

FIVE STEPS TO SUCCESSFULLY MANAGING A/R

BY TRACEY ERBERT



Best practices are more important than ever and with many managed care contracts squeezing reimbursement, facilities have to be on top of their A/R game. When thinking back on my career as a business office manager, I have recognized five best practices that have allowed me to succeed for so many years in the ASC industry.

Not much has changed since I started in 1988. The same day-in, day-out events occur, we've just had more added to our plates. It's all about following the five steps.

» **Verify benefits prior to service and contact the patient to be sure they're aware of their financial responsibility.**

Be sure to collect this before any procedure to prevent having to go back to the patient to collect additional, unexpected fees.

Because of changes in healthcare, patients are opting for plans with higher deductibles and more out-of-pocket expenses. If you're doing out-of-network services, make sure to ask the payor for both in- and out-of-network expenses to ensure that patient is covered properly for the planned procedure.

» **Drop the claim within 48 hours. Don't wait a minute longer.**

The faster the claim gets to the payor, the faster the money ends up back in your hands. Be sure to stay on top of your doctors to make sure they're dictating in a timely manner and attaching operation reports to their paperwork. Many payors require extensive operation reports for workers compensation fillings, so be sure to provide as much information on the claim as possible. Payors also want to see all invoices related to implants, so be sure to include those as well.

» **Know your payor's requirements and be prompt and thorough on all claims.**

the executive suite

This must begin with confirmation that the payor received the claim through your electronic clearinghouse or through online tracking where possible.

As mentioned above, many payors require operation reports and implant invoices in order to receive payment on your first pass through. This will prevent you from having to resubmit your claim or send in additional information, which will delay your payment. If you can confirm that they received your claim, plus all the necessary information, you'll be less likely to encounter delays.

» **Call on all unpaid claims 21 days after submission, and then at least every 14 days until paid.**

Keep on top of this to ensure that you're calling regularly until the payment is received.

If your e-mail calendar or software system has the

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capability, program it with your daily call reminders. However, if you don't have that ability, use a written calendar or other electronic calendar to keep track of each day's calls and the next time that a claim should be followed up. If you fall behind

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on your 14-day cycle, it'll only get that much harder to stay on top of claims that haven't been paid yet.

» **Track and trend denials each month to ensure you're not chasing the same type of errors.**

If you waste too much time chasing the proverbial White Rabbit you'll be running in circles, only to come up empty-handed again and again.

As previously mentioned, know your payor's requirements. Consider every zero-pay as a denial. Be sure to track and trend every response to ensure you don't submit future claims to the same payor and end up with the same denials.

At my current consulting firm, we trend every zero-pay and code every denial. Some of the potential problems include: missing or invalid patient ID numbers, ineligible on date of service, no preauthorization or referral, wrong insurance, request for medical records, non-covered procedure code, additional information requested or timely filing. These are all issues that can be sourced to your staff, so you'll want to keep track of the errors to prevent them from happening again. We tally and total monthly tracking percentage, month

to month. We also keep a running annual log to keep our denials low. This allows us to see spikes, which permits us to see if it's a staffing issue or payor issue.

While these five management tips are important, more often than not, one of the first things that causes operations failure is nothing more than keeping up-to-date or follow-through. If you don't keep track of trends of denials, then you'll end up submitting the same type of claims to the insurance companies and getting the same denials. ●



Tracey Erbert is the president of in2itive Business Solutions. Erbert has an exceptional track record of exceeding industry standards for A/R management and more than 22 years of ASC operational experience, including four years at Nueterra Healthcare as the manager of the regional billing office. Erbert has also served as the business office manager for both the Surgicenter of Kansas City and the Surgicenter of Johnson County. While under her supervision, the Surgicenter of

Johnson County was awarded "Best Accounts Receivable Management" by HCA's ambulatory surgery division two years in a row.

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