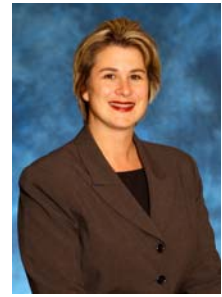




MAXIMIZE YOUR REVENUE CYCLE BY IMPROVING YOUR CHARGE CAPTURE AND BILLING PROCESSES



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Healthcare practices lose money daily from insufficient charge capture and billing processes. Even if you are satisfied with your accounts receivable indicators, a review of these processes can uncover deficiencies in your practice. Simple, yet effective, changes to your current operations can have a significant impact on your bottom line.

CHARGE CAPTURE

It may be obvious that physicians need to bill for services rendered. Yet, healthcare practices lose thousands of dollars yearly simply because physicians do not submit the correct information on the services provided to patients. Due to their busy schedule, physicians forget to report the proper level of service, provide the wrong diagnosis codes or fail to submit the billing information all together. Steps to improve charge capture can include:

- Supply each physician with a charge capture form or system. A 3 x 5 note pad can be used or, another popular alternative is a Personal Digital Assistant (PDA) with charge capture software, such as PracticeValue or e/MD2.
- Include all of the information billers need, such as the patient's name, diagnosis code, secondary patient identifier (date of birth or social security number), CPT code (include a list for the physician to choose from), time and date of service, name of the referring physician, patient's location (office or hospital room), coding review checklist, information on additional services or tests provided.
- Encourage physicians to make notes after each patient visit and submit their charge capture information on a daily basis.
- Establish an internal procedure of numbering all encounter forms and check at the end of each day to ensure that there is an encounter form for each patient.
- Have your billing staff call the hospital daily to ask about admissions or connect to the hospital's computer system to download information on newly admitted patients.

BILLING PROCESSES

Effective billing procedures start when a patient schedules an appointment. Set the tone by advising the patient about your payment policies before they visit your office, and then again when they arrive. Be sure to:

- Establish an expectation that billing and collections are important.
- Capture and verify information on patient demographics, insurance coverage and benefits eligibility.
- Review the patient's financial responsibility before and at the time of service (co-payment, coinsurance, deductible).
- Inform the patient before the appointment if the services are not covered and that payment is expected.

- Include information on your payment policy in your appointment reminder call.
- Require each patient to pay their co-payment, coinsurance or deductible before services are rendered. Collect at least a portion of the bill from self-paid patients.
- Accept all forms of payment.

INSURANCE REIMBURSEMENT AND CLAIMS SUBMISSION

Timely submission of accurately coded patient charges to insurance companies can have a significant impact on your practice's cash flow. Be sure to:

- Provide ongoing training to your staff in procedure and diagnosis coding.
- Read all of your carriers' bulletins for updates to submission requirements.
- Post all charges within 48 hours for inpatient services and within 24 hours for outpatient services.
- Submit claims electronically on a daily basis.
- Analyze errors reports from claims not successfully transmitted.
- Review underpayments and denials from insurance carriers regarding coding issues, such as bundling and downcoding, within five business days. Resubmit or appeal claims with a letter of explanation and supporting documentation.
- Key payments within two business days.
- Make deposits daily.
- Process overpayments within 60 days or according to the relevant carrier or state regulation. If refunds become overwhelming, review a sample of the accounts to determine if there is a payment posting problem.
- Run a report weekly of all unpaid claims more than 45 to 60 days overdue. Review the status of these claims online.
- Use technology to avoid manual posting processes.
- As claims are paid, transfer any appropriate balances to the patient and bill within 30 days.

PATIENT COLLECTIONS

Whenever possible, patient collections should be managed at the front office. This will decrease the billing office's workload and allow them to focus on insurance receivables. When billing patients:

- Send a series of billing statements.
- Call the patient or follow-up with a letter after two or three statements are sent.
- If payment is not made within 15 days, send a final letter with a payment deadline.
- Send the account to a collection agency if payment is not made.
- Measure the effectiveness of your collections process on a quarterly basis.
- Work statements returned with bad addresses or outdated insurance information and enter this information into the patient's account and reprocess the claim.



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BAD DEBT

Bad debt is uncollected payments from patients or insurance carriers. Establish write off codes so that you can track the reasons for non payment. If you use a collection agency, write off the amount due when the account is sent to the agency. You can then reverse the transaction if the agency is successful in getting the payment. Make sure you:

- Evaluate accounts before they are written off.
- Track and monitor bad debt.
- Post payments that are received on bad debt accounts.
- Manage your bad debt so that you can focus on active accounts.

For further information on how you can maximize your revenue cycle by making improvements to your charge capture and billing processes, contact Deborah Mathis at 732-349-6880 ext. 114 or dmathis@cowangunteski.com.



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