Ann & Robert H. Lurie
Children's Hospital of Chicago™
Children's Community Physicians Association

TABLE OF CONTENTS

ccpa news

FALL 2025

Letter from CCPA/CCPAPP's Executive Director Kena Norris, D.Sc., MJ, FACHE

We have all probably heard the adage, "Failing to plan is planning to fail," so much so that it is deeply engrained in many of our conscious. Despite this understanding, it is easy to become overwhelmed by daily professional demands, thus leading us away from being "proactive" to "reactive" when encountering operational challenges. To operate more efficiently, as well as prevent fraud and embezzlement, we must strategize and then organize to run a thriving business.

Being proactive is a reoccurring theme in this edition of CCPA News. There is an article on managing the practice's finances to maximize revenue, plus a corresponding financial policy template located on the Children's Community Physicians Association (CCPA) website. Also, included is an article with detailed instructions on how to prevent fraud and embezzlement, which sadly occurs at some point in over 50% of medical and dental practices nationwide.[1]

We hope that these articles and resources will assist CCPA members with maximizing their practice's revenue while improving financial security. Thereby, ensuring the often-coveted longevity to care for generations of patients for many years to come.

Reference

1. DeVries, T. (2020, December 28). The Doctor's Guide to Employee Embezzlement. MDManagement Group. https://mdmanagementgroup.com/employee-embezzlement/

Association Updates

2025 CCPA Annual Meeting: Time for a Check-Up – Videos Available

CCPA's Annual Meeting: Time for a Check-up was held on Wednesday, May 14, 2025, at Fountain Blue Banquets & Conference Center. Session topics covered budgeting for the medical practice, key financial reports to track financial health of practices, and human resources information with a focus on strengthening employee retention and engagement. To view the recording for this event, please visit the Member's Portal section at www.ccpaipa.org.

CCPA Member Benefit Reminders

CCPA has added a few new benefits for our members to the American Academy of Pediatrics (AAP) pediatric care online which includes: the 33rd edition of the *Red Book®* and *Quick Topic Review* videos to provide an overview on a variety of topics such as acute bronchiolitis and acute otitis media to name a couple, but there are many more topics in development. Additionally, CCPA members have access to the AAP's newest mental health eBooks collections; that includes the *4th Edition of Pediatric Psychopharmacology for Primary Care*.

Other benefits include the Pediatric Coding Newsletter, which gives members access to past coding issues and other pediatric coding resources that are free to CCPA members. The above AAP benefits can be accessed via the CCPA website at www.ccpaipa.org in the Members' Portal section.

Also, as a reminder, cardiopulmonary resuscitation (CPR) reimbursement is available up to $60 for all CCPA members. Please submit your paid invoice and a copy of your CPR card to ccpa@luriechildrens.org or by fax to 312.227.9526.

CCPA Credentialing Corner

One of the most frequent questions that CCPA staff receive is about CCPA's initial and recredentialing processes. Therefore, practice staff and members can find written instructions on completing the initial and recredentialing Illinois applications, practice checklists for both processes, and much more. You can access Credentialing Corner on CCPA's website at www.ccpaipa.org in the membership section.

Lurie Children's Physician Services Webpage

The Physician Services' department webpage can be accessed at luriechildrens.org/physicianservices including the following resources:

- Satellite clinic schedules
- Referral and consultation to/from Lurie Children's
- Community Provider Symposium Video Library
- LurieMD Provider Call Line (1.855.LurieMD or 1.855.587.4363)

CCPA Purchasing Partners, LLC

CCPA Purchasing Partners, LLC (CCPAPP) is an industry leading group purchasing organization that leverages the collective purchasing power of multiple physician practices to negotiate better prices with suppliers. By joining CCPAPP, independent practices can access discounted rates on vaccines, medical supplies, equipment, pharmaceuticals, and other essential items, resulting in cost savings. CCPAPP is free to join with no monthly or annual dues. All eligible members receive an annual administrative award payment based on member purchases. Moreover, CCPAPP staff are knowledgeable, they provide exceptional customer service, and are committed to supporting your practice. Please call Paresh Patel, Director of Operations, to join, at 312.227.7436 or email him at papatel@ccpapp.org.

In the Spotlight

Did you know that CCPA has several members who are pediatric specialists? This section will provide a rotating spotlight on CCPA's subspecialists.

