Insurance 102: Accounts Receivable Management

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Course Objectives

- Understanding the Fundamentals of Accounts Receivables
- Utilizing an Insurance Coordinator
- Understanding Payment Policy
- Understanding Collection Policy

Fundamentals of Accounts Receivable

What is the Definition of Account Receivables?

The amounts owed to the practice by patients, vision plans or insurance which also includes the length of time the amounts have been outstanding or unpaid. The standard categories for this type of report are:

Current -	**DUE IMMEDIATELY**
1-30 days -	**DUE WITHIN THE NEXT 30 DAYS**
31-60 days -	**A MONTH OVERDUE**
61-90 days -	**2 MONTHS OVERDUE**
91 and over -	**MORE THAN 2 MONTHS OVERDUE**

Why Do Practices Fail at Managing their Account Receivable?

Why Practices Fail

- ✓ No formal insurance process in place to begin with
- ✓ Under utilization of software functionality
- ✓ Responsibility not clearly defined or assigned to anyone
- ✓ Lack of education and knowledge of the plans
- ✓ Inadequate training
- ✓ *No Insurance Manual*
- ✓ Poor verification processes in place
- ✓ Poor financial management processes overall
- ✓ Focusing on Adjusted Gross rather than Receipts
- ✓ FEAR

How do we evaluate and manage the data?

Best Practices

1. Insurance Coordinator to run **Accounts Receivable** reports weekly
2. Utilize clearinghouse dashboard
3. Incorporate scrubs tracking
4. Run **Outstanding Authorization** reports for VSP, EyeMed etc.

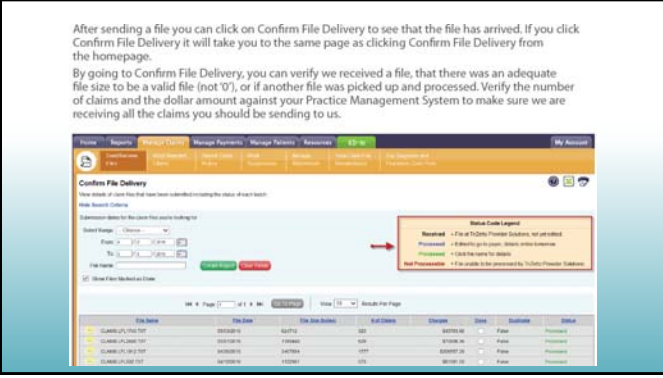
Accounts Receivable Reports

What Account Receivable reports do we need to evaluate regularly?

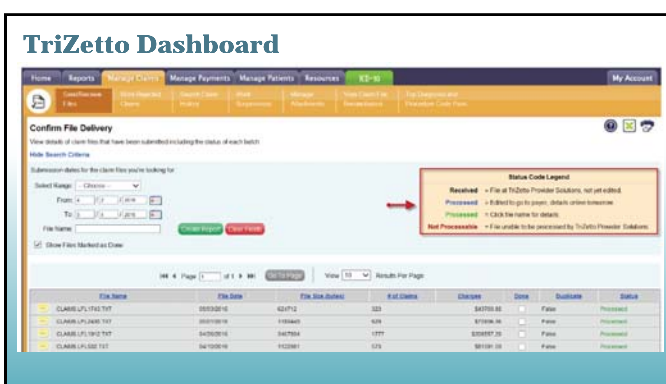
Accounts Receivable Reports

- **Accounts Receivable Patient Aging Summary** – reports outstanding patient balances only
- **Accounts Receivable Insurance Aging Summary** – reports breakdown of the amounts owed by a third party
- **Accounts Receivable by Provider** – Reports amounts owed to the organization by the provider from the invoice level
- **Accounts Receivable Invoice Detail** – Reports breakdown of the office AR down to the individual invoice level for each patient for both patient and insurance balances

Where to pull data for Aging Accounts Receivable reports?


After sending a file you can click on Confirm File Delivery to see that the file has arrived. If you click Confirm File Delivery it will take you to the same page as clicking Confirm File Delivery from the homepage.
By going to Confirm File Delivery, you can verify we received a file, that there was an adequate file size to be a valid file (not '0'), or if another file was picked up and processed. Verify the number of claims and the dollar amount against your Practice Management System to make sure we are receiving all the claims you should be sending to us.

