in the vendor’s network. The system learns why other practices’ claims have been denied recently, so it can proactively prevent similar denials for your practice in the future.
The impact of billing software with a robust rules engine includes:

1. **Higher first pass resolution rate (FPRR)** – Since potential denials are caught before the claims are submitted, practices have a much better shot of getting paid on the first submission. A system with a strong rules engine can help practices improve their FPRR from the national average of 70% to 97% right out of the box, with the rate going even higher as the rules are improved.

2. **More collections at a greater speed** – Catching potential denials early allows practices to submit cleaner and more accurate claims that get processed faster, improving the average time it takes for practices to get paid. And since many denied claims never end up being paid, improving the FPRR keeps practices from leaving a lot of money on the table.

3. **Less work for practice staff** – Getting more claims paid the first time eliminates the time-consuming task of reviewing denials and going back and forth with payers to resolve issues. That makes practices more efficient overall and gives staff more time to take care of what’s important – helping patients.

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**PAYER CONTRACT MANAGEMENT**

In addition to denials, another problem keeping medical practices from collecting the full amount of money they’ve earned is payer underpayments.

The main problem is the complexity of all the contracts the practice has signed. For example, four different patients could come in for the same Level-3 office visit, each with different coverage from, say, Blue Cross Blue Shield, Aetna, United, and Medicare. Even though all of the patients received the same service, the practice could be reimbursed four different amounts due to the individual contracts the doctor has with each payer.

With all the other work that must be done in a medical practice, it’s almost impossible to manually keep track of every payer contract. Therefore, it’s impossible to know when the practice is being underpaid.

That’s why it’s important to select software that eases the tracking of contracts and can automatically compare the actual payments the practice received against the payments specified in each payer contract.
Those systems allow practices to load the details of their contracts and calculate the amount they should be collecting for each claim, making it easy to spot underpayments.

This feature allows practices to:

1. **Collect the payments they are owed** – Automatically checking contracts for underpayments can allow practices to raise their net collection rates (NCR, or the total percentage of claims that are paid the full amount allowable according to the contract) up to 100%.

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. **Forecast future collections** – The system can use contract terms to give A/R an accurate picture of what money will be coming in and when, which is a big help for making budgeting decisions. Automating the process means those predictions will accurately match future collections.

**DAILY AGING OF RECEIVABLES**

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

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

Therefore, the 30/60/90 model is no longer applicable.

For example, a practice may typically receive payments from Medicare in 14 days, whereas they must wait 40 days for a regional payer to pay. If the practice follows up on unpaid claims after 30 days, the action is way too late regarding the Medicare claim, but way too early for the regional payer claim.

A practice’s best bet is to act on claims based on each payer’s individual schedule. That can’t be accomplished with a manual process, so it’s important to use a system that allows for daily aging of receivables.

Those systems can automate collection incidents – for example, generating a letter, resubmitting a claim, or creating a collection incident and sending it to the collector’s queue – on outstanding
claims to make sure the practice is taking the right action at the right time.

That gives practices several tangible benefits:

1. **Faster collections** – Practices improve their days sales outstanding (DSO) figures because they can ask for payments as soon as they’re considered late. And the sooner the practice follows up on late payments, the lower the likelihood that the claim will become lost or ignored.

2. **Improved staff productivity** – A/R staff members are automatically notified when collection incidents are needed so they don’t need to spend time manually tracking claims.

3. **Less money left on the table** – Automatically 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.

### WORKFLOW ENGINE

The entire physician revenue cycle, from scheduling patients to collecting final reimbursement, involves many steps, several of them requiring tedious paperwork.

That manual work not only makes practices less efficient, but the more manual steps that must be taken during the process, the greater the likelihood of costly and time-wasting mistakes occurring. Every mistake or missed assignment creates a bump in the road that impedes the process further down the line.

That’s why the most efficient medical practices use software to automate their workflow. For example, after a scheduled patient visit, the system can automatically begin all the steps required for submitting a claim.

Top-notch systems can respond in defined ways to all kinds of different events, such as patient scheduling, expired due dates, and upcoming deadlines. That makes sure all the right information is delivered to the right people, and tasks are properly assigned and monitored by management.

Customized responses can range from automatically generating forms to e-mailing employees a new assigned task or notifying management when jobs haven’t been completed.
That helps practices by:

1. **Improving efficiency** – When practice workflow is automated, a lot of time-consuming manual tasks are eliminated, and fewer mistakes are made that can lead to the practice failing to collect all the money it’s owed.

2. **Increasing visibility and control** – The system can also provide an organized view of every single charge, denial, underpayment, and lost or ignored charge and claim.

3. **Better staff management** – Using a system’s workflow engine to manage the practice’s revenue gives the company an easy way to make sure all work is being completed by practice staff in a timely manner.

**MODERN REPORTING, ANALYTICS AND BUSINESS INTELLIGENCE TOOLS**

Making the right decisions for a medical practice requires access to complete, easy-to-understand sets of data. Real-time news feeds and ubiquitous access to practice information through web-based software allows for early trend recognition.

It’s important to be able to mine data for billing and collection trends to figure out where the practice can improve. The only way to do that is to have all the data in one place electronically and use a system with robust reporting and analytics capabilities.

