Making A/R results A-OK

A case study of 11 process improvements you can make in your practice

By Chris Plemons, MS, and Doral Davis-Jacobsen, MBA, CMPE

about the authors

Chris Plemons, MS, MGMA member and practice administrator, Greenville (S.C.) Ear Nose and Throat, chrisplemons@greenvilleent.com

Doral Davis-Jacobsen, MBA, CMPE, MGMA member and manager, Physician Services Unit, Dixon Hughes PLLC, Asheville, N.C., ddavis@dixon-hughes.com

At Greenville (S.C.) Ear Nose and Throat, a new accounts receivable (A/R) process gave physicians a 35 percent increase in their compensation in just nine months. Professional revenue increased by 7 percent; expenses from the previous period dropped by $93,745. General overhead went from 54.1 percent of total revenue in 2006 to 46.9 percent in 2007.

A/R in our five-physician practice had suffered insidious woes. Physician compensation had declined from reduced reimbursement and increased expenses. The doctors called for an A/R consultation. Based on data in the Medical Group Management Association (MGMA) *Performance and Practices of Successful Medical Groups Report* and recommendations from a consultant, we added four full-time-equivalent (FTE) employees: two in the front office, one phone triage position and a surgery scheduling employee who focused on collecting surgery deposits.

Improving the bottom line

Over three months, we detailed the reasons accounts ended up in collections by physician and dollar amount and designed a remedy. The physicians agreed to support the administrative team's 11 process improvements.

1. Collect deposits prior to surgery

We hired an employee to collect patients' prepayments on their estimated share of charges.

2. Restructure A/R team by payer

We created ownership of accounts by payer, assigning staff on the basis of complexity and volume.

3. Monitor accounts sent to collections

Focusing on the front end, we accelerated our process for turning accounts over from 180 days to 90 days. Before sending accounts to collections, we review a checklist of necessary tasks, such as verifying Medicaid numbers for retroactive eligibility. We cleaned up our letters and financial policy to reflect our approach and communicated our expectations to patients. Within one year, we decreased accounts sent to collections by 30 percent.

4. Create a financial counselor

We created a position dedicated to helping patients understand their health insurance. We worked with local hospital systems to connect to their "hardship database," which reduces our time to determine patients' eligibility for hardship write-offs. We aim to obtain payment through arrangements acceptable to all parties.

5. Create an A/R audit function

Every day we perform random audits of accounts in A/R over 35 days, capturing results in a spreadsheet. This identifies training opportunities and helps the management team understand the issues.

6. Create meaningful policies and procedures

We involved the individuals responsible for the tasks in developing our A/R guidelines — clarifying what we do and why we do it.

Sample 'report card' for Greenville Ear Nose and Throat

Indicator	Acceptable range*	2006	2007
Gross collections/charges	53%	46%	47% - actual, 50% est. w/o charge increase
Adjusted collections	98%	100%	113%**
Gross days in A/R	43	56	37
Charges, payments and adjustments	relatively consistent trends	relatively consistent trends	relatively consistent trends
A/R aging	18% over 90 days	56% over 90 days	15% over 90 days
Bad debt per MD	$12,000 per FTE† MD / year	$45,000 per FTE MD	$30,000 per FTE MD
A/R per FTE physician	$143,000 per FTE MD / year	$307,000 per FTE MD	$232,805 per FTE MD

*Acceptable range based on MGMA *Cost Survey: 2005 Report Based on 2004 Data*
**Higher-than-normal adjusted collections reflect clean-up of old A/R
†full-time-equivalent

7. Verify eligibility before rendering services

With our clearinghouse, we are working to verify surgical patients' insurance coverage, including deductibles.

8. Collect patient's share of bill at time of service with real-time claim adjudication

We collect co-pays and old balances at the front desk before the visit and the remaining balance at check-out. We ensure that the front desk has the information on balances due and that patients know what they owe *before* they arrive. We track what we collect, keep tabs on unsuccessful collection efforts and share these data with staff.

We implemented real-time claims adjudication by placing an A/R team member in the check-out area to oversee transactions with one of our largest payers. This — and process re-engineering — increased our front-desk collections 52 percent in three months.

9. Monthly meetings with A/R staff

In regular meetings, we review relevant statistics and hear reports from each team member on their payers. Employees have a sense of ownership for their contributions. Managers have a better feel for financial performance relative to each payer.

10. Renegotiate managed care contracts annually

We developed a managed-care contracting strategy to enhance current relationships and address new possibilities. We used historic data and information from the state Department of Insurance to establish our argument relative to fees and language, and structured a plan based on average length of time for negotiations with specific payers.

11. Create metrics understood by all, share results monthly

The table (above) shows the benchmark statistics we review quarterly.

Keys to success

Some physicians, staff and patients resisted these changes, but we succeeded because of:

- Physician buy-in;
- Willing employees;
- Good communication with staff and physicians throughout the process; and
- Commitment of management.

Yes, we increased our staff expenses by adding employees, but our practice has markedly improved performance and profitability.

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- In the *MGMA Store*, enter 6751 in the *Search Products* box for MGMA's *Performance and Practices of Successful Medical Groups: 2007 Report Based on 2006 Data*; 6355 for the Medical Practice Management Body of Knowledge Review Series: Financial Management; 6721 for the MGMA *Cost Survey: 2007 Interactive Report Based on 2006 Data*
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