North Carolina Community Health Center Association

Improving Collections In Health Centers

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What Areas of Operations Affect How Much Cash is Generated?

- Collecting Information
- Appointment Scheduling
- Recording Information
- Efficiencies of Staff
- Communication with :
  - Patients (Teaching Compliance)
  - Staff
  - Community
- Patient Experience
- Management Oversight

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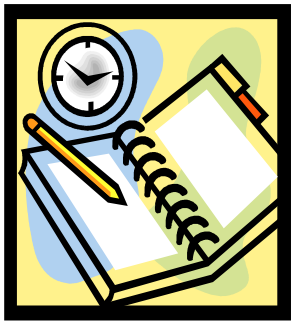
Pre-Visit Activities

Scheduling staff should:

- Remember that new patients consume more registration, financial counseling, health records, and provider staff time than existing patients
- Use telephone calls or postcards to remind patients of appointments
- Confirm patient appointments prior to the visit (e.g., day before)
- Re-schedule cancelled appointment slots immediately



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Pre-Visit Activities (con't)

Scheduling staff should:

- Always consult documentation of chronic "no show" patients before assigning appointment times
- Counsel repeat no-show patients about their history, the preparation required for each visit and, the importance of either keeping or calling to cancel appointments
- Consider double booking chronic "no shows," treating them as walk-ins or appointing them at the end of the day

Pre-Visit Activities

Scheduling staff should:

- In a managed care environment, always ensure that the patient is assigned to your health center. If not, direct them to their designated primary care provider (PCP)

- Identify the need for required pre-authorizations/referrals.
  - Secure them before the appointment date, or
  - Explain to patients how to get them before the appointment date

Pre-Visit Activities

Scheduling staff should:

- Determine the need for financial counseling
  - Continuously remind patients about your collection policy
  - Instruct new uninsured patients that they must bring documentation to qualify for discounted charges
  - Counsel established patients about outstanding balances from prior visit(s)

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Patient Visit Activities

Registration staff should:

- Instruct patients to sign in at the registration desk upon arrival
- Make a copy of each patient's identification and insurance card(s)
- Verify insurance coverage before provider visit on each occasion of service
- Ensure that verified coverage is the primary payer in each patient's financial record
- Always request basic visit fees, co-payments and/or deductibles for the anticipated services/charges consistent with insurance plan and/or health center guidelines, preferably before each visit

Patient Visit Activities

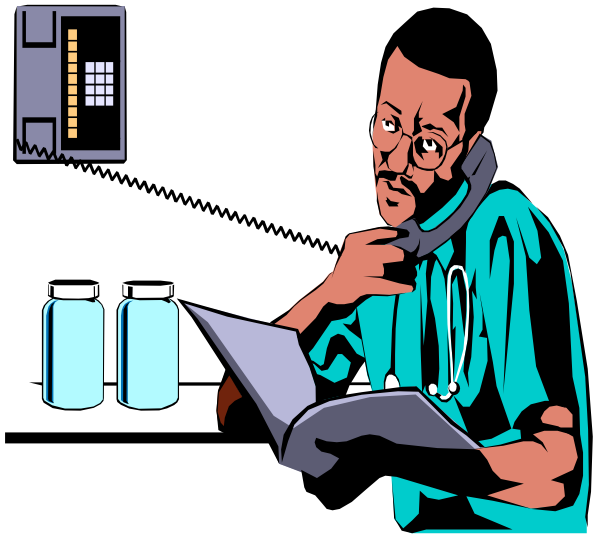
Registration Staff should:

- Review uninsured patients' eligibility for health insurance coverage
- Provide plan enrollment forms and assist with their completion, if necessary
- Direct patients to the local Medicaid or other programs to enroll
- Counsel patients about the plans with which your center participates, especially during open enrollment or mandatory Medicaid managed care enrollment periods
- Refer to on-site Medicaid eligibility workers to expedite coverage determinations

Checklist for Patient Visit Activities

Providers should:

- Complete medical records daily
- Complete any forms required to be returned to Registration/Discharge
- Sign referral requests and other forms needed by the patient



