Managing Your A/R for Greater Profitability

Here's how to get a grip on your uncollected balances

BY GIL WEBER, MBA

Keeping a tight rein on aging accounts receivable is one of the most important functions for any practice's business office. As everyone knows, the longer such debt remains uncollected, the more likely it becomes that some or all of that money will never be seen.

The dynamics of managed care plans have changed significantly in recent years and placed even greater importance on collecting as much as possible up-front, or certainly within the first billing cycle. In past years, a significant majority of A/R was owed by insurance companies and a much smaller percentage of total A/R was patient-owed. Now, however, the growth of high-deductible health plans has put a significantly larger share of the cost onto patients' shoulders. That's starting to create some cash-flow problems for those who do pay careful attention to receivables, and it's creating havoc for those who are not vigilant.

Traditionally, monies owed by third-party payors were almost always collectible—assuming no disputes over eligibility or benefits. Though the contracted rates might not have paid as much as we'd have liked, payments typically did arrive in reasonable time. And with the enactment and enforcement of stronger prompt-payment laws, we now have some added protections courtesy of various legislative and regulatory bodies.

But with difficult economic conditions and with many patients now having greater financial responsibilities, particularly for surgeries where amounts owed might be hundreds or even thousands of dollars, the game has suddenly changed. Previously, a patient might have had a nominal co-payment or owed a relatively small amount (e.g., 20%) as co-insurance and usually paid that with minimal hassle. Now, under these newer managed care plans, patients have to come up with big first-dollar payments, typically $1,000, $2,000, even $5,000 deductibles, and then perhaps another 40% co-insurance. Often a patient may not be prepared to hand over such large amounts prior to or immediately after receiving services. And state prompt-payment laws offer

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the practice no protection since they apply only to third-party plans governed by state law. They do not apply to patient debt.

Issues to Think About; Steps to Take

How do you decide when A/R has turned "bad," and how do you calculate the amount of bad receivables you're carrying? How much in extended receivables is reasonable and/or acceptable, and how much is too much? Do you base a decision on a calculation that takes the amount you've decided to write off and divide by total A/R, or by some other method? And how often do you address all of this? Monthly? Quarterly? Yearly?

Everyone recognizes that A/R becomes increasingly arduous to collect when it extends past about 60 days. After 90 days, it becomes almost exponentially more difficult to collect—especially from patients. As you look at 120 or 150 days, it becomes nearly impossible. It's probably time to consider categorizing A/R as possible/probable bad debt when it clicks over 90 days. Absolutely no later than that, and preferably before, the practice's books need to be scrutinized very closely.

Your analysis of debt vs. bad debt (i.e., likely collectible vs. less likely or unlikely uncollectible) should be done every month. To let it go for months-on-end before categorizing monies owed as bad debt probably means mostly fruitless efforts to collect, with resources expended showing little return or, perhaps, not enough return to make worthwhile the investment in time and resources.

So jump on the analysis sooner rather than later—start to act before A/R reaches 90 days. Decide whether repeated billings are worth the time and expense. If you're regularly receiving something meaningful from the patient, then maybe it's worth keeping that A/R on the books. But if you're not, then maybe it's time to consider turning over certain debt to a collection agency. And any collection agency will tell you that the sooner you turn over the debt, the better their chances of collecting on it.

Further, it's essential to look at extended receivables and any amounts you're considering writing off to differentiate those uncollectible amounts owed by patients vs. uncollectible amounts owed by payors. These should not be aggregated!

Hopefully you won't have much in the "payor" column of your ledger extended past 45–60 days, especially if you're in a state with a strong prompt-payment law. But if you do have extended payor-owed receivables, then there likely could be some serious issues with your practice's billing and/or contract management. That will necessitate some careful investigation and corrective action. (Note in particular that you can't depend on state prompt-payment laws to help if your extended receivables are from ERISA-governed payor/benefit plans.)

