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Three Steps for Improving Your AR: Restore profitability to your practice.

By Ron McLauglin September 6, 2010

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Medical billing and processing insurance claims have garnered much attention lately, prompted in part by physicians' need to collect fees and payment quickly to maintain razor-thin margins. Fueling this focus on a more intense level is a report from the American Medical Association (AMA) released this summer.

The key finding of the AMA's 2010 National Health Insurer Report Card is that one in five medical claims are processed inaccurately by health insurers. According to the AMA's findings of the nation's participating seven largest commercial health insurers, the health insurance industry as a whole has about an 80% accuracy rate for processing and paying claims. The implications of these findings for the financial health of a physician's practice are varied and significant.

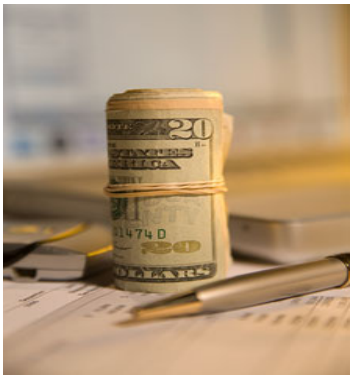
Consider these statistics:

- 1% improvement in claims processing accuracy is equivalent to an estimated savings of $777.6 million in unnecessary administrative cost.
- The healthcare industry spends approximately $210 billion annually on claims processing.
- Physicians spend an equivalent of 5 weeks annually to untangle insurer red tape.
- Physicians spend as much as 14% of their revenue to keep up with the administrative tasks required by health plans and to ensure accurate payments from them.

The systems health insurers use to process and pay claims were measured according to:

- Accuracy
- Denials
- Timeliness

Since denied, rejected, resubmitted and underpaid claims can cost you as much as $100,000 per month, depending on **your practice**, according to the AMA, **every effort you can make to reduce denials, rejections and delays will mean money to your bottom line.**



One effective strategy that may work for many physician practices involves implementing an automatic insurance benefits verification system that is triggered before the patient sets the appointment. Ideally, this the best practice for optimum cash flow.

In many practices, the standard process is to check insurance eligibility when the patient arrives for the appointment. However, this is not the best time to check eligibility because the staff is often very busy working directly with patients in person or on the phone. Additionally, manual verification can take substantial time the office staff needs for other more productive tasks.

Automatic verification will enable your medical billing partner to immediately identify patients who may have changed carriers, have pre-existing exclusions or large deductibles. Plus, this will improve patient relations because your patients will know and be prepared, in advance, for their financial responsibility. Also, you can then immediately collect patient portions at time of service.

All batch verification information is stored in the patient's account, in case there are any disputes later with the insurance company over when, or if, the eligibility verification occurred. When verification is automated, a billing vendor can place a printed notice in a patient file to help busy staff follow up.

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You can significantly reduce overhead with practice automation features such as automatic eligibility verification. Electronic verification can eliminate up to 50% of denials on the spot and save your staff from hours on the phone. This strategy, along with offering a pay by credit card with optional storage of information, will substantially reduce your accounts receivable.

The following case study demonstrates three steps a Chicago area multi-specialty practice took to improve its days in accounts receivable by 34.5%, resulting in improved cash flow:

- Chicago Lake Shore Medical Associates is a multi-specialty physician group with 43 physicians that experienced A/R of 55 days. Initially, the practice was sending out bills once a month rather than weekly. One third of its electronic claims had to be rebilled because of incorrect insurance or incomplete information--primarily due to the office staff scheduling appointments was simply too busy to accurately record information. The hectic pace a front office staff experiences often makes it difficult to verify insurance information and patients themselves can easily be confused by changes in their insurance plan. Once these problems were identified, the following steps were taken to implement and improve Chicago Lake Shore's A/R:

    1. When all patients called for an appointment, the staff booked the appointment, and requested new patients or patients not seen in several months to contact the billing firm's insurance verification department to update their insurance and demographic information. This practice alone decreased rebilling dramatically.

    2. While initially this reduced a lot of the rebilling issues, too many claims were still not billed accurately or in a timely fashion. To improve claims submission, the practice and its billing partner shifted to a batch eligibility verification system that would begin 2 days before each patient appointment. With batch eligibility, a list of all patients and their information is submitted via an electronic file to each insurance carrier for that day. A report is then returned, showing each patient's current coverage and eligibility status. Inaccurate information was immediately corrected or updated in the patient's record and the client and patient were provided with current deductible and coinsurance information along with well coverage information prior to the appointment. This enabled Chicago Lake Shore to reduce incorrect claims submissions by 98%.

    3. Chicago Lake Shore Medical Associates and its medical billing partner also implemented a program to call any patient with a 90-day past due balance prior to their next scheduled appointment to arrange payment options. The physician's office is notified via e-mail if the patient states they will pay at time of service or if the patient is unreachable by phone, a notice with that patient's past due balance is forwarded to the physician's assistant. The doctor's assistant is also notified if the patient promised to pay at time of service.

    4. Finally, patients were given the choice to pay online with the option of storing credit card information to collect deductibles, coinsurance or past due amounts automatically.

The case study reveals that when providers clearly inform patients about their financial obligations in advance, patients are more likely to fulfill their responsibility and profitability or cash flow is more likely to be optimized.