Clearinghouse Dashboard

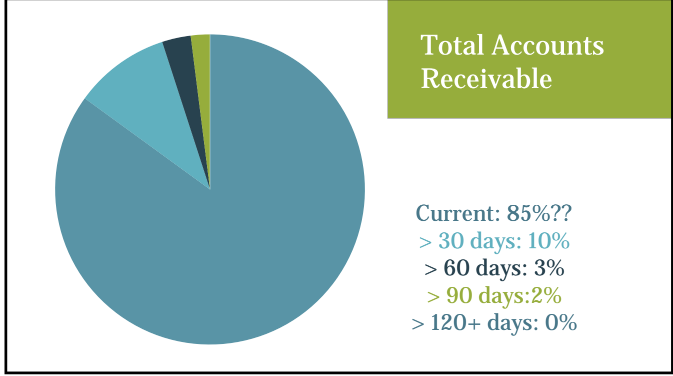

TriZetto Dashboard
Confirm File Delivery
Status Code Legend

Accounts Receivable Benchmarks

Total Accounts Receivable =
Current / 30 /60 / 90+
as well as Both Patient and
Insurance balances

Average of 3 months gross revenue:
(1 month+2 month+3 month)/3

How much aged cash should be setting
in Current, 30, 60, 90+?



Aging Value

Decrease in Value as Receivables Age	
Age	Value
Current	90-95%
>30 days	70-85%
> 60 days	60-75%
> 90 days	15-50%

How many offices have a designated Insurance Coordinator?

Utilizing an Insurance Coordinator

Characteristics of an Insurance Coordinator

Insurance Coordinator:

1. Detail oriented
2. Time management skills
3. Drive
4. Accountability
5. Consistency
6. Analytical problem solver
7. Embraces Challenge
8. Self Starter

Management Plan

Expectations and Goals	Training	Follow Up	Accountability
• Behavioral expectations: Number of hours spent, when, and where • Use of technology to optimize results • Monthly collections goals based on benchmark	• Insurance Manual • Practice Management software • Clearinghouse dashboard	• Daily reconciliation of all patient filings • Biweekly: problem claims 60+ days • Comprehensive follow up report for monthly meeting review • Monthly AR meeting with Office Manager and Doctor	• Positive reinforcement • Realign expectations, if not met • Cash is King!

Time Study

1. 8 to 10 minutes to process one insurance claim from posting to reconciliation
2. 2 minutes on the posting side
3. 6 to 8 minutes on the reconciling side
4. Example: 500 claims per month, would equate to 83 hours on billing and insurance per month - 21 hours per week

When do you post?

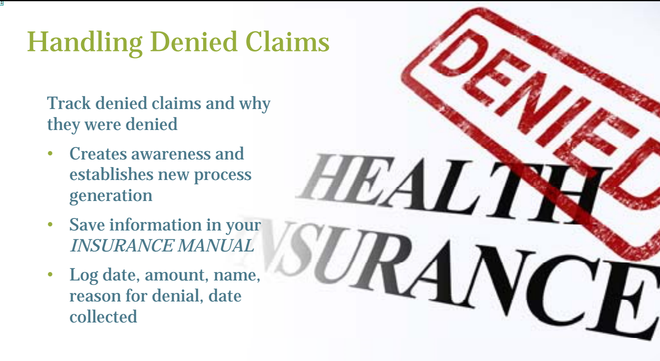
Best Practices

- All charges for the day *must be* posted to current day.
- Scrubbed, batched, and submitted within the date of service or purchase.
- All posting, reconciliation, write-offs, corrections, adjustments, etc., should be dated on the day they are actually done, even if the date of service is in the past.
- Reconcile all EOBs that have been received during the previous month by the end of the last day of that month.

Best Practices

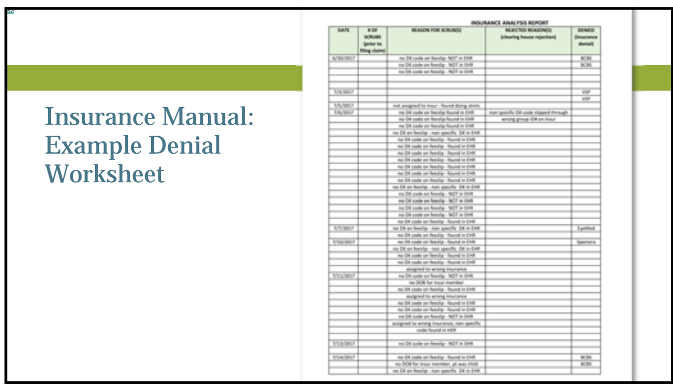
- If any share of cost has been transferred to the patient, a statement should be generated and sent to the patient as soon as reconciliation has been completed.
- Biweekly and/or monthly patient balance statements at minimum.
- To understand time allocation and efficiency, monitor the time it takes for each claim to process completely
- Work backwards on aging claims (start w/90-120).
- When making calls to payors, make sure to address all outstanding claims for the respective company at that time.

How do you handle denied claims?