Steven R. Boas, MD, FAAP, FACSM

Chicago Pulmonary Specialists
191 Waukegan Road, Suite 200
Northfield, IL 60093
847.998.3434
chicagopulmonaryspecialists.com

Steven R. Boas, MD received his medical degree from the Renaissance School of Medicine at Stony Brook University in New York. He completed his pediatric residency at Boston City Hospital and Nassau County Medical Center in New York and he completed his pediatric pulmonary fellowship at the Children's Hospital of Pittsburgh. Dr. Boas also holds an academic appointment of Clinical Professor of Pediatrics at Northwestern University Feinberg School of Medicine. He is board-certified in pediatrics and pediatric pulmonology, and he has received awards from the Cystic Fibrosis Foundation for his work with children with cystic fibrosis (CF). Moreover, Dr. Boas has been awarded numerous research grants supporting his professional commitment to finding new therapies for people affected by CF. Furthermore, Dr. Boas is nationally and internationally known through lectures on various pulmonary topics such as asthma, CF and exercise-related disorders, his presentations of his ongoing CF research, and his widely published peer-reviewed articles in medical journals. In addition to his clinical and research practice, Dr. Boas founded and is the CEO of the not-for-profit Cystic Fibrosis Institute.

Steven R. Boas, MD

Dr. Boas is continually sought out by doctors throughout the Chicagoland area for his expertise as a pediatric pulmonologist specializing in the care of patients with asthma, cystic fibrosis, exercise-related breathing difficulties, and complex pulmonary conditions. He serves as a readily available regional referral resource for the area's pediatricians, allergists, and other specialists to discuss advanced level care of difficult-to-treat medical cases. Additionally, he has participated in leadership roles for local, national, and international committees and organizations, including: the American Academy of Pediatrics, American Association of Respiratory Care, and North American Society of Pediatric Exercise Medicine. Dr. Boas has focused his career on patient care, research, and advocacy. In his spare time, Dr. Boas is an avid baseball fan, a cyclist and enjoys spending time with his supportive wife and two adult children.

Guarding the Gates: Key Vulnerabilities to Prioritize in Fraud and Embezzlement Prevention.

By: Shawntea Gordon, MBA, FACMPE, CMOM

and Kem Tolliver, FACMPE, CPC, CMOM

Introduction

Medical practices, regardless of size, are vulnerable to fraud and embezzlement—threats that can compromise financial stability, patient trust, and regulatory compliance. As the front line of defense, practice managers and/or managing physicians must vigilantly monitor all entry points in the revenue cycle and front office operations. Understanding these vulnerabilities, and proactively mitigating them is essential.

Financial health and revenue cycle integrity go hand in hand. Your greatest defense is prevention. We'll dive into eight high-risk areas that practice leaders should prioritize in work plans to prevent fraud and embezzlement.

1. Patient Scheduling and Registration Fraud

Vulnerabilities:

Accuracy of Information: Office staff cannot control the validity of the information they are given during scheduling and check-in, but we should ensure that they are on the look-out for incomplete or falsified patient information. Inadequate verification of insurance eligibility leads to many downstream issues.

Manipulated Scheduling: This is a tactic by which individuals can overbill or create ghost appointments in your system. A ghost appointment is a fraudulent entry in a medical practice's scheduling system where an appointment is recorded but no actual patient visit occurs. This can be used to commit fraud in several ways:

1. Billing for Nonexistent Services
   A staff member or provider enters an appointment and assigns procedures or services to it, then bills the insurance or patient—even though the service was never rendered.

2. Skimming Copays or Cash Payments
   A fake appointment is created, and when a real patient pays cash for a visit, the payment is posted to the ghost appointment. The embezzler then pockets the money, leaving no trace of the actual service.

3. Boosting Productivity Metrics
   Fake appointments can be used to artificially inflate provider productivity stats (e.g., number of patients seen), which might influence bonuses or performance evaluations.

4. Creating a Paper Trail for Phantom Patients
   This is a tactic deployed by more sophisticated embezzlers where entirely fictitious patient profiles are created solely for the purpose of fraudulent billing.

Prevention Strategies:

There are things you can do to help prevent bad actors. Leverage Red Flag Rule policies which focus on identity theft strategies. Train your staff in how to identify fraudulent information and what they should do once it has been identified.

Implement automated systems for batch insurance verifications and use your practice management software's auditing features to monitor for scheduling anomalies.

To detect and prevent ghost appointments:

1. Regularly match daily schedules to patient sign-in sheets and encounter notes.

2. Use check-in/check-out workflows to include systems with required check-in timestamps which make it harder to fabricate visits.

