Where is Your Practice Losing Money?

by Carol Hoppe, CPC, CCS-P, CPC-I of MedLucid Solutions, LLC

Having done thousands of chart audits, I am still amazed at how many times things are billed incorrectly resulting in lost revenue. It might be just a few dollars here and there, but it quickly adds up to thousands. If you have any type of surgery charges, it adds up even faster! In five years, that could replace the old copier or add an additional staff member to the practice. There are many areas where your practice could be losing money. This month, we will take a look at some of the most common areas.

Uncollected Copays and Outstanding Balances

How much money are you collecting at the front desk? This is a critical part of the job. Front desk staff should be encouraged and incentivized to ask for money and collect it. If they are not comfortable asking for money, they are in the wrong job.

Collecting copays at the time of service is a requirement of your payer contracts. It is not optional. Collecting outstanding balances when the patient is in the office is much more economical than printing and mailing statements, opening and posting mail payments, or chasing down dollars with phone calls, collection letters or a collection agency. The longer the dollar goes uncollected, the less it is worth.

The best way to monitor this is to track and trend the percentage collectable from copays and outstanding balances compared to what is actually collected daily and monthly. Offer movie tickets to the person who collects the highest percentage each month or throw a pizza party for the front office if they reach percentage goals.

Missed Appointments

The practice only makes money when physicians see patients. They do not get paid for dictating or doing paperwork. If there are holes in the schedule, there is lost opportunity to generate revenue. No-shows and last minute cancellations can cost the practice hundreds or even thousands of dollars each week when the physician(s) could be seeing other patients.

Although time-consuming to do manually, reminder calls can save significant dollars throughout the year. Automated patient reminder calls, emails or text messages are readily available at a very reasonable cost from companies who offer this service. When you consider the number of missed appointments and the average revenue generated per patient visit, it is evident you cannot afford to leave things to chance especially when appointments are booked many months in advance. Offices need to be proactive, not reactive when it comes to missed appointments.

Non-covered or Unauthorized Services

There is no excuse for denials due to non-covered or unauthorized services in today's healthcare environment. Many of the larger payers have online prior authorization tools available; there is no more waiting on hold for someone to answer your phone call. Urgent and emergency services can normally be authorized within 24 to 48 hours of providing care. Any time there is a reason to believe Medicare may not cover a service due to frequency or non-covered diagnosis, Medicare beneficiaries should be asked to sign an Advanced Beneficiary Notice (ABN) making the patient responsible in the event the claim gets denied. This is good practice to do for all patients with a form similar to Medicare's ABN. Seeking authorization for things like surgical procedures and psychiatric services should be a routine part of scheduling.

Missed Charges

It is so easy to miss charges because of the constant interruptions that invade our space these days. Posting charges should be done in silence; but does such a place even exist anymore? I usually find at least one missed charge in every 10 to 20 charts that I audit. Sometimes it is a data entry error and sometimes it is a lab, venipuncture, vaccine administration or procedure that did not get marked on the charge ticket by the clinical staff or physician.

How many times do you draw blood, give vaccines and therapeutic injections, do EKGs or take x-rays in your office and never bill for them? They do not usually represent a lot of money individually, but are still worth a minimal amount of time and effort to capture the charges and recover some of the expense involved.

There are multiple ways to catch these errors:

1) Balance to "hash" totals. After posting charges, add up the CPT codes from each charge ticket (Example: 99213 + 99215 + 99204 + 36415 + 11700 + 99024 = 444,771). A good revenue management system will give you hash totals on your daily balancing report or some other report in the system. Ask your software company how to find this information. The beauty of balancing to hash totals is that if you do not balance, the difference between the two numbers should be the total of one or two CPT codes that you missed. From the previous example, if the report said 481,186 and you subtract 444,771, you know you have missed a 36415 somewhere. You can go through the charge tickets quickly and locate the one that was missed.
2) Reconcile the number of lab orders to venipuncture charges posted. If you submit 12 samples to the lab on Monday, you should have 12 units of 36415 billed that day.

Compare test results to patient billing and make sure you have a charge for every result.

