METHOD TO THE MADNESS

10 payment collection strategies that work

Availity

An e-book from Availity to help medical business professionals optimize payments to their organizations
HERE’S THE DEAL

If you’ve found your way to this e-book, the chances are good that your business—like a lot of provider organizations and health systems—is up against unprecedented revenue and margin pressure, and figuring out how to boost revenue has become the focal point of your work life.

You’re not alone. With significant payment responsibility shifting to consumers, medical businesses are increasingly battling bad debt, long A/R cycles and reduced revenue. So now you need help—**but where to start?**
Getting ahead

Historically, most payment collection activities occurred long after the patient left the facility, which creates back-end work that can significantly delay payment and reduce total collections. But health care reform, the growth of high-deductible health plans and decreasing reimbursements are forcing a shift of collection efforts upstream.

Savvy medical business professionals are placing a new importance on revenue capture at point of service. This e-book will help you collect more up-front. At the same time, you’ll want to take a long, hard look at back-end collections, and adopt new billing strategies to combat debt. We’ll help you with that, too.

What’s inside

In this e-book, best-practice guidance from our team of Availity experts, lessons learned from our most successful customers and leading market research all come together to give you the definitive guide to collecting payment.

OUCH!
PAYMENT COLLECTIONS ARE A PAIN

In some hospitals, the rate of bad debt for insured patients has increased to well over 30 percent per year.¹

Out-of-pocket payments for insured patients are expected to grow to $420 billion in 2015, a 68 percent increase from 2010.²

In 2010, bad patient debt in the United States was estimated at more than $65 billion.³

An estimated 49 percent of health care providers do not know how much to collect from a patient at the time of treatment.⁴

While 78 percent of a provider’s patients know their responsibilities, they do not commonly volunteer payments if not asked.⁵
Optimize your pre-appointment workflow
You may not realize it, but the revenue cycle—and the groundwork for successful account resolution—begins at the front desk, with patient scheduling. There are many important patient access functions that can and should occur before the patient encounter (and some even before the patient steps foot in the office).

One of the most important steps is to verify insurance eligibility, benefits and service authorization prior to the appointment. Industry best practice is to verify 98 percent of patient eligibility and benefits prior to every visit, but few practices consistently check this information. Make these pre-appointment checks part of your standard workflow, coupled with a liability estimator (available through a clearinghouse, practice management system and certain payers) so you know how much to collect from the patient up-front.

These steps collectively provide you with information necessary to educate patients about the availability of financial assistance programs, screen qualifying patients for coverage and walk them through the account resolution process—all before the appointment. Financial clearance steps ensure your services stand the best chance of being properly billed and paid.

Build a thorough financial clearance program into your office staff’s standard pre-appointment workflow and clearly define who is responsible for these tasks. Combined with a good payment estimation tool, you are not only armed with information you need to discuss a patient’s financial obligation with them, you can provide greater payment transparency, which leads to better patient satisfaction.

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The importance of patient statement design
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Extensive research has shown that the lack of effective financial communications in health care is a significant problem for both patients and providers. Patients who don’t understand their bill or have questions are less likely to pay than those who have a clear understanding of their responsibility and payment expectations.

To avoid tripping up your patients with jargon and confusing bills, be sure your statements are designed so that your practice’s typical patient can easily understand the language and format. The Healthcare Financial Management Association has established some simple guidelines through their Patient Friendly Billing® project that can help ensure your statements are doing their job.

Patients who don’t understand their bill are unlikely to pay.

PATIENT FRIENDLY BILLING GUIDELINES

CLEAR
All financial communications should be easy to understand and written in clear language. Patients should be able to quickly determine what they need to do with the communication.

CONCISE
The bills should contain just the right amount of detail necessary to communicate the message.

CORRECT
The bills or statements should not include estimates of liabilities, incomplete information, or errors.

PATIENT-FRIENDLY
The needs of patients and family members should be paramount when designing administrative processes and communications.
THREE
Set expectations early and often
Set expectations early and often

The biggest opportunity to collect from patients is when they are standing in front of you. In fact, your chances of collecting payment are reduced by 62 percent once the patient leaves the office. Point-of-service cash collections are a trending indicator of collection efforts, and may indicate potential exposure to bad debt and reduce collection costs.

Make it a regular practice to ask for payment and collect at the point of service. Top-performing practices don’t just ask if a customer would like to pay today, they ask how. This sends a clear signal to patients that payment is expected at the point-of-service.

But first, you’ll want to make sure that office staff is comfortable doing so. It can be difficult asking friends, neighbors and hard luck cases for payment—so take time to train your team on the best way to approach a variety of payment scenarios. Then, document those scenarios and develop scripts to reference. Scripts can be both helpful and empowering, while ensuring consistency for front office or patient access staff.