3. Monitor high no-show patterns in comparison to services still being billed.

4. Restrict access to scheduling and billing by ensuring only authorized personnel can modify appointments and link charges.

2. Copay Collection and Front Desk Transactions

Vulnerabilities:

Time of service payments can be seen as easy targets for cash skimming or underreporting of payments. There may also be instances in which patients are not issued receipts for cash transactions which can lead to an inability to track cash payments. Misapplication of payments to patient accounts will also delay confirmation of payments.

Prevention Strategies:

Enforce a strict receipt policy for all payments. This may include implementing dual signature access to petty cash or separation of duties at the front desk. Perform daily reconciliation of cash drawer balances. Some facilities with recurrent issues have prevented the loss of cash by converting to a cashless front desk.

3. Charge, Capture and Coding

Vulnerabilities:
Upcoding or unbundling services are one of the most common challenges in this category. The goal of the bad actor, in this situation, is to improperly inflate reimbursement especially in instances where compensation is productivity based. This can include altering documentation to justify higher charges.

In some situations, the opposite is true. We see providers lowering charges to stay below the auditing radar or even failing to document services rendered which can lead to uncompensated care and inaccurate financial recording.

Prevention Strategies:
Conduct annual or routine internal audits of coding and documentation using national accuracy benchmarks. Providers who do not meet the accuracy requirements should be put on a corrective action plan requiring prospective documentation reviews prior to claim submission. Consider using certified coders and provide regular compliance and coding training to providers. Implement software with real-time coding validation and alerts.

4. Billing and Claims Submission

Vulnerabilities:
Submission of fraudulent claims is seen in many situations in which payment is based on a percentage of what is collected. Duplicate billing for the same service might mistakenly occur. However, that is considered abuse but if it is done intentionally, it is fraudulent, as is the alteration of billing information to maximize reimbursement.

Prevention Strategies:
Automate claims checks to flag duplicates or anomalies and follow up to confirm claim payment. Separate the roles for billing, posting, and claims submission. In addition, review the Explanation of Benefits (EOBs) and Electronic Remittance Advice (ERA) thoroughly. Run evaluations of procedure code utilization and assess your outliers.

5. Payment Posting and Adjustments

Vulnerabilities:
Unauthorized write-offs or adjustments, payments redirected to personal accounts, and failure to post payments accurately.

Prevention Strategies:
Limit access to adjustment functions in the billing system. The permission to write-off a claim or a service should not be granted widely. Once access to perform adjustments is given, create specific adjustment codes and run adjustment reports to monitor write offs regularly. Require dual authorization for large write-offs or refunds to include rationale and financial impact. Lastly, ensure that you are reconciling payments every day against bank deposits and remittances.

6. Patient Collections and Refunds

Vulnerabilities:
Misappropriation of mailed-in or in-person payments, issuing refunds to fictitious patients or accounts, or deliberate failure to follow up on delinquent accounts.

Prevention Strategies:
Consider using third-party collection reports to cross-verify internal tracking. Make sure to monitor refund requests and require management approval. Work credit balances regularly and within state and federal regulations. Finally, implement robust patient communication logs for full transparency and the ability to audit.

> Some portals only allow one user which forces shared credentials. If this is the case, monitor access and reset access in the event anyone with shared access leaves the organization.

7. Information Technology (IT) Systems and Access Control

Vulnerabilities:
Unauthorized access to billing systems and financial data by staff who do not have these assigned responsibilities. Lack of audit trails for sensitive transactions. Shared or unmonitored user credentials.

Prevention Strategies:
Enforce role-based access controls and document access changes as they occur. Require multi-factor authentication (MFA) for critical systems. Yes, MFA can be annoying, but it is also essential for security.

Regularly review and deactivate inactive accounts, including accounts of employees who have exited the organization. Some portals only allow one user which forces shared credentials. If this is the case, monitor access and reset access in the event anyone with shared access leaves the organization.

8. Employee Oversight and Ethics

Vulnerabilities:
Lack of background checks during hiring, the absence of ongoing ethics training and/or inadequate reporting or follow-up mechanisms for suspicious behavior.

Prevention Strategies:
Perform comprehensive pre-employment screening that incorporates prior employment verification including a check against the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE). Conduct Systems and Organization Controls (SOC-2) audits to assess the operating effectiveness of internal controls. Foster a culture of transparency and accountability by having an open-door policy, a compliance officer, and routine training. Documentation is critical for every step of employee training and processes.

