Improving a Practice’s Receivables Collections

There are many causes, and indicators, of problems in this area. Some offices lack either a defined collection system or their collection duties are delegated among employees. In other practices, collection activities take a back seat to a myriad of other daily office activities. In larger practices, the sheer volume of revenue tends to mask certain collection inefficiencies within the billing and collection department. In other words, when cash flow is good, most offices do not pay much attention to potential problems that might be occurring within the collection department. Here, for your use, is a review of some of the principal causes and actions needed for improved collection performance and cash flow.

Information First!

It is important to remember that accounts receivable management STARTS with information. In other words, a practice must adopt the policy of printing and reviewing accounts receivable aging reports in detail each month. This is the only real way to assess how well the office’s collection efforts are doing. However, many offices have a lax attitude towards this simple issue - even large practices. In addition to the simple aging report, a practice should also print and review an aging by insurance company and, separately, for patient receivables and insurance receivables. Unfortunately, many practices’ computer systems cannot print these specialized reports that are so important to good receivables management. Without good information about a practice’s receivables, it is almost impossible to adequately manage its overdue accounts. You should make sure these reports are being printed and reviewed on a regular basis. Many times one gets so consumed with so many other practice issues that simple basics, such as making sure accounts receivable are not getting out of hand, are ignored.

Patients’ Account Statements

A number of offices do not send out patient statements consistently each month. You can not just assume that the statements are going out. The employee responsible for billing needs to ensure that account statements go out each month to all patients who have balances due. There should not be any exceptions to this rule.

Many practices like to prepare and mail the statements no later than the 25th of every month so that the statements will arrive before the first of the next month, when most patients typically pay their bills. Under no circumstances, however, should the billing employee send the patients’ statements later than the 10th day of the following month. Some surgical practices like to mail patients’ account statements as soon as the patients’ insurance companies have reimbursed the practice. The practice’s collections will improve if the billing employee can send the patients’ account balances as early as possible. In larger practices,
statements usually are sent out weekly in batched cycles. This is done either by the age of the accounts or in cycles using the patients’ last names. For example, balances of patients whose last names end in A through K will be mailed out during the first week of the month.

You might want to recommend that a practice continue to send account statements if a balance is due and even if the patients’ insurance company will pay for the services. Account statements should state clearly that insurance reimbursement is pending. This alerts patients about the billing and what their ultimate liability might be. If there is no mention of the insurance pending, patients might pay the balance and create a problem with multiple credit balances in accounts receivable. You also need to watch for practices that collect reimbursement from a patient’s insurance and write off the remainder of the balance without sending the patient an account statement. The routine writing off of copayments and deductibles is usually considered an illegal practice, especially according to Medicare. The practices should always make an effort to collect these balances, unless the practices can demonstrate a patient’s particular financial hardship.

A question that often gets raised is whether or not a practice should charge some type of finance charge for overdue accounts. The generally answer is no. This is because most state laws state that a person must legally contract (i.e. agree) to pay a finance charge but mainly because finance charges violate most provider agreements with insurance carriers. For example, finance charges violate Medicare law because a doctor would collect more than the “allowable” from the Medicare patient. This applies to both participating and nonparticipating doctors. Also, finance charges likely violate managed care arrangements because most provider contracts state the doctor cannot collect more than the copayment and/or deductible from the patient.

All patients’ statements should include some type of dunning message on them. A dunning message is a short message on the statement, usually at the bottom. For example, “Your insurance is still pending” or “Your account is overdue” are dunning messages. Like collection letters, each message should be tailored to the age of the account. This provides basic communication with patients and it may improve the practice’s collection activity. You need to make sure the practice’s employees know the difference between a dunning message and a collection letter. They are different. Collection letters are considered a much stronger form of account collection; dunning messages are friendly reminder messages.

The office visit collection problem

A major collection-policy goal for a practice should be to collect something from every patient who comes to the office for an appointment, unless payment is not allowed by law. You need to conduct a periodic check of the front-desk collection
activity to determine if the front-desk employee is collecting the necessary monies. Remember: If payment is collected at the front desk, it does not become a receivable!!

**Front-desk collection analysis**

One way you can check the effectiveness of the front desk collection policy is to analyze the percentage of potential office visit payments that are actually paid (at least partially) while patients are in the office. You can do this by using the following process:

1. Select a sample of patients’ office visits, generally covering 20 to 25 separate days.
2. Count all the visits in which patients could have made payments, no matter how small. This includes patients who could have paid in full, made a partial payment, paid their copayment, or paid their deductible. Exclude visits in which the office cannot legally accept payment from the patient (e.g., Medicaid and workers’ compensation).
3. Count the number of visits in which patients actually made payments, regardless of the amount.
4. Divide the number of payments by the number of potential payment situations to compute the percentage of patients who made a payment at the time of their visits.

A practice should be able to collect some form of payment for at least 90 percent of the visits for which a payment can legally be accepted. If your analysis indicates a lower percentage, you should investigate immediately. Find out if the front-desk employee has been properly trained on collections and whether the employee is complying with the office’s collection policy. Keep in mind that some people feel uncomfortable asking patients for payment. Such personnel might not be suited for front desk duties. Keep in mind that service-area politics often dictate the practice’s collection policy. In some communities, especially smaller ones, the standard is to bill a patient’s insurance first before attempting to collect directly from the patient.