On the other hand, if as expected, most of the "iffy" receivables are owed by patients, then you may have an issue with the amounts not collected on the day of service. That means addressing with staff the financial impact of timely collection of co-pays, deductibles, and co-insurance so that more is brought in up-front and less is left on the books possibly to become uncollectible.

Getting a Grip on Things

Is any of this hitting close to home? If so, then perhaps one or more of your billers has not been doing a stellar job over the past months, and you could be looking at some considerable amount of bad debt coming home to roost—monies that just won't be collectible at this late date despite repeated monthly billings, phone calls, and "nasty-grams." So what can you do to lessen the chances of this becoming your future reality?

First, carefully consider how many billers and A/R staff your practice really needs to allow for efficient management of collections. You can have a great biller(s) and staff working on collections, but if they are totally overwhelmed by the volume of work generated by the practice, then it's not their fault if A/R starts to extend past the number of days you determine is reasonable. So, start by tapping into resources that will help you determine if the problem is related to the quality of work and workers or if, instead, it's one resulting from an impossible workload.

Annual review performance targets should be established and benchmarked for collection of deductibles and co-insurance.

Ask administrators or office managers at local, similarly sized practices about their workloads and biller and collector ratios. Inquire on listserv discussion boards to get a broader perspective from others outside your area. Review staffing ratio surveys that typically are available from national specialty societies, or from state medical societies.

Then as to evaluating individuals, all practices should make the percentage of copayments collected on the date of service by responsible staff a performance measure for annual reviews. Except in those instances of documented financial hardship or emergencies, one hundred percent collection of co-payments on the date of service must be established as a critical front-office target, and not less than 95% should be the minimum acceptable monthly standard. And since all insurance plans state to their members that the co-payment is due on the date of service, why are we not collecting these minimal amounts up front in all but exceptional circumstances?

Similar annual review performance targets should be established and benchmarked for collection of deductibles and co-insurance. Now,

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obviously, staff is not going to be able to collect 100% of all deductibles and co-insurance on the date of service since those amounts will be considerably more than nominal co-pays, and each patient's unmet financial responsibility as to deductibles and co-insurance may not be known to the exact dollar on the date of service. Still, responsible staff must be tasked with collecting some significant amount from most patients. If a patient is going to owe $750 or $1000 (or more) then collecting $25 on the date of service and $25 sporadically after that isn't going to make it. To collect so little surely will lead to a higher risk of extended receivables and, ultimately, bad debt that's written off. On the other hand, collecting $450 of $750 up front, and/or getting an agreement to charge some amount each month on a credit card, and/or having the patient secure financing through one of several companies that specialize in medical payment plans lessens the chances of a big write-off in five or six months.

It's not easy, and staff may resent being made the "bad guys," but it must be done. With the growth of high deductible plans where patients are responsible for a much larger share of the costs, collecting as much as possible up front becomes essential. Staff cannot let patients leave without some meaningful dollars in the drawer. Remember, medicine is a business, and you're not in business to provide care for free.

The following case study illustrates what can occur when A/R goes unmanaged and unmitigated.

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Case Study

Out-of-Control Accounts Receivable

The really frightening part is that this nightmare scenario actually happened.

Several years ago, a client asked me to look at some contracts and to address a serious collections and cash flow problem. This was a very busy solo practice whose physician did a lot of surgeries that should have brought in considerably more income than was being realized.

The amount of money in accounts receivable extending out past 120 days was significant, and the amounts in the 150, 180, and 180+ day buckets were simply astounding. It was immediately clear that there were two interconnected problems. First, not enough patient-owed amounts were being collected at the time of service. Second, efforts to collect after the fact by billing third-party payors for contracted reimbursements and billing patients for balances owed were inefficient and ineffective. There were several staffers doing the billing and collections work but seemingly without focus and defined effort. People seemed to be going in circles and accomplishing little.

Not enough patient-owed amounts were being collected at the time of service.