Conclusion

Fraud and embezzlement are persistent threats that thrive in unchecked systems. Practice managers and managing physicians are uniquely positioned to create a culture of integrity by identifying operational vulnerabilities and enforcing strong internal controls. True prevention requires a mixture of vigilance, technology, training, and accountability.

With the right safeguards, managing physicians and practice managers can protect their practice's financial health and uphold their responsibility to patients as well as the providers.

Shawntea Gordon, MBA, FACMPE, CMOM is the CEO of Atlas & Perpetua Healthcare Consulting. She obtained her Executive MBA in healthcare management at Creighton University and as a subject matter expert in several facets of healthcare management and process optimization, and she has held senior level executive management positions in private practices, collaborative institutes, and national care coordination organizations. Shawntea now educates and consults on all areas of healthcare operations including revenue cycle integrity, workflow efficiency, denial prevention, and legislation.

Kem Tolliver, FACMPE, CPC, CMOM is the President and Chief Executive Officer of Medical Revenue Cycle Specialists (MRCS), LLC. She holds dual Bachelor of Science degrees in healthcare administration and organizational management, summa cum laude and magna cum laude respectively. For over 20 years, she has provided strategic and operational leadership to medical practices and hospitals. As the President of MRCS, her team leads health care organizations in: practice start up and transformation, revenue cycle improvements, clinical documentation improvement, educational programing, payer contracting, HIT software development, EMR/PM software customization, and telehealth integration.

The views and opinions expressed in CCPA News are those of the authors and do not necessarily reflect the views of CCPA.

Implement Proactive Revenue Cycle Policies and Procedures. Stop Chasing Money.

By David J. Zetter

Revenue is the lifeblood of any business and any significant impact to the revenue of a business could mean the difference between success and business closure. Therefore, revenue cycle management is very important, but especially for medical practices because the source of the revenue can come from so many different patients and payors. What is even more of a concern is that the payors have many rules by which a practice and its providers must adhere to in order to receive the remuneration the practice so rightly deserves.

> Most patients and their families are paying more for healthcare today than in previous years. Consequently, the landscape is changing, practices can no longer run "business as usual."

Over the years, healthcare has definitely changed. Resulting in a higher percentage of this revenue as the responsibility of the patient, hence the term, consumer-driven healthcare. Most patients and their families are paying more for healthcare today than in previous years. Consequently, the landscape is changing, practices can no longer run "business as usual." The policies, systems and tactics previously utilized in the revenue cycle management process will no longer ensure that the funds will show up in your bank account or in your mailbox. Most medical practices and facilities have implemented a "reactive" revenue cycle policies and procedures. This causes them to chase money because co-pays are not always collected at the time of the visit, and the front desk staff does not request payments from patients on their account balances before seeing a provider. Why continue to do the same processes and expect a different outcome? Therefore, develop a "proactive" revenue cycle.

A proactive revenue cycle requires more changes in the billing and collection processes. So, what should those changes look like? Exploring new policies and strategies, along with proactive ideas will assist you in ensuring that payments arrive where they belong, which is ultimately in the practice's bank account. So here are some practical points on the changing landscape to improve the revenue cycle processes for medical practices.

Financial Policies

Financial policies are written communications to your patients on the practice's financial expectations. This is the opportunity to inform your patients on what they need to do to keep their billing account paid in full.

Many financial policies are arbitrarily developed or implemented without consideration on how this will affect cash flow, the staff, or the practice's ability to be efficient and solvent. Thus, practice leadership needs to decide what is best for the practice and create written expectation for patients to follow.

Developing or updating the practice's financial policy should include an assignment of benefits (AoB) statement. The AoB is the only language that provides the physician the right to bill for services provided to the patient and collect the payment from the payor on behalf of the patient. Without a properly drafted AoB, billing staff have no legal authority to submit the claim or collect the money. The Employee Retirement Income Security Act (ERISA) and Patient Protection and Affordable Care Act (PPACA) regulations provide this right to physicians as long as they are named the "authorized representative" of the patient, for which proof is needed that the patient signed an authorization document. However, if the managed care payors discovers that the practice does not have a signed AoB, they can demand repayment of funds paid to the practice because the claim was submitted and collected illegally.