3) Track hospital visits by putting patients on the schedule when the hospital calls for a consult and monitor hospital visits until the patient is discharged. Provide physicians with a pad of forms for tracking hospital visits with appropriate codes to choose from and collect them weekly.
4) Put surgeries on the schedule and track surgery schedules to charges billed. Run reports weekly to make sure physicians are turning in their surgery charges and follow up until you get them.

Not Balancing Daily and Reconciling at Month-End

It might seem overwhelming, but balancing charges, payments and adjustments daily is a key to monitoring the success of a practice. There are lots of reasons to do this, such as discouraging employee theft, minimizing lost charges and avoiding inappropriate write-offs. But in order to manage and ensure the success of your practice, you need to be able to monitor and evaluate what is going on from month to month. Why are charges down this month? Did the physician take a vacation? Have they turned in all their charges? Or is there a stack of claims that did not get entered into the system, because they are buried under a pile on the biller's desk? Why are payments down? Is it one payer or across the board? There are many reasons why payments can be low and you have to be able to look at trends over a period of months and years to see what is truly going on.

How would you know if your A/R is accurate if you are not reconciling YTD charges to payments received, adjustments taken and charges posted each month? Billers complain when they are not used to balancing adjustments. In one audit, I found a patient's copay written off and a non-paid surgery charge written off by mistake while posting insurance payments. There was no documentation in the day's batch to support the adjustments taken on several accounts sent to collections, but one account still had insurance payments pending.

It is a FACT: We are human; therefore, we make errors. They do not have to be intentional, they just happen. We get tired, the numbers are starting to blur on the screen, and we get a phone call from an irate patient who really ticks us off. It takes ten minutes to calm down and refocus. By then we cannot remember if we were done with the patient on the posting screen or not. Things like this happen all the time in a billing office. We have to check our work and balance every day.

Working Your A/R

Following up on A/R is an absolute necessity. I am surprised when people think that just because you submit a bill for payment, you automatically get paid and paid correctly. There is nothing further from the truth! Having a documented and well-executed follow-up plan for your A/R is one of the most important functions of the billing office. Goals should be established and monitored for the average number of days in A/R, percentage of A/R over 90 days, and percentage of bad debt written off each month.

First of all, do not delay. Most states have a prompt pay law that requires insurance companies to reimburse for a "clean claim" or provide notification of non-payment within a maximum of 45 days, some as few as 30 days for electronic claims. Each state is different so check with the Department of Insurance in your state. With Medicare's 14-day payment response, A/R follow-up should begin anywhere from 15 to 30 days of claim submission.

Follow claim processing electronically via payer websites or cumulatively at payer sponsored locations like Availity.com. Do not simply resubmit unpaid claims with the hope of reimbursement if the payer has already received the claim. This results in unnecessary denials and delayed efforts sorting through the zero-pay EOBs. Medicare tracks the number of duplicate claims that are submitted and will notify you to stop if you habitually resubmit.

Find out what is holding up any unpaid claims and get the issue(s) resolved. Document all phone calls, instructions given, and actions taken. Mark for follow-up in another two to three weeks or whenever payment is expected. If you have a good tracking system in your revenue management software, the claim will not reappear for follow-up if it has been paid appropriately and timely.

Finally, do not hesitate to get help. If you have done due diligence, made reasonable attempts to collect without success and feel you are getting the runaround, contact your state's Department of Insurance (DOI) and file a formal complaint. They will contact the insurance carrier and, under most circumstances, you can be assured of prompt payment.

Make sure you file a separate complaint for each patient or claim. Each complaint counts as one. If ten practices complain about a particular issue with one complaint each, that counts as ten complaints regardless of how many claims are involved. If those same ten practices submit 12 complaints of inappropriately denied or unpaid claims, the DOI now has 120 complaints. This has far greater significance and warrants more attention. Payers do not like to be reported to the DOI and will act promptly to resolve any issues identified by the DOI.