**Collection Procedures**

The following is a basic, general procedure used to collect payment from overdue patient accounts in a medical practice.

**Accounts receivable**

Each month, the billing employee should age the accounts receivable to determine the priority for collection. All computerized billing software systems can print a report aging receivables in categories of current, 30 days old, 60 days old, and 90 days old.
Telephone calls and past due notices

Using the accounts receivable aging, the person in the office responsible for collections should make an initial friendly phone call to the patient. Because of personnel shortage, busy schedules, or other reasons, calling all patients sometimes is impractical. If this is the case, you should try setting a limit on the telephone calls. For example, the office policy may be that the collection employee will call patients whose account balances exceed a particular dollar amount. For most practices, the balance is between $200 and $500. However, if the practice is large, you may have to raise the balance limit to make the number of phone calls manageable. You need to also stress the importance of having the front-desk employee collect overdue receivables at the time of a patient’s visit. Because of the time required to collect individual patient accounts (not insurance accounts), the office could increase productivity and cash flow if the front-desk employee collected money on overdue accounts. If a practice is too busy to make telephone calls, the office should send friendly past due notices to patients whose accounts are 30 days delinquent. The collection employee should send past due notices to patients whose insurance has not yet paid, assuming insurance claim forms have been filed. The employee responsible for the practice’s collections needs to document his or her follow-up conversations with the patients either within the medical billing system. This not only documents any promises by the patient, it is also a way to make the collection person accountable for follow-up duties. If this documentation does not exist or is sporadic, it could be because the collection employee is not following up with collection calls. It is very important that you make sure the practice makes its collection employees accountable for their collection efforts. This is one of the best ways to maximize collection activities.

If patients do not respond to the friendly 30-day approach and their accounts become 60 days old, the billing employee should send stronger collection letters. The employee should continue to place collection calls to the patients and to document all conversations. This documentation should be reviewed periodically to assess what patients are saying about not paying their accounts. This way, the practice’s collection policies can be finetuned to improve collection efforts.

After accounts are 90 days old, the practice’s billing employee should begin to work the accounts rigorously. The 90-day and final collection letters should be sent to all patients who have not yet contacted the office about their delinquent accounts. Many practices utilize what is normally called a “ten-day letter.” This letter is automatically sent to all patients who have received three statements; the letter basically tells the patient that:

1. The account is seriously overdue.
2. The practice is understanding and thus is willing to work with the patient to come up with a mutually favorable payment plan.
3. The patient should call the office within ten days to discuss the account; otherwise the office will have to pursue a more serious form of collection effort.

If a patient does not call within the ten-day period, he or she probably is not going to pay the account. In other words, it is a bad debt. The practice may opt to write off bad debts (but only with a physician’s approval) and, if appropriate, turn over the accounts to a collection agency.

Collection agencies

Many practices are reluctant to turn accounts over to a collection agency, perhaps because they fear that the patient may threaten a lawsuit or because the physician is simply uncomfortable about taking this step. Keep in mind that as long as it is doing its job trying to collect overdue accounts in both an efficient and timely manner, patients who do not pay are probably trying to skip out on their bills. Essentially, these people have stolen the office’s services and the office should not feel guilty about resorting to a collection agency.

Many medical offices express a lack of confidence in the agency or agencies they use or have used in the past. The most common cause of such poor results is that accounts are turned over too late to be collected. To obtain the best performance out of a collection agency, the office manager should turn over accounts to the agency when they are 90 days old (or after the ten-day letter has been sent out as discussed earlier). By handing the accounts over in a timely manner, the agency can work on delinquent accounts and the office staff can work on more current accounts. It does not make good collection sense to have employees spend a majority of their time trying to collect accounts that are 90 days old or older. The practice should let someone else do it. Medical practice collections will improve if the majority of time and effort is spent on collecting accounts less than 90 days old.

Other collection options

Some offices utilize three other collection methodologies: small claims court and the collection bureau, and the Internal Revenue Service (IRS). The first option is small claims court. The practice files a lawsuit against the patient for the amount owed. Many physicians do not like to use this approach because they fear this may cause patients to consider some type of malpractice claims against them.

The next collection method is to turn the bad-debt information over to a collection bureau. By doing this, the bad debt goes on the patient’s own credit record. A patient faced with bad credit will often attempt at some point in the future to contact the office regarding settling his or her delinquent account.

Unpaid Insurance Claims
Every week the collection employee should identify unpaid insurance claims that are at least 25 days old. You should be able to print a report that lists these claims. Some billing systems can even print this report by individual payor.

For each claim that is at least 25 days old, the collection employee should place a call to each insurance company. This conversation must always be documented in the computer. The employee should include the name of the contact at the insurance company, why the claim has not been paid, and when payment can be expected. The reason for starting with claims that are 25 days old is because the office must find out as soon as possible whether claim forms even got to the insurance companies and were entered into their computers. A chronic problem for many practices is that insurance companies will say they have no record of receiving claims. By starting with claims that are 25 days old, the collection employee can refile claims early. In addition, the earlier the employee starts the follow-up process, the quicker claims will be paid on balance. A major goal of every medical practice is to obtain payment within 30 days to 45 days for all insurance claim forms filed.