When engaging in discussions about payment options or plans, lead with asking how much time the patient needs to pay in full and encourage payment options based on your cost to collect. Establish easy-to-understand parameters, including maximum time and minimum payments, as well as consequences for failing to adhere to the plan, such as lead time before beginning collections activities. Be sure to document the agreement, then send a copy home with your patient and have it on file for your staff.*

By proactively addressing financial information and solutions regarding payment options, you can boost transparency, and help patients feel more engaged in their care.

*Providers and their employers are responsible for ensuring that all payment options and collection efforts comply with all applicable laws.

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FOUR

Convenience makes it easier to pay
When it comes to billing, patients have different expectations, practices and preferences in how they pay. If you can tap into a little technology and build more flexibility into your collections, you can reduce your reliance on paper statements and bill collectors, get quicker payments and reduce administrative costs.

Most practices, hospitals and billing services already include the option to pay by credit card on statements, but have you considered an online payment option? There are many vendors and services that offer an online payment portal, including clearinghouses or practice management systems that you may already be using. Look for options that allow automated monthly debits for payment plans, which reduce your reliance on a patient taking action each month.

You can also let your phone do some of the work for you. You may already have an interactive voice response (IVR), or automated telephone system, to route calls through your office. Evaluate whether it is feasible to add automated payment options to the menu, and reduce or eliminate the need for human intervention. You might also consider an inexpensive SMS text-messaging service to send pre-visit reminders or post-visit balance-due notifications via email or text.

Determine which options make the most sense for your business, based on your unique patient demographics.
FIVE

Invest in training
Invest in training

Medical office administration requires a unique skill set: communication skills for educating patients about plan coverage and financial responsibilities, plus a detailed memory and reference skills for tracking ever-changing payer payment and follow-up processes. Office staff must be able to react knowledgeably to any situation and solve challenges.

If you are not hiring employees with solid blended skill sets, it is important to invest in training, particularly for client-facing roles. Evaluate whether your onboarding is effective or whether you should look into external resources, such as on-demand training modules in areas like insurance plan design, medical office customer service or HIPAA regulations, for example. Professional associations are often good resources for training, and free or low-cost online training may be offered by your vendors.

Seasoned staff benefit from ongoing education, too. Establish a culture where continuous improvement is expected, and encourage or incent your team to seek continuing education through webinars, conferences or user group meetings.
Scrub claims clean

Several hundred new and revised codes are introduced every year, not to mention thousands of new ICD-10 codes that are just around the corner. That adds pressure to coders, whose accuracy can affect their practice's reimbursement.

While certain manual efforts like training, documentation and periodic quality checks can support accuracy efforts, a professional claim scrubbing tool can automate claim reviews to scan for compliance with National Correct Coding Initiative and other coding regulations and requirements—a review that, when performed manually, can be daunting for even the most experienced coders.

Take advantage of automated technology tools that build coding rules into your practice management system, check for errors and correct mistakes prior to claims submission to reduce denials.

Equip your office with information to identify and correct recurring issues. When you find a product that best fits your specific needs, you will find it pays for itself several times over in staff time savings, increased efficiency and recovered revenue.

A GOOD CLAIM SCRUBBING TOOL CAN HELP YOU GENERATE REPORTS THAT PROVIDE INFORMATION ON:

- Coding errors found
- The number of claims affected
- The dollar value of affected claims
SEVEN Measure and monitor
There’s a burgeoning market for data analytics in health care, from data-mining tools that provide business intelligence to those that support clinical decision-making. When applied to billing operations, analytics tools can provide greater transparency into the payment cycle, and pinpoint areas to focus improvement efforts to maximize performance.

Comparative analysis is one such approach that enables productivity and performance comparison against peers (even by specialty), locally and nationally. By discovering peer-to-peer benchmarks on key metrics such as payer processing times, staff productivity and denial rates, you can reveal actionable insights within your revenue cycle.

If it’s not possible to deploy business intelligence for your practice, you can instead establish and monitor key performance indicators in your billing processes. Key performance indicators to consider:

- **Denial rate.** Aim for an overall denial rate of less than 7 percent, an industry best practice. Pay special attention to your zero-pay denials, which show your organization’s ability to comply with payer requirements and a payer’s ability to accurately pay the claim. You can go one step further and identify the root cause of the denial—by payer, department, physician or procedure—and create strategies for prevention.

- **Bad debt.** Aim for a bad debt rate of 2 percent or less for a healthy balance sheet. Collaboration between departments, effective patient communications and thorough financial education are keys to lowering your bad debt rate.

- **Accounts receivable.** The older an account becomes, the less likely it is to be paid. You’ll want to make sure accounts more than 90 days old make up no more than 20 percent of all accounts. Net collection rates of at least 97 percent are also an industry best practice.

- **Staff productivity and efficiency.** Measure the time from a patient encounter to claim submission, and time from a patient encounter to payment or denial receipt. Measure coder
throughput, accuracy and compliance, as well as denials by staff member and denials due to ineligibility. Measure productivity through claim aging and error summary reports. Set targets, then monitor performance against them.

