Step By Step Guide On Managing Your AR

A NextServices Publication
Accounts receivables is one metric that directly affects the bottom line of medical practices. AR buckets give a clear picture of how synchronous operations are and is a direct reflection of revenues. Ambulatory surgery centers and medical specialty practices typically decide on day/s of week when they plan on working on AR. The problem with this approach is outstanding accounts don’t wait. There are denials encountered everyday and with every passing day without action, the count and dollar value increases.

This ebook outlines the different aspects of AR in a way to better plan, understand and manage your accounts receivables.
Accounts Receivables is the financial reflection of your business and yet the least enjoyed work area. Ambulatory surgery centers and medical groups focus on increasing patient volume, work towards building the most profitable operations but when it comes to managing the AR, they struggle. As with every aspect of the revenue cycle management, AR should be viewed as a macro process which is a cluster of different micro processes. The elements of this process can be eligibility and benefits verification, authorizations, tackling denials and denial management, etc. To manage AR effectively, go back to the drawing boards. Identify each micro element and scrutinize it to identify gaps. Build a process plan and effectively re-org the right resources for the right process.
RUNNING THE AR REPORT

Medical practices traditionally rely on AR work report (usually excel based) to determine pending claims, unworked claims and denied claims. It is very important for this report to always be current else, it will lead to work on claims which have been already paid causing time and resource wastage.

DO THIS:

- Generate a new AR work report at least once a week.
- Refer to the practice management system to work on the most current AR report.
- Have clear indicators based on your approach- dividing the AR report as per 30-60, 60-90, 90-120, 120+ buckets OR via insurance specific average turnaround dates- Medicare: 15 days from the date of service, Blue Cross: 20 days and so on.
- Build/use custom automations to generate the AR report.
Let’s do a simple exercise, open your most recent AR file. From the report, filter the denials for non-covered services, missing authorizations, policy not effective at the time of service and co-ordination of benefits. These denials could have been easily averted by implementing a pre-visit verification process.

DO THIS:

- Implement a process to verify eligibility, benefits and procedure authorizations for every patient.
- Document the policy effective dates, plan type, verify primary/secondary/tertiary insurances, copay and deductible portions for all the patients.
- Use real-time eligibility programs to verify eligibility status at least 2 days prior to service date.
- Take the necessary procedure authorizations at least 5-7 days in advance.
- When a patient is not entitled for coverage from the insurance, update the patient upfront.
There are several permutations for denials. However, the trend of denials remains more or less specific depending on the center. Each denial is different and hence approach for tackling claims should be different. Concentrate more effort towards proper allotment of claims within your billing staff to get the most out of your pending accounts.

**DO THIS:**

- Segregate claims according to complexity - ranging from the claims that can be resolved easily to those which would require a particular expertise.
- Identify denial specific experts to distribute claims within the team depending on the type of denial.
- Target high dollar value claims and easier insurances.
- Create a plan for daily claims review.
Daily denial management is an effective tool to manage denials in a methodical manner. By definition it means getting a pulse of what your denials are on a daily basis and equipping yourself the tools required to tackle the denials. It’s relatively simple to practice, doesn’t take a lot of time and the outcomes are significant.

**DO THIS:**

- Determine the top denials encountered by the center.
- Consolidate similar denials to create buckets based on the denial type (eligibility, medical records, authorizations, etc)
- Send a consolidated list of all denials encountered to the AR team on the same day of occurrence.
- Take action on the claims and consistently follow up.
- Make sure payment reconciliation is current.
There is no certain way to calculate how much money is stuck in your accounts unless you know the status of claims. Depending on the mode of claim submission (electronic or paper), claims should be followed up regularly and document the most recent status of the claim. Medical practices should ideally aim for 100% status on each and every claim.

**DO THIS:**

- Calculate the average turnaround time for your top carriers (Medicare 15 days, Blue Cross 20 days).
- Build a calendar representing when the claim was submitted and the follow up date.
- Use an automated system or manually review the claims falling in a particular date range.
- Have your AR team follow up on the claims. If a particular claim is paid, gather payment associated information like paid date, check number and check release date. If the claim is denied, resolve the denial and put a claim follow up date.
- Make sure to follow up within the timely filing limit specified by the carrier.
As important it is to undertake daily denial management and regular follow ups, it is equally important to track and measure the movement of your accounts receivables. Even tough the AR process at the core is the same, there is no definitive way for one protocol to work. Every center or medical practice has a different style of work, hence the tracking AR numbers daily goes a long way in determining strategy and direction.

**DO THIS:**

- Calculate bucket movements - how many claims are about to enter 90-day bucket.
- Determine the number of unpaid claims and action items.
- Use real-time dashboards to track overall AR trajectory.
- Base your decisions according to AR status and create a work plan around it.
- Undertake month on month AR comparison.
Your patient population may constitute an array of different insurances and there would be plans/insurances that you may be non-par with. Negotiation with third party payors is extremely important especially if you are non-par with certain insurance plans. It is a methodical process, if done correctly can get you reimbursed at the highest possible rates.

**DO THIS:**

- Verify your or your physician’s participation status with insurance plans.
- For non-par plans, determine the third party responsible for processing the claims.
- Determine the reimbursement rates with TPAs.
- Negotiate with TPAs for maximum possible reimbursement rates.
- Do not accept the initial reimbursement percentages by the TPAs, there is always a scope for higher rates.
- Reimbursement rates should be determined based on procedure type.
At times it is inevitable that insurances deny, underpay and delay payments. Even after consistent follow ups the chunk of claims remain unresolved. So do you leave the claims unattended? Practices should look into appealing on such claims. Spending the time and resources on denied claims would absolutely work in recovering lost reimbursements.

DO THIS:

- Generate a list of claims that require appeals.
- Devise a strong case for appeals. Supplement the relevant medical case notes to build a solid case.
- Build a powerful appeal letter. Hire a professional who can help you with the management of end to end appeals process.
- Document the sent date and payor details for all appeals.
- Follow up and ask questions to get clarity and status.
Often practices dedicate more effort towards insurance collections while money is left sitting on the table with hard to collect patient balances. Determining the actual money due and finding effective ways to recover balances becomes tricky. It is a slow, time-consuming and uncomfortable process for many centers and hence takes the back seat while determining AR action plan.

**DO THIS:**

- Run a detailed patient balance analysis report to arrive at a specific dollar amount.
- Divide the report into definite collectable and non-collectable accounts.
- Look for patterns- it's easier to collect form recently seen patients.
- Determine whether you are willing to write-off certain accounts v/s aggressively pursue.
- Follow up with patients and build a protocol- three phone calls followed by warning letters.
- Give electronic payment plan options to patients willing to pay.
- Resort to collection agencies as the last option of recovery.
THANK YOU FOR READING!

ABOUT US

NextServices was founded in 2004 with the simple insight that two of healthcare’s biggest challenges: administrative efficiency and access to clinical care, required much better solutions. Starting out in the Ann Arbor campus of University of Michigan, we developed a powerful services and software platform that has today transformed how healthcare organizations see patients and get paid. We work with solo practices to ambulatory surgery centers to hospitals who are as passionate about healthcare as we are.

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