The best systems allow you to schedule reports to be created at certain intervals for ongoing analysis, as well as generate custom reports on the fly when specific information is needed quickly. It’s also important to find a system that allows those reports to be shared with all the people who need to see them.

The top reporting engines create reports in a variety of formats (for example, HTML, PDF, CSV, etc.), automatically send them to distribution lists, and allow multiple users to view the reports online, comment on them, share their perspectives, and ask questions, all within the system.

Choosing a system with strong reporting capabilities offers several
benefits for practices:

1. **Better decision making** – Allowing key reports to be easily created – as well as easily understood – helps make sure all the necessary data is digested 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.

3. **Catch underpayments and other mistakes** – Advanced reporting capabilities make it easier to audit payments received against the practice’s payer contracts, so the practice can make sure it’s being paid according to its contracts.

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**ELECTRONIC REMITTANCE, AUTOMATED DENIAL, AND IGNORED CLAIMS POSTING**

One key element of an efficient, hassle-free revenue cycle is payment accuracy, so practices need ways to ensure their claims are being accurately paid in full.

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

Choosing a system that accepts ERAs allows practices to cross-examine those payment details against payer contracts, so the practice can make sure it’s collecting according to its contracts.

Likewise, choosing a system with the ability to post denials 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 more denials in the future.

The best systems also automatically post lost or ignored claims based on the practice’s daily aging of receivables.

These features impact practices by:
1. **Increasing collections** – Electronic remittances help practices make sure they’re receiving what their payer contracts say they’re owed. And automatically posting denials and ignored claims helps keep better track of unpaid claims so each issue can be resolved.

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 processes helps practices drastically improve their DSO (days sales outstanding) metrics.

### ADVANCED COLLECTIONS APPLICATION

The most effective A/R management applications need a variety of advanced tools to greatly improve a practice’s efficiency and workflow. The features that will benefit practices the most are:

1. **Work queue for collectors** – The system should be able to send information and assignments to collectors and queue up an automated list so they can work quickly.

2. **Skills-based routing** – The system should be able to automatically send assignments to employees with the appropriate skill sets. For example, the practice can identify an employee as a Medicare specialist and the system can automatically send Medicare denials to that person.

3. **Advanced tracking** – Practices should be able to track all denials, underpayments, and lost or ignored claims and charges for a better-organized workflow.

4. **One-click action** – All tasks within the system should be as easy and intuitive as possible. Common collection item needs – resubmissions, appeals, demographic and insurance data changes, electronic eligibility verification – should be able to be accomplished with one click.

5. **Electronic claims status checking** – Many payers allow prac-
tice to check the status of their claims electronically so they can easily know when to expect a payment or when to follow up on a claim. Make sure you choose a system that can connect with your payers and allow electronic status checks.

6. **Advanced organization** – One of the appeals of using an electronic system is the ability to store and easily access all A/R data in the same place so they can make better decisions and improve collections. Therefore, the system allows practices to sort denials by payer, responsible party, provider, payer type, billing amount, and any other category.

7. **Tracking expected value of denials** – Practices need to know how much denials are costing them so they can assign collection resources appropriately.

8. **Standardized denial types** – Finally, the system should be able to categorize denials based on their type – for example, justification, enrollment, authorization, coverage, medical necessity, and others. These denial types should be able to be standardized into the same category themes across different payers. That gives practices another data point to analyze when trying to minimize denials.

**CONCLUSION**

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

Installing your first practice management system or upgrading to a different system with the features described above is one major step toward improving your practice’s accounts receivable operations.

Better billing and collections not only saves practices money and adds to their revenue, but it also allows medical practices to focus more time on what they do best – caring for patients.
CONTRIBUTORS

Francis Guasp
CareCloud

Francis Guasp is a billing and compliance expert with over 15 years of experience in the healthcare industry. She is a Certified Professional Coder, designated by the America Academy of Professional Coders (AAPC), and is an expert in multi-specialty billing and payer specific guidelines.

Richard Lopez del Rincon
CareCloud

Richard Lopez del Rincon is an executive with over 20 years of sales, marketing and client service experience in revenue cycle management, technology-enabled outsourcing and healthcare. He ensures the highest level of customer service and satisfaction while leading the sales and marketing teams.

Juan Molina
CareCloud

Juan Molina has a decade of Healthcare IT experience in revenue cycle management, technology and process transformation. He has a passion for helping medical practices and billing services of all sizes improve workflow, profitability and efficiency through technology.

Follow Juan on Twitter: @hitevangelist

CareCloud is a leading provider of web-based practice management, revenue cycle management, electronic health record (EHR) and medical billing software and services for medical groups. The company’s products are connecting providers to one another – and to their patients – through a fully integrated digital healthcare ecosystem that can be accessed on any browser or device.

CareCloud is helping physicians in over 30 states increase collections, streamline operations and improve patient care. The company was named a winner of IBM’s SmartCamp Silicon Valley 2010 for its innovative technology and received over $20 million in Series A funding from Intel Capital and Norwest Venture Partners.

To learn more about CareCloud, please visit www.carecloud.com.
1-877-342-7517 – hello@carecloud.com