- **Customer satisfaction.** Consider placing comment cards in your office or mail them to customers and ask them about their visit, from scheduling and check-in to payment follow-up. Or even try an inexpensive automated online survey delivered via email. Record calls for training opportunities or have office management sit in and provide coaching. Satisfied customers are more likely to pay their bills.

**Analytics tools can provide greater transparency into the payment cycle, and pinpoint areas to focus improvement efforts to maximize performance.**
Be aggressive with claim denials and rejections
Managing denials and rejections is an ongoing challenge that's more than a hassle—it's a pain in the wallet. Some 23 percent of claims are denied annually from commercial insurers. Some portion of that money is never recovered, either because it is not resubmitted or because the claim contains medical coding errors that cause underpayment. In fact, less than 50 percent of denied claims are reworked and resubmitted. That’s not including claim rejections, which are claims that never make it into the adjudication system to be processed for payment.

Reviewing electronic claim rejection reports on a daily basis can help you determine where in the process the claims are rejected—in-house, at the clearinghouse, at the payer or at another trading partner. Regular review of these reports can reveal underlying issues that need to be addressed, such as internal training on correct coding or formatting, or technical issues at a clearinghouse, for example.

Denials, or, claims received by the payer’s adjudication system and denied for full or partial payment, should be managed by a separate workflow. Have your billing staff group and work denials according to required follow-up actions:

• Does the claim need to be written off? Write it off using the appropriate adjustment codes.
• Does the claim need to be corrected? Correct and resubmit it.
• Does the claim need to be appealed? Develop your case using the payer’s process and appeal it.

Set daily and weekly targets for working claims based on your high performers, and reward productive employees. You can also run an open claims report every 60 days to more aggressively manage aging claims and use online claim status research tools to track the process of resubmitted claims.

Less than 50 percent of denied claims are reworked and resubmitted—and that can be a real pain in the wallet.
Offer financial incentives and discounts
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While you want to make every effort to collect payment in full, up-front, it isn’t always possible for patients to pay large lump sums at one time. That’s why now more than ever, medical offices are applying retail payment tactics to help them collect:*

• **Discounts for paying early.** Some practices offer discounts of 10-15 percent for either paying up-front or paying in full within the first 30 days. Discounts can motivate bargain shoppers and avoid payment procrastination.

• **Discounts for uninsured or underinsured.** Discounted rates for self-pay patients in the range of 25 percent, or even sliding-scale pricing where charges are based on a patient’s income, can mean the difference between getting paid a portion of usual and customary charges for services and not getting paid at all.

• **Payment plan options.** Payment plans are an increasingly popular option to help increase cash collections and reduce bad debt, so offer this option to resolve outstanding balances. Work out a plan that is reasonable for the patient while meeting your organization’s policies and financial commitments.

• **Health care gift cards.** Some health care providers and insurance companies are now offering gift cards that can be used to pay bills and insurance premiums, or pay for specific services at eye doctors or dentist offices, enabling easy pre-payment.

• **Incentives for staff.** Financial incentives for achieving billing and collections goals can be both motivating and rewarding. Just be sure to set specific, measurable and realistic goals, and watch out for bad behavior.

*Providers and their employers are responsible for ensuring that all discount programs and collection efforts comply with all applicable laws.

Discounts and payment plans are common retail tactics that medical offices are using to help collect patient payments.
Timing is everything
Timing is everything

If you are unable to collect payment in full at the point of service, you should send billing statements immediately. Aim for fewer than 24 hours to release patient statements, an industry best practice. Initial billing is the starting date for the account resolution process, and all time-bound activity should be driven by that date.

Timing of collection activities from that point can vary greatly from practice to practice. There is a proposed IRS rule to disallow credit bureau reporting by non-profit hospitals until at least 120 days from the date of the first bill. However, many practices wait as long as 180 days before extraordinary collection actions—such as engaging a collections agency—begin. Others are more aggressive, sending patients to collections after six to eight weeks. The right window of time before initiating collections activity is between 90-120 days. After that, the chances of being paid are significantly lowered.

Whatever your timeline, make sure to have a written policy (that is made available to patients) that documents any measures your office may take to resolve accounts. And be sure to notify patients at least 30 days prior to collections action.

Ultimately, your organization’s ability to liquidate accounts receivable is essential to a healthy balance sheet. For a trending indicator of receivables, look at your aged accounts receivable as a percentage of billed accounts receivable at 30 days, 60 days, 90 days and 120 days. Another trending indicator of overall accounts receivable performance, and your revenue cycle efficiency, is net days in accounts receivable. Top performers have accelerated billing and collection cycles, with about 40 days in accounts receivable.

Aim for fewer than 24 hours to release patient statements.
The final word

It can take time to adjust your policies, practices, culture and even technology to align around new payment expectations, but optimizing your billing cycle is possible. If you are strapped for time or resources, start small and implement one or two changes at a time. Over time, you will begin to see the difference on your organization’s balance sheet, and be a hero for your business.

REFERENCES

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