Looking at the A/R, one could see that the amounts owed by third-party payors and patients were not well segregated. So the first challenge was to put all the amounts owed by third-party payors into one easily identifiable basket and the amounts owed by patients into another. Then, certain staff were assigned to focus on collecting from third-party payors while others focused on collecting patient-owed amounts.

Collecting from Third-party Payors: If It's Owed, Why Is It Not Being Paid?

To pursue the amounts owed by the third-party payors, the practice first had to understand the payment terms and conditions of each contract. What did each say about timely payment of clean claims? And what did the state's prompt payment statute say about timely payment and penalties, if any, associated with a payor's non-compliance with the statute?

If contracts stipulated that clean claims would be paid within 30 or 60 days, why were so many of this practice's claims not being paid in a timely manner? Digging into the files, we found that, in some cases, claims had been kicked back to the practice with a specific request for more information but then had not immediately been resubmitted. With no response sent back to the payor, the amounts owed on such claims would move from the 60-day to 90-day bucket and beyond. Incredibly, no one followed up on these kicked-back claims, and no one seemed to notice that no follow-up was being conducted. And so claims needing reworking sat on or in someone's desk and just kept aging.

To discover this and describe it as disheartening would be putting it mildly, but at least a piece of the puzzle was revealed. Staff needed training not

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only in proper billing and coding but also in how to collect up-front and then in how to follow up when timely payment was not forthcoming.

So, a staff person was charged with overall responsibility for cleaning up the payor A/R mess and "riding herd" on other staffers in the department. We looked at how much was owed by each payor and for how long. We looked at the amounts owed by claim. If a payor owed $1,000 for one surgery and that amount was in the 120-day bucket, then efforts to collect on that one claim deserved more decisive, immediate attention as success would result in a better return on time and resource investment than trying to chase and collect 20 disparate claims worth $50-$60 each.

Staff working the payor A/R were told to push, push, push for payment on these big-ticket claims.

Now, this is certainly not to say that the staff could ignore the smaller dollar claims but, rather, they first were to go after the big dollar, older tickets that contractually were owed by the third-party payors and for which there seemed no good reason to remain unpaid.

Phone calls went out to ask "Why has this claim #ABCDE not been paid? It was submitted 120 days ago—now well past the timely payment terms of section XYZ of our contract and the requirements of this state's prompt payment statute."

Staff working the payor A/R were told to push, push, push for payment on these big-ticket claims. If phone calls were unsuccessful or if nobody in the claims department could be reached by phone, then follow-up letters were sent and copied to the claims department manager and to the state regulatory department that held authority over the third-party payor.

Did this effort result in every well-aged, big-dollar claim immediately being paid? Of course not, but the efforts did reduce the amount of outrageously aged third-party A/R and put the payors on notice that going forward, A/R aged beyond contractually allowed limits would not be tolerated. At the same time, it refocused the billing staff's efforts on getting every claim documented properly the first time.

Here is where today more than ever a clearinghouse can provide great assistance in identifying why claims are being rejected, and in providing staff with updated information so that payor policy changes result in fewer surprises. Still, we know that some payors will kick back a claim for the most inane reasons, and billers may have been 100% accurate the first time, yet claims will be sent back for reprocessing and refiling. But we're looking for ways to reduce reworking the work already done.

We found, in other cases, that some claims had not been sent back to the practice for reprocessing. They simply had not been paid and the payor apparently was all too happy that nobody from the practice was doggedly following up to pursue the money. It's a sad reality that some third-party payors seem to ignore their contractual responsibilities until a practice screams loud enough. Perhaps the payor has a closely held secret that every nth claim will be set aside for a while? Perhaps it will quickly pay a batch of small-dollar claims to make it appear as if it's meeting contractual obligations while at the same time holding onto big-dollar claims past the contractually required payment timeframe? There can be a multitude of reasons, any of which make it more tedious to get monies owed into the practice's bank account.

