BUSINESS INSIGHTS
for healthcare professionals
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How to Get Paid What You're Owed

Work with your administrative staff to capture revenue quickly.

Unpaid receivables are growing at an alarming rate. In fact, debt from uncollected patient deductibles runs practices about 18 percent annually—and the default rate for self-insured patients tops 30 percent.

The fact is, these patient accounts cost you, whether you write off the debt or attempt to collect by researching delinquent accounts, making reminder phone calls and mailing statements—all of which require staff time. The key to saving time and money is proactively eliminating or minimizing past-due receivables. These techniques may help you get started.

▶ **Make policies crystal-clear.** Create a new-patient brochure outlining your office payment requirements. Post your policies in the waiting and exam rooms. Then train your staff to firmly but politely request payment at the time of service.

▶ **Verify patients' insurance eligibility.** Reduce denied claims by confirming insurance coverage for every patient, at every visit. See page 4 for ways to make the process easier.

▶ **Confirm financial hardship.** Have patients complete a "financial hardship" form that outlines any special concessions they need and the reasons for them. Those who truly need assistance will fill out the form; those who balk at it (for reasons other than cultural, literacy or language concerns) may not truly require payment help.

▶ **Embrace your role.** As a clinician, your focus should be on the patient's health. Assign financial tasks to the appropriate administrative staff.

▶ **Offer a reminder.** During the scheduling call, remind patients of any outstanding balances. Collect credit card information at this time, too, if possible.

▶ **Take action.** After you've sent three clearly worded reminder notices, take action. Decline to provide additional service until the debt is satisfied. Turn it over to a collection agency. You might even dismiss the patient from your practice.

▶ **Be careful with charitable care.** Offering reduced-fee or pro bono care can lead to unexpected legal risk if you don't pay attention to the details. Waiving copays may violate the terms of your insurance agreement. Without a clear policy for financial-hardship discounts, you could be accused of having changed your "usual and customary fee," which would prompt payers to demand discounts. Document your guidelines, such as providing free care only to uninsured patients below the federal poverty line, and at a sliding fee to those with incomes up to 150 percent of the poverty level. For help in determining income thresholds, visit **census.gov**.

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Simple changes keep patients happy and money flowing

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Make the best use of time to avoid cutting staff

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cash flow options
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5 Tips for **Smarter Scheduling**

If your waiting room looks like a bus station at rush hour, take action.

In today's increasingly consumer-focused delivery model, a timely encounter is a critical driver of patient satisfaction. Botched and bottlenecked appointments are among patients' top-named pet peeves. Here are five ways to work the kinks out of your systems.

1 Get real. The secret to getting your practice running like clockwork is basing your schedule on reality. Look at who your patients are and how you and your staff actually work. Pretending that every patient requires the same 10-minute visit sets you up for failure. Instead of squeezing yourself into the schedule, make the schedule work for you.

2 Start on time. Opening the doors late is the single biggest schedule killer. If you arrive at the office at 9 a.m., greet the staff, check your e-mail and get an update from the nurse, all on your way to your 9 a.m. appointment, you are guaranteed to feel behind in the first hour. Plan to arrive before your first patient, so that by the time that patient is in the exam room, you are ready to go.

3 Work smart. When your front desk schedules appointments, have them send required forms to patients prior to their appointments. Also, ask them to check for future appointments that can be moved up or combined.

4 Process patients quickly. During peak hours, free your front desk staff from phone duty so they can focus on checking patients in as they arrive. Spacing out new patient arrivals will help, too. Those patients who have already filled out their forms (that you mailed them, or that they pulled from your website) can be roomed nearly as soon as they arrive.

5 Make preparation a priority. Train your staff to anticipate needs. Make sure they are prepared with the right equipment and materials on hand.

Meet briefly each morning and afternoon with staff to plan the day. With strategic scheduling, you can keep your schedule full while improving patient satisfaction.

The Rise of the Online Consultation

More than one-third of all healthcare professionals and physicians use e-mail, text messaging and online tools to communicate with their patients, according to a recently released report. Dermatologists lead the pack, followed by oncologists, neurologists, endocrinologists, infectious disease specialists and primary care physicians.

Of course, some physicians have concerns about liability and efficiency. However, the option to receive online consultations and referrals is increasingly attractive to time- or mobility-challenged patients. That's why some insurers have begun paying for online communication between providers and patients. Even in cases where it's not reimbursed, patients seem willing to pay reasonable fees for the convenience.

Under CPT code 99444, online consultations are considered billable when they address a specific problem not associated with a prior visit within the previous seven days. The code should be recorded only once, and the visit must be made part of the patient record.