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Patient Visit Activities

Registration/Discharge staff should:

- Review the completed patient record to determine if the rendered service was beyond that originally anticipated and warrants additional patient payment
- Notify the patient of balance, collect any additional fee and issue receipt, as appropriate or
- Inform patient that bill will be mailed and payment is expected prior to or upon next visit

Patient Visit Activities

Registration/Discharge staff should:

- Schedule follow-up visit(s), as specified by the Provider
- Determine if a pre-authorization is needed for the next visit and inform the patient

Post-Visit Activities

Billing/collections staff should:

- Understand payer bill submission requirements and payment timeframes
- Generate claims within 48 hours of the date of service
  - Note: Sample bills should be spot checked periodically for completeness and accuracy
- Submit bills to third party payers, preferably electronically to expedite payment

Post-Visit Activities

Billing/collections staff should:

- Review Remittance Advices within 48 hours of receipt to:
  - Ensure that the payer received all submitted bills
  - Identify pended and denied claims
  - Resubmit bills that did not appear on received Remittance Advices within 48 hours of realization
- Correct and resubmit pended and denied bills within 48 hours of notification

Post-Visit Activities

Billing/collections staff should:

- Generate and submit bills to secondary payers within 48 hours of receiving payment from primary payers
  - Attach a copy of the Explanation of Benefits (EOB) form sent by primary payer

- Conduct periodic reviews of pended and denied bills to identify common underlying operations problems

Post-Visit Activities

Billing/collections staff should:

- Resolve common operational problems causing pended and denied bills:
  - Procedural changes;
  - Provider and Staff re-education;
  - Systems modifications; and/or
  - Payer communications
- Reconcile Remittance Advices to checks within 48 hours of receipt
- Post payments to patient accounts and bill secondary payer, as appropriate, within 48 hours of receipt

Management Responsibilities

- Management must establish billing and collections direction for staff that result in maximization of revenue from all sources
- Management needs Board "sign-off"
- Management sets the tone, so all (CEO with final say-so) must agree on approach
- Management must monitor and oversee activities to assure staff is executing based on the planned approach

Standards for Patient Billing Systems

- Written Policies and Procedures with Board approval (including registration & certification)
- Annual Review and adjustment of fee schedule
- Patient Statements sent monthly
- Staff person to field billing questions
- Installment plan system
- Registration entry data validation
- Patient info verified at each visit
- Providers attend coding workshops
- Billing staff attend coding workshops

Standards for Patient Collections Systems

- Written Policies and Procedures approved by the Board
- Dunning Notices (30,60,90, etc.)
- Staff person designated for collections
- PMS/EMR supports notes on system
- Total balance requested at each visit
- Track % of collections at front desk
- Front desk and billing staff attend collections workshops
- Procedure to restrict services for chronic non-payers

Collecting Patient Accounts

- *Establish Collections System* – a collections system should be established that includes policies and procedures approved by the Board of Directors and should create knowledge within the communities served that the health center expects payment for services rendered.
- This system should be managed by in-house staff and not rely on outside agencies.
- An important component of successful collections systems in health centers is to adopt the policy that if patients ignore all requests for payment or ignore making arrangements for payment, that the health center will restrict services until such time as the patient makes arrangements for payment.
- It should also be noted that by certifying and placing a patient on the sliding fee scale, they have been given a payment status that is based on their ability to pay, and they should pay their part.
- Here are the important component parts of a collection system that must be in-place:

Process for Collecting Patient Accounts

- Must send statements monthly to all patients. Statements should be somewhat easily understood by the reader and have the current month's new charges and any old balances, showing a total amount due the health center.

- Dunning notices should be sent for past due amounts each month. The theme throughout the aging of the account is the request that patients contact the center's financial department and make arrangements for payment.

- If at 120 days past due, the patient hasn't made any effort towards payment or arrangements for payment, a letter should be sent informing the patient that if they do not contact the center's financial department and make arrangements for payment within the next 30 days, their account will be placed on restriction and they'll be asked to find another doctor. A list of these patients should be shared with providers and providers can determine that there are certain patients with chronic conditions that should not have any restrictions placed on their account.