Handling Denied Claims
Track denied claims and why they were denied
• Creates awareness and establishes new process generation
• Save information in your *INSURANCE MANUAL*
• Log date, amount, name, reason for denial, date collected
DENIED
HEALTH
INSURANCE

Performance at a glance.
Click on each tab to see all of your results
OVERVIEW
CLAIMS
TOP REJECTIONS
DAYS TO FILE
REMITS
DENIALS
Practice Performance
Report Card
Your Error Rates
TriZetto Provider Solutions Customers Average Error Rate
View Report
Rejection Percentage



Insurance Manual: Example Denial Worksheet
INSURANCE ANALYSIS REPORT

Understanding your Payment Policy

What are best practices for payment policies?

Payment Policy Best Practices

- 100% owed by patient due at time of service/order
- Fluency in payor processes will improve collection track record
- Collect full amount owed on frame and lenses
- Collect full amount on contacts upon order, even on the phone
- Offer Care Credit – add website here
- HSA/FSA Accounts

Understanding your Collection Policy

What are best practices for collection policy?

Collections

1. First call made following statement receipt
2. Second call when 90 days delinquent
   - Use personal and friendly tone, assume simple oversight was made.
   - Do not place blame.
3. Document all communication
4. Stay consistent to your policy

Script: Patient Collections

Hi, this is Jan from Local Eye Care, Dr. Smith's office. I am calling to ensure you have received your most recent statement.

Our records show the patient balance of $55.03 for your portion of the exam. This will be applied to your deductible.

I can accept a CC payment over the phone today if that's more convenient for you.

Script: Insurance Collections

Hi, this is Jan from Local Eye Care

Our Provider number is 123456

I am waiting for payment on a few outstanding claims

I have received an EOB that read pending. Can you help me with this?

First patient ID XXX-XX-XX

Date of Service; 3-1-16

Case Studies

Case Study: No Statements Sent

Someone in the office realizes that statements haven't been sent for 2 months or more.

What would be the best course of action to solve this issue?

What would you do to resolve this?

1. Establish a protocol for monthly completion
2. Run a report of patients with outstanding balances
3. Prepare training schedule with Insurance Coordinator to educate on how to run the report and prepare statements.
4. Print and send statements – daily, weekly or monthly.

Case Study: Denial of Claims

During January the Insurance Coordinate notices that there is an increase in insurance claim denials.

What would be the best course of action to solve this issue?

What would you do to resolve this?

1. Review the denial
2. Determine if insurance company is denying the claim by provider, diagnosis or procedure codes, insurer, or change of information on payor
3. Resubmit if error is evident or contact insurance company
4. Ensure claim is accepted by insurance company within 2-3 days
5. Follow up at 2 weeks to ensure it has been paid, if not call insurance company

Case Study: DMERC

Office has submitted claims to DMERC for an extended period of time but has not been paid.

What would be the best course of action to solve this issue?

What would you do to resolve this?

1. Determine why claim was not paid:
   a. Office is not a provider
   b. Place of service has not been changed – 11 to 12 or 12 to 11
   c. Are surgery dates correct
   d. Was Frame Deluxe used?
2. Pay for a Surety Bond of at least $50,000 per provider
3. Contact Medicare and request additional provider number
   a. Identify the individual within your office that has access to the EDISS Connect account (Doctor). For example, this would be the person responsible for enrolling the office in electronic transactions
   b. Log into EDISS Connect and look for the blue header within the account
   c. Locate the field titled 'SubmitterId' within the blue header
   d. Use the 'SubmitterId' listed when registering for the Noridian Medicare Portal
4. Set up DMERC as an electronic submission in EHR
5. Verify correct information with your clearinghouse
6. Submit a claim, look for acceptance from the payor or follow up

Case Study: Pay-at-time-of-service Policy

Office has not been collecting for services or products at the time of the visit.

What would be the best course of action to solve this issue?

What would you do to resolve this?

1. Establish a payment policy
2. Train all staff
3. Collect 100% of costs associated with visit at time of service

The Equation For Change

Vision	+	Skills	+	Incentive	+	Resource	+	Action Plan	=	Change
X	+	Skills	+	Incentive	+	Resource	+	Action Plan	=	Confusion
Vision	+	X	+	Incentive	+	Resource	+	Action Plan	=	Anxiety
Vision	+	Skills	+	X	+	Resource	+	Action Plan	=	Gradual Change
Vision	+	Skills	+	Incentive	+	X	+	Action Plan	=	Frustration
Vision	+	Skills	+	Incentive	+	Resource	+	X	=	False Start

Homework

1. **Set Expectations and Goals**
   - Analysis number of hours required
   - Utilize technology to optimize results
   - Monthly collections goals based on benchmark
2. **Training**
   - Create and utilize Insurance Manual
   - Utilize Practice Management software reports
   - Utilize Clearinghouse dashboard
3. **Follow Up**
   - Conduct a daily reconciliation of all patient filings
   - Biweekly review of problem claims 60+ days
   - Review comprehensive follow up report monthly
   - Meet monthly with Doctor and Office Manager
4. **Accountability**
   - Realign expectations, if goals not met
   - Cash is King!