What's the Right Staff Size For Your Practice?

When times are tight, the temptation is to reduce payroll, invoke a hiring freeze or cut training. Sure, there may be short-term savings associated with these efforts, but the long-term impact can be disastrous. After all, there's still work to be done and the standard of care to uphold.

- **Look at downtime as an opportunity** to take care of larger issues that may help you save money or improve your practice. For example, this is the time to conduct patient satisfaction surveys or poll your referring doctors. You may also put out calls for routine appointments—among all female patients over age 60 who haven't had a recent bone density test, for starters.

- **Cross-train your staff** to perform multiple job functions, or consider allowing two part-time employees who don't need benefits to share a job. Take advantage of the buyer's market (thanks to record unemployment) to invest in an excellent medical coder/biller who can assure faster reimbursements and higher overall revenue for your practice. You might also automate your appointment reminder service to reduce the number of no-shows and free staff to focus on other patient- and revenue-focused opportunities.

Instead of reflexively cutting staff when the economy lags, take a look at your practice's total financial picture. Addressing overhead, reimbursement and patient volume issues may have the same budgetary impact.

As Goes California?

The state of California has introduced rules that, for the first time, establish time standards for delivery of healthcare services. Pundits predict that if this shows promise, similar initiatives could roll out nationwide.

In essence, the state is requiring that HMOs provide access to a general practitioner within 10 business days of a patient requesting an appointment (48 hours for urgent needs), and access to a specialist within two weeks.

Furthermore, providers must return a patient's call for treatment within 30 minutes and be available 24 hours a day.

Health Reform Hints

Now that the bruising debate over healthcare reform has ended and the Patient Protection and Affordable Healthcare Act is law, the head scratching begins. Your patients will undoubtedly have questions for you and your staff about how they will be affected.

You can have the answers at hand with a "cheat sheet" for your patients drawn from resources online. Most lists identify about 10 things that are important to pass along to your patients—from coverage for children and pre-existing conditions, to flexible spending accounts and Medicare reimbursements. Just type "what does healthcare reform mean to me" into Google, Bing or your search engine of choice and you'll find results from reputable organizations and media outlets at the top of the list.

Verify Eligibility Upfront

Asking for an insurance card is the first step, but get more information to be on the safe side.

Coverage-related (eligibility) denials cost your practice more and typically occur more frequently, than other denials. They also affect entire claims rather than specific charges and take longer to resolve. In addition, the rise in consumer-directed insurance plans and the increasing variety of copay levels make it critical to sort out the patient's payment responsibility.

To reduce the number of denied claims, be sure your administrative staff confirm eligibility for every patient visit. This includes:

- Determining whether the patient has health coverage.
- Determining the patient's specific benefits.
- Confirming that the patient's benefits cover typical treatments.
- Checking the current status of the patient's deductible.
- Verifying the copay or coinsurance the patient must pay you.

Check the status of patients whose insurance offers the highest risk of denial and the longest payment cycle first, those with moderate risks next and those with low risks last, as outlined here:

- **Medicaid plans** have the longest cycle time. The most accurate way to verify eligibility is to check on the day of the appointment—in some states, that can be done up to midnight.
- **Commercial payers** (such as Blue Cross Blue Shield plans) require the most verification for specific services. These payers sometimes impose referral or authorization requirements for particular types of services, or may specify service limitations such as the number of allowed visits, PCP requirements and visit frequency.
- **Medicare plans** have historically denied at a relatively low rate. However, Medicare computer systems require that a patient's identifying information (name, date of birth and member ID) match their files exactly. Mismatches trigger denials.

Tap Into Technology

Manually verifying insurance eligibility can be time-consuming and costly. So embrace automation whenever possible. For example, many practice management programs offer "e-Eligibility" functions that pre-check insurance eligibility. Developers like HealthFusion and MedCurrent have embedded insurance eligibility verification functionality or offer it as an add-on module.

In addition, more third-party payers are offering Web-based tools to enable real-time insurance verification for their members.

Ask the Right Questions

Finally, it may be time to update the standard question, "Has anything changed?" Instead, simply ask, "Has your insurance or employer changed?" Or, "What insurance do you have, and who is your employer?"

The Bottom Line

Coverage-related denials are extremely costly—and highly preventable. Take the time to develop sound processes for verifying patient eligibility before you render care.

▶ **For more:** Listen to the replay of our webinar "Verifying Patient Eligibility: How to Accelerate the Check-in Process and Receive Payments Faster" at pnc.com/hcprofessionals.

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