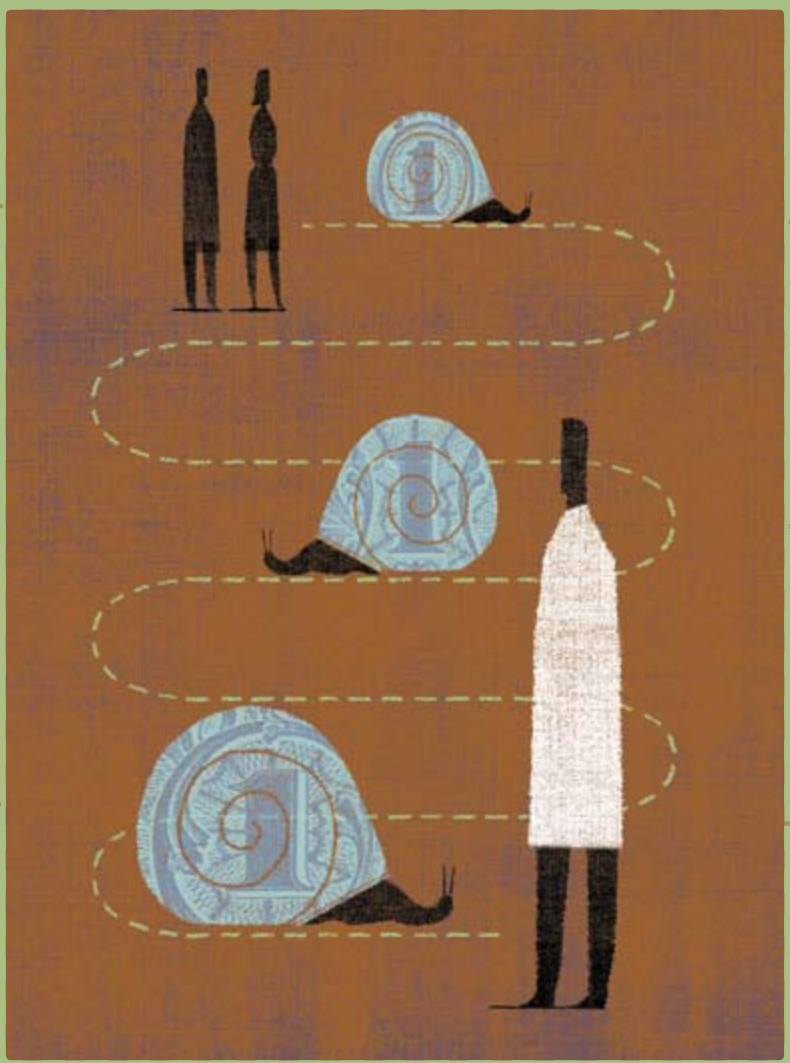

In less than a year, this practice cut its accounts receivable in half by changing its approach to billing.

PATIENT BALANCES

Getting to the Root of the Problem

Kristen Dillon, MD

We thought things were going well financially for our practice. Our accounts receivable had fallen by 20 percent over a six-month period and stabilized, while charges and receipts had continued to climb. However, when we looked closer, we realized we weren't doing as well as we thought. Patients owed us over $90,000 – more than a third of our total accounts receivable – and most of this was for services we had provided months ago.

When we examined the "old" accounts receivable, we found that unpaid charges more than 120 days after the date of service totaled about $53,000. Although this amount was respectably close to the national average published by the Medical Group Management Association, we found it worrisome, as most of the $53,000 was owed to us by patients. ➤

JIM FRAZIER

Patients owed us over $90,000 – more than a third of our total accounts receivable.

After closely examining its accounts receivable, the author's practice realized unpaid patient balances were getting out of hand.

Some of the causes were that patients struggled to pay for expensive procedures and that the practice passed along charges to patients that should have been collected from insurers.

The practice now requires that payments for obstetrical care and other procedures be paid in advance.

One problem; several causes

Because patient balances can be difficult to collect, we knew we might end up writing off a large percentage of this amount. Before we tackled the problem, our practice administrator and I met with the billing staff to discuss how patients had come to owe so much in the first place.

As it turned out, there were several ways patients were accumulating debt. First, many patients were unable to pay their share of large one-time expenses. For our practice, the most common expenses of this type were obstetric packages, services provided during hospital stays, circumcisions, vasectomies and intrauterine device (IUD) insertions.

Second, we discovered charges that we should have collected from insurance companies, not from our patients. When the insurance companies rejected certain claims, such as for a newborn whose paperwork had not been processed yet, our staff transferred the balances to the parents instead of pursuing the issue with the insurance company.

Third, our administrator discovered a number of families who were using us as a low-cost HMO. Most of these patients had insurance with substantial co-insurance or deductibles. They were dutifully making the $25 monthly payment that we had arranged with them. At the same time, they were continuing to receive frequent medical care from our practice. Their balance would go down for a few months until we performed an uncovered procedure or until a new year arrived and they had a $500 deductible to meet. Then they would be back in the hole with a balance rising faster than their payments. We were basically providing all their medical care for $25 a month without forcing them to pay their balances.

Once we identified these causes, we decided to implement several strategies to solve the growing problem.

Collect payments before procedures

We decided to follow the example of another practice in town and arrange for patients to pay for their share of obstetrical care in advance. During the second trimester, each pregnant patient meets with a member of the billing staff, who explains how much the medical care for her and her baby will cost. The patient signs a payment agreement that requires her to pay in full by the time of the birth. This system is not without flaws; deductibles or insurance can change mid-pregnancy, and complicated pregnancies and births will cost the patient more. However, it's better than what we were doing before. The last thing a family with a new baby needs is an unexpected four-figure medical bill.