The financial policy should also communicate the following areas of information:

- Payment at time of service, fees, and collections
- Co-pays and deductibles
- Requirement of producing a health insurance policy or summary plan description
  - This is important because this is what dictates your requirements for prior authorizations, procedures that are experimental, etc.
- Credit/debit card on file
- Elective procedures, non-covered procedures and No Surprises Act
- Submission of claims
- Payment options and requirements
- Cash-paying patients
- Medical debit/credit balances
- Medicare patients
- Non-contracted insurances

- Uninsured and self-pay
- Missed appointments / Late for appointment / No Show Fees
- Referrals
- Forms and other medical record fees
- Authorization to Release
- Assignment of Benefits and Authorized Representative

Once the financial policy is signed by the patient, it should be retained in their chart, and the practice should enforce all policies contained in the document. It is best to review this with the patient at the first visit to ensure that they understand the financial policy.

Patients should be reminded to review the financial policy at the time of scheduling their appointment, at the reception desk upon arrival for their appointment, and at checkout. In addition, the financial policies should be posted on your website and should be reviewed by practice leadership and updated as the needs of the practice change.

A revised sample financial policy has been provided and is posted on the CCPA website, www.ccpaipa.org, in the Member's Portal section.

No-Show Fees are becoming more popular in medical practices, and it is perfectly legal, as long as you do not maintain credit balances in patient accounts, as every state has escheatment laws that prevent you from holding credit balances.

Credit/Debit Card on File

With the increased percentage of revenue becoming the responsibility of the patient, it is now time to seriously consider having all patients to maintain a valid debit or credit card on file. This should be implemented properly and with the correct forms and communications to patients to ensure federal laws are not violated and that PCI-compliance is met, which is required for all credit card transactions. However, by implementing a "proactive" revenue cycle option, practices can store the patient's credit/debit card information on the merchant services system.

These systems can then automate charges to patient's credit cards for the preauthorized amount for co-pays and patient balances after claims have been adjudicated by the insurance carrier. Thus, bringing in revenue more efficiently and at a lower cost is to collect the revenue at the time of service or immediately when patient responsibility is applied. So how is this accomplished?

The financial policies must be developed to inform the patient of the practice's preferred way of handling payments is to receive a PCI-compliant credit card on file. For patients who do not have a credit or debit card or are unwilling to take advantage of this service, the following process is suggested. Patients can authorize an ACH to draft monies directly from their checking account. For patients without a checking account, requiring a deposit (an amount to cover the co-pay or deductible), to hold their next scheduled appointment. During patient check out, the practice will reimburse the patient the difference of the deposit after deducting the co-pay, and any deductible owed at the time of their visit.

The credit or debit card authorization should be obtained from the patient at the time they schedule their first

appointment because if they do not show for their first appointment, you have no way to collect your No-Show Fee. The No-Show Fee should be high enough to "hurt" the patient's wallet. Therefore, $150 is the suggested amount to hold until the patient arrives for their appointment. This allows you to charge the card on file the amount of the No-Show Fee immediately upon determining the patient is not arriving for their appointment. This is becoming more popular in medical practices, and it is perfectly legal, as long as you do not maintain credit balances in patient accounts, as every state has escheatment laws that prevent you from holding credit balances. You are required by law to report all credit balances that you have not been able to return to the patient. Reporting is always to the state treasury department, and you may find these escheatment laws on your state's treasury website.

Demographic Collection

Demographic collection begins when the patient schedules their initial appointment. This is where the patient is informed of the practice's financial policies and their obligations as a patient in your practice. Whether taken verbally or copied from intake paperwork completed by the patient, it is imperative that the demographic information is entered into the billing system correctly. For example, if the office staff register William Smith as Bill Smith, or transpose a policy number, social security number or any other information, the insurance claim maybe rejected.

Rejected claims can be prevented if the rejection errors are evaluated and then communicated to staff to ensure it does not occur again. This is also the point where the education and staff training are important to ensure that they obtain all the required demographic information with accuracy. Specifically reviewing each point of contact in the practice where patient information is collected; it is essential to determine the source of any errors and resolve them. If there are errors made, there should be a process in place where the errors are tracked, reviewed and communicated to those responsible to correct behaviors as a means of error prevention. A little time and effort spent upfront will produce greater efficiency down the road.

Insurance & Eligibility of Benefits Verification

All practices should verify insurance and eligibility of benefits for each patient a week in advance of the patient visit. Why so far in advance? More time may be required to follow-up with the patient if the insurance is unverifiable with the information the patient provided and to confirm their benefits. This is the "proactive" way of handling this versus waiting until the patient arrives for their appointment.