- At 150 days if those patients contacted at 120 days still make no effort to contact the financial department and no effort to make payment arrangements, they should be sent a letter stating that until they make such arrangements, their account will be placed on "restricted status" and they cannot receive services from the health center.

Process for Collecting Patient Accounts

- Restricted accounts' balances should be written off as bad debts at the 150-day mark. Lists or computer flags should be shared with front office personnel and instructions issued to the effect that if a restricted account patient calls for an appointment or presents as a walk-in, they must be told that their status is restricted and that until they receive clearance from the financial department, they cannot be seen at the health center.
- An installment plan system must be established by the health center that allows patients to make payments on at least a monthly basis. There must be a staff person to manage this system and assure that payment plan statements are mailed monthly and notices and phone calls are made for those missing payment due dates.
- Another collections staff person should be hired easily justified by monies now paid to the collection agency.
- Policies and procedures for this system should be in writing, approved by the entire Board of Directors, and the policy should be shared with patients during registration and re-certification of the sliding fee scale, and at visits if needed.

Standards for Claims Billing Systems

- Written Policies and Procedures for Claims billing approved by Board
- File claims electronically
- Daily check of encounter form information and patient insurance status
- Management report of claims filed by payer
- Claims s/b filed daily, weekly, bi-weekly
- Insurance staff attend regular billing trainings provided by payers
- Staff person designated to review and advise others of 3rd party bulletins and correspondence

Standards for Claims Collections Systems

- Dunning notices and f/u with payers on past due claims
- Log denied claims; management report
- Work denied claims by paying payer; prioritize denial codes
- Aged report of outstanding claims
- Staff develops relationship with payers; documentation of calls/contacts
- Denied claims are routinely reviewed with provider staff
- Insurance processing staff attend insurance billing workshops offered by payers

Checklist for Management Activities

Management should:

- Develop and maintain a detailed billing and collections policies and procedures manual that delineates procedural differences for each payer
  - Revise job descriptions, as appropriate
  - Assign responsibility and include a timeframe for completion of each defined task
  - Educate ALL staff about newly defined policies, procedures, job functions, and regulatory changes
  - Monitor staff adherence to newly defined policies and procedures

Checklist for Management Activities

Management should:

- Ensure Registration/Discharge, Billing, and Financial Counseling staff have input in developing/refining policies and procedures
- Ensure that policies and procedures address cash and credit card payments (including physical management and accounting for cash)

Checklist for Management Activities

Management should:

- Establish electronic funds transfer with each payer, whenever possible and/or
- Define procedures to ensure timely bank deposits (i.e., within 24 hours of receipt) and identify the responsible party(ies)
  - Bank deposits should not be made by a staff member who can adjust patient accounts

Checklist for Management Activities

Management should:

- Establish a liaison with each third-party payer
- Conduct periodic (e.g., quarterly) meetings with a provider representative from each major payer to resolve problem bills and payment issues, and clarify regulatory and and claims adjudication changes
- Define the content, format, and production frequency and distribution points of accounts receivable (A/R) management reports (e.g., days in A/R, dollars in A/R)

Checklist for Management Activities

Management should:

- Periodically (e.g., semi-annually) engage a certified coder to review sample health records to ensure adequate documentation and appropriate coding practices
  - This is particularly important for small organizations where providers frequently also perform coding function
  - Educate care providers during orientation and on an ongoing basis

Checklist for Management Activities

Management should:

- Review service charges, procedure codes (e.g. CPT), and staff job descriptions at least annually to determine the need for modifications

- Train staff (i.e., scheduling, registration, care provider, information technology, and billing and collections) about resulting changes

Checklist for Management Activities

Management should:

- Periodically review the physical flow of patients to ensure that registration, financial counseling, and collections activities can be easily and confidentially performed
- Periodically observe waiting room operations to see how established policies and procedures are carried out and can be improved
- Work with registration, financial counseling, care, and collections staff to improve your organization's physical layout

Questions???

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