Incorrect Payments

Just because you get paid, does not mean you were paid correctly. Remember that in most cases, claims are processed and paid electronically based on algorithms and edits set up by the payers. How many times have you heard a payer say they had a "computer glitch"? How do you think they found out they had a "glitch"? It takes people like you monitoring claim payments to find errors in payment and report them. The best way of doing this is to have your top ten payer fee schedules loaded into the revenue management system so you can run reports on payments that do not match the expected amount. Always take into consideration multiple procedure payment rules where secondary or bilateral procedures are paid at 50%, but for the most part you should be paid at 100% of your contracted fee schedule. A $2 or $3 difference might not seem worth the effort, but multiply that times the number of times you bill that code each month and see how quickly it adds up.

Also, pay attention to payer newsletters and monitor their websites for information on where claims were paid or denied inappropriately and they have fixed the error. Sometimes they will reprocess all of the claims on file where that error was made, but more often they ask the providers to resubmit those claims. This means if you did not know you were paid in error, you will not get paid correctly. I have seen examples where a payer referred back to an error in payment that occurred three years prior. Many providers do not even have data that goes back that far if they purchased a new revenue management system recently or archived old data.

Likewise, remember that just because you got paid, it does not mean you coded it correctly. Again, a computer is processing claims based on how it has been programmed. If you add a modifier just to get something paid but it is inappropriately used, this is considered fraud. If you receive a duplicate payment or are overpaid because two payers both paid as primary, you are obligated to return the payment or refund the appropriate payer(s). Keeping money that does not belong to you is also considered fraud. Medicare requires that all overpayments be refunded to the carrier or patient, if appropriate, within 30 days. Failure to refund could result in severe consequences, including recoupment with interest, additional fines and even jail time.

Lack of Appeals

The opposite of overpayment is no payment at all. Few people ever appeal unpaid or incorrectly paid claims. Medicare recently provided statistics on appealed claims under its Recovery Audit (RAC) program. For FY 2011, the number of claims with over-payment determinations equaled 903,372. Of that number, only 6.6% were appealed, and of that number, 24,548 claims or 43.4% were reversed with a decision in the provider's favor resulting in $37.9 million in overturned appeals (Medicare Fee-for-

Service Recovery Audit Program Appeals Update, 2012). Imagine what that number would look like if more people appealed. Instead most people assumed that the recoupment was legitimate and let that money slip right through their fingers.

Unauthorized Write-offs

The other loss of revenue that astounds me is the number of employees who are authorized or simply have access to write off unpaid charges. It is one of the questions I ask every time I do a practice assessment. Most people tell me that their front office or clinical staff does not know how to do anything on the financial side – all they know how to do is schedule appointments. Even in the billing office, billers and coders have carte blanche ability to write off anything they want. The question nobody can answer is "How often does someone write off a friend or family member's copay or outstanding balance? How often does a person posting insurance payments accept the payment as correctly paid-in-full and write off the remainder owed by the patient? How often does an A/R specialist look at a claim denial and decide it is not worth appealing? These questions, and others, give reason to believe that practices and hospitals are writing off millions of dollars inappropriately. They do not even know why because they are not tracking denials or adjustments. Everything gets lumped under "insurance adjustment". Best practice is to have a manager review all claim denials once they have been worked and post those write-offs with specific denial codes. The practice should have a written policy that describes how much a biller can write off without approval, when a patient balance gets sent to collections, when a physician decides what gets written off and when someone other than the physician needs to approve write-offs.

Conclusion

If you are not doing these things now, you will be amazed at how frequently revenue is being lost every day. Multiply that by weeks, months and years to forecast what has been lost and, more importantly, what you can expect future revenues to look like with these processes in place. These are just some of the areas where you could be losing money. To find out where your practice is vulnerable, contact Carol Hoppe at (317) 537-7553 or carol@medlucidsolutions.com for a financial assessment of your practice.

References

Medicare Fee-for-Service Recovery Audit Program Appeals Update. (2012, June). Retrieved July 24, 2012, from Center for Medicare and Medicaid Services (CMS): http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/Medicare-FFS-Recovery-Audit-Program-Appeals-Update-June2012.pdf