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We found that some claims had been rejected as "not a covered service." On occasion this determination certainly seemed dubious and should have resulted in an immediate inquiry from the practice when it appeared that a plan's benefits and claims databases might not be in sync. Or, perhaps, a plan that supposedly was following Medicare guidelines was not when it came to paying for certain benefits on its Medicare Advantage Members.

There were instances that when upon receiving a legitimately rejected claim (e.g., on a service accurately rejected as non-covered), staff had not immediately then switched focus to pursue the patient for payment. Why not? There were no acceptable answers. There was only the shocking reality of ignored, aging patient debt.

Collecting Patient-owed Amounts from Very Aged Accounts (aka Chasing Shadows)

We all understand today's reality of high deductible plans. Patients who taste the sweetness of lower monthly premiums

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suddenly are confronted with the bitterness of high dollar deductibles that must be met before their plans assume any financial responsibility. If staff is not collecting some meaningful amount up-front, particularly on surgeries, the chances of collecting after the fact are decidedly slim and grow slimmer as the days pass.

For this practice, it was not necessarily the problem of so many of today's patients suddenly confronted by financial nightmares after being sold a bill of goods by the healthplans they chose. Rather, it was a matter of the practice not having a policy of collecting something meaningful from the patient at the time of service. Instead, far too many patients were allowed to leave the office saying, "Bill me. I didn't bring my checkbook today." And an unfortunate number of practices continue to allow this today.

So a lot of money walked out the door never to be collected, or collected very late and only in part. At this practice, most patient-owed amounts were not in the thousands of dollars as they were with some of the payor-owed balances. Instead, there were just an extraordinary number of relatively small dollar amounts owed for a considerable time. The unfocused A/R staff seemed to be spending most of its time working the newer and relatively easier-to-collect 30- and 60-day buckets, rather than trying to clean up some of the very aged and considerable dollar mess that nobody had bothered with for so long.

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Too often, after sending a couple of bills or making a phone call without achieving success, an account was put aside and forgotten, moving then inexorably to the 120, 150, and 180+ day columns. Periodic review of aging A/R certainly should have set off alarm bells that these harder-to-collect sums were growing increasingly less likely to be collectable as patients who failed to pay on the day of service ignored their financial responsibilities. These folks were not likely to call the practice out of the blue and ask "How much do I owe and where should I mail the check?"

Given that state prompt payment laws apply only to amounts owed by payors, not to amounts owed by patients, in too many cases trying to collect from those who did not pay anything up front and then ignored early collection accounts amounted to chasing shadows. The monies had been owed and requests for payment ignored for so long that it was time to consider turning over the accounts to a collection agency, or to follow the accountant/CPA's advice on how to make the best of a bad situation by advantageously (if possible) writing off certain bad debt.

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With Time Things Did Get Better

It took a while but things did get considerably better. Aging A/R was reduced and cash flow improved. Collecting from more patients up front helped reduce amounts in the 30- and 60-day buckets and allowed staff more time to pursue and reduce those aged patient-owed amounts still on the books from so far in the past. Having a staff person dedicated to and experienced in dealing (battling) with third-party payors helped to reduce collection time on the bigger-dollar surgical claims and the third-party claims in general that are so critical to a practice's cash flow.

So, These Tips Are Recommended for All Practices

1) Segregate patient-owed A/R from payor-owed A/R,

2) Have at least one A/R staff person well-versed in dealing with third-party payors,

3) Collect, collect, collect up front some significant portion of patient-owed amounts (and consider rescheduling those who "forgot" their checkbooks),

4) Have an alarm system in place that alerts when A/R accounts go past 60 days,

5) Have a written policy in place for writing off uncollectable amounts/bad debt (flag the "flakes" and be wary of booking any new appointments with them until outstanding debt is paid or scheduled for payment),

6) Have a written policy in place for writing off uncollectable amounts based on documented financial hardship.

If your practice is going to provide care for free, then make sure that charity work is by your choice—not the patient's and not any third-party payor's. ●