

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.

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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.