We also started preauthorizing elective procedures like circumcisions, vasectomies and IUD insertions and expect our patients to pay their share of charges beforehand. Patients are informed of our financial policies when they schedule the appointment for the procedure, and we arrange a series of payments in advance, if necessary. Our billing staff reviews physician schedules a week ahead so they can call insurance companies and determine patient responsibility for the scheduled procedures. We have occasionally turned patients away when they come for the procedure wholly unprepared to pay for the service, but this has occurred only a few times per year for our six-provider office.

Make insurance companies pay their share

Some families in our practice had large balances because they hadn't properly enrolled

About the Author

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their infants in their insurance plans within the 30-day window after birth. In addition, we had many babies whose hospital charges had been denied by the insurance companies, and staff had simply rolled the charges to the patient. Although these infants had been properly enrolled after birth, there is a lag between enrollment and the time they actually appear as eligible in the insurer's system. Because we weren't reliably rebilling for the initial hospital and office care, some patient balances included charges that we should have been collecting from insurance companies.

Now, instead of billing for these charges immediately, we hold charges for newborns until they're two weeks old. At that time, the billing staff verifies eligibility with the family's insurer and follows up if there are any problems.

This approach has probably contributed to only 10 percent of the improvement in our total patient accounts receivable. It has, however, made work easier for our billing staff. They are sending clean claims for insured newborns only once instead of getting early rejections that they have to pursue further or resubmit. In addition, our patients appreciate our help getting their babies' insurance coverage in place.

Because some insurance companies do not promptly enroll newborns after birth, the practice now holds charges for two weeks before submitting claims.

Ask for what you want

Although the solutions above helped, there were still patients who owed us money. We took a good look at our patient statements and payment agreements, and we realized we weren't asking for what we really wanted: prompt and complete payments.

Credit card companies have forced people into the habit of making partial payments on their bills. Partial payments are fine if you're the lender, but in our business, we don't earn any interest on the money sitting in our accounts receivable – not to mention the staff time and postage it takes to send three separate bills to cover a single $45 charge. To curb the number of partial payments coming in, we reprogrammed our practice management system so that our patient statements now have the "Amount Enclosed" box already filled in with the balance due or the patient's budget payment.

This step has substantially reduced the patient balances between 30 and 120 days old and has cut our older balances by about 20 percent. In addition, it has significantly reduced work for our billing staff. We used to receive partial payments on 50 percent of our statements; now we receive full payment on 95 percent of our statements. Our billing staff can now post a complete payment once instead of posting a partial payment, sending a second statement and posting again. Their workload for processing patient statements and payments has been cut by one-third.

Billing staff now spend significantly less time resending claims for insured newborns.

Revise payment agreements

Previously, when patients failed to pay their charges in full within 60 days, we had been sending out blank forms so they could make a payment agreement with us. These forms indicated that the minimum monthly payment would be $25 and allowed the patients to fill in the amount they could pay us each month. Not surprisingly, many chose the $25 option, resulting in some patients spending years paying off larger amounts. Those with significant deductibles or co-insurance were incurring charges faster than they were paying them.

We decided to ask patients for a monthly payment of 10 percent of the amount they owed at the time the agreement was signed. This meant that a patient owing $1,200 from an obstetric package would be asked to pay $120 per month, with the goal of paying the total amount within the year.

Our practice administrator reviewed all patient balances over $200 and identified those who needed a revised payment agreement. We sent the new payment agreement with a friendly letter explaining the policy and requesting that

The practice rewrote their patient statements to encourage patients to pay their balance in full rather than a minimum payment.

We realized we weren't asking for what we really wanted: prompt and complete payments.

For patients who cannot pay their balance in full, the practice created a policy to collect a monthly payment of 10 percent of the total balance.

Seven months after implementing these processes, the practice's oldest accounts receivable decreased by 50 percent.

The practice continues to monitor its progress through its practice management system.

patients who couldn't make the 10 percent payment contact us for an adjustment. Those who can't pay 10 percent are handled individually by the billing staff or practice administrator, and are often offered the lower $25 payment or a several-month suspension of payments if they're experiencing significant financial hardship.

Outstanding results

Our efforts have been a great success. Over a seven-month period, our accounts receivable over 120 days old fell from $53,000 to $34,000. The total amount that patients owed us stayed about the same, but our charges and receipts rose by 10 percent during this same time. Our "really, really old" accounts receivable (i.e., payments due for services from more than six months ago) has decreased by half, from $34,000 to a recent record low of $17,000.

The improvements in older balances were initially the result of asking for higher monthly payments. Now they are the result of preventing patient balances in the first place. In addition, asking for payment-in-full with each statement has shifted the distribution of patient balances so that many more are carried on the books for only 30 to 45 days before they're fully paid.

Our office was able to accomplish this project with the same number of staff we had before, about 2.5 full-time equivalent. Because our staff is spending less time on some activities (e.g., handling statements, posting multiple partial payments and rebilling rejected claims for newborns), they have more time to tackle some of their new duties, like preauthorizing procedures and meeting with pregnant patients.

We're continuing to monitor our accounts receivable using the standard reports from our practice management system. The reports break down the numbers into 30-day periods – from the date of service to more than 150 days after. Staff members enter each month's numbers into a spreadsheet that lets us look at trends over time. So far, the trends look good, and with our new processes, we're confident they'll continue into the future. FPM

Send comments to **fpmedit@aafp.org.**