Patient Presents at Your Practice

As patients arrive for their appointments, practice staff should verify the patient's insurance by viewing and copying their insurance cards. After insurance verification, the front desk staff should collect the co-pay and required payment on any account balance at every visit until fully paid. Moreover, the patient should sign off on all intake/required forms that were not completed prior to their visit. This is also an opportunity to communicate the practice's financial policies, to ensure the patient understands them, and to obtain a signature on the policy. It is always easier to collect money from a patient when they are present for their appointment.

Daily Reconciliation and Deposit Preparation

Each day, the front desk staff should print out a schedule for the day and track all payment collections and No-Shows on the printed schedule to complete the reconciliation process. All checks, credit or debit card receipts and cash should

be placed in an envelope or cash drawer for safe keeping throughout the day. This should be marked for each patient to reflect how they paid and what amount, so that each visit can be documented. No-Shows should be identified so someone can charge the authorization form on file for the patient. Another staff member should prepare the bank deposit from the schedule and reconciliation documents. This will ensure that there was a check and balance between the collection revenue process. Once the deposit is prepared, someone else should take the deposit to the bank and then the deposit slip processed by the bank should be attached to the schedule/reconciliation form and kept in the practice's records. Having different staff members complete the reconciliation process ensures that embezzlement is not occurring.

In addition, these reconciliation forms and the deposit slips should be matched to your monthly billing reports to ensure your billing report records on revenue and the deposits match. They may not match by small amounts due to the timing of entry into the billing system versus the deposits made and when claims are adjudicated and payments posted into the billing system. However, this should only be a variance of a couple thousand dollars or less a month and should be positive and negative from month to month, but at the end of the year, the variance should be minor.

Charge Entry, Claims Processing, Rejections or Denials, and Claims Adjudication

All services should be entered into your billing system as soon as the patient visit is completed, and the medical record is closed by the provider. Medical records should be completed daily or within 48 hours. If providers are not closing records within 48 hours, a counseling session should be done with the provider in question. Claims cannot be submitted until the medical record is closed. Claims should be submitted daily. Therefore, charges should be entered as soon as the current procedural terminology (CPT) codes and charges are communicated by the provider to those that are conducting charge entry.

Any rejections or denials should be evaluated the same day and worked to be corrected and resubmitted. **Never** resubmit a denied claim without correcting it. Educate all providers on any denials so that these errors can be avoided to prevent them from reoccurring. Denials and rejections should reduce over time if you are educating the providers, otherwise, inefficiencies and reduce revenue will continue to occur. Once claims are fully paid and you have verified that you received the full contracted allowed amount from the insurer based on the fee schedule, you can write-off the contractual amount (the difference between your charges for the services and the contracted amount). The patient's co-pay, any deductible owed by them and any insurance payments should equal the contracted rate in your contract.

Collections

Collection services are not recommended because the practice typically receives a small portion of whatever is collected. Therefore, here are two collection alternatives that practices can consider other than the collection agency. Hiring an attorney to send collection notices to the patient for a minimal cost and utilize the district court services to collect on patients' overdue accounts. Patients may be inclined to pay their bills versus being sued in the local district court. The second option is to charge interest on patients' overdue balances. If applying this option, be sure to verify and follow any state and federal laws that regulate charging interest for late payments. If choosing either collection option, make sure to add them to the practice's financial policies. Lastly, practices need to be consistent with enforcing every policy implemented in the practice.

Patient Satisfaction

One of the last areas to address is patient satisfaction. As the healthcare landscape evolves, patient satisfaction scores will be utilized as a benchmark for payment. By helping to automate the payment of copays, deductibles or payments on accounts, your staff will have more time to focus on the more important needs of the patient.

By utilizing a more proactive revenue cycle process, the practice can stop chasing money and implement changes to ensure that the revenue makes it to the practice's bank account.

David Zetter is the founder and president of Zetter HealthCare, LLC in Mechanicsburg, PA and has over 30 years of operational and healthcare experience. He has evaluated existing ambulatory care facilities and practices with respect to patient flow, operations, use of ancillary services and financial considerations; developing strategic plans to improve profitability and productivity. David's activities in management and compliance include physician practices, hospitals and other healthcare facility types. Early in his career, David has conducted chart audits on behalf of Medicare contractors and Blue Cross/Blue Shield, giving him the knowledge of what managed care payors expect from practices. He also re-engineered operational and human resources, addressing coding and billing issues for providers to curtail fraud, OIG, and IRS issues.