Accounts Receivable Management Tool

Accounts receivable (A/R) is money owed to your practice for services that you have rendered and billed for. Collecting monies that are due to you is an important part of your financial sustainability. Measuring and managing the A/R on an ongoing basis is essential to ensure that you receive the expected money due to you in a timely manner. Managing A/R is also useful to identify practice trends or third party payer (TPP) trends that may slow down the reimbursement process and negatively impact cash flow.

Your practice management (PM) software and/or electronic health record (EHR) software will typically have capabilities to produce reports that make the measuring and management of A/R possible and easier. While it may cost to have A/R and other Key Performance Indicator reports set up for you, having these established and set to run will be a tremendous asset in managing your A/R. Whenever possible, work with the PM software vendor or technical support consultant to design these reports. These reports may have different names in each of the PM/EHR software programs. The report(s) “names” will be **highlighted** throughout this document.

# Managing A/R Before Claim Submission

Managing your A/R begins well before the service is rendered and the claim is filed. Getting “clean” claims out in a timely fashion will save you much time managing denials received due to errors.

* Utilize a contractual obligation tracking spreadsheet to correctly bill and submit claims (track any services requiring prior authorization, specific labs to use, claim submission timeframe, etc.).
* Implement use of an electronic verification system to check patient eligibility for the date of service to reduce “not eligible on date of service” (patient does not have active coverage with insurance on record/with insurance card presented that day) denials prior to claim submission for Medicaid and/or other TPPs.
	+ This may be done either the night before and/or at the time of visit, depending on your resources and system capabilities. Poor or non-existent eligibility verification causes denials, delays in getting reimbursed, and rework.
	+ Consider electronically saving the verifications for potential future adjudication issues.
* Run a **Not Eligible on Date of Service report** on a weekly basis as another check.
* To avoid missing submission of data from a patient encounter, run a **Kept Appointments with No Charge report**. This type of report identifies clients that had been checked-in and checked-out and have no associated charges.
* Run an **Incomplete Claims File report** to identify all encounters and associated charges including those that can’t be billed because of missing information such as a diagnosis code.
	+ If it can’t be sent/billed to the TPP due to missing or incorrect information, the aging process never starts.
* Assure any authorizations are obtained for services if required by a specific TPP.
* Assure all clinicians are credentialed with all TPPs and that credentials are maintained.
* Get the TPP claims out weekly for services provided during that week (avoid filing too late or past filing limits).
* Common denials that can be avoided by efforts before filing a claim:
	+ Medical necessity (diagnosis or procedure coding errors)
	+ Registration issues: Not eligible on date of service, insurance verification, incorrect payer, cannot identify patient, date of birth documentation
	+ Credentialing of your clinicians with the TPP to whom you are submitting the claim
	+ Referrals and Pre-authorizations: Missing referral/preauthorization

Implement fee collection best practices.

* Communicate the full charge for the service to the patient as well as the portion that they will owe at the time of visit.
* Collect fees (sliding fee discount schedule payments, co-pays, deductibles, or co-insurances) at the time of the visit.
	+ *TIP: Establish patient payment policies, inform your patients of the policy, and train employees on collection practices. When necessary include a written document the patient signs regarding payment terms.*
	+ *TIP: Use credit card processing as a payment option at the time of the office visit. This increases the probability that you will collect more of the patient’s self-pay balance.*
* Establish policies regarding when an outstanding patient balance is turned over to collections, and assure the client understands this policy long before their account goes to collections.

# Managing A/R After Claim Submission

At the aggregate level, review **monthly A/R aging report** (For more information refer to Tab 4, A/R Aging and Tab 5, Days in A/R in the Title X [Financial Dashboard, a free resource available on the Sustainability Community of Practice](http://fpntc.org/cop/sustainability)). The A/R Aging Report is a good barometer for the health of your practice. Utilize an A/R report available in your EHR or PM software, or create one with the data from your system. In addition to illustrating how much a business is owed, your A/R report should distribute what is due by how old the money is that is owed to the practice. Below is a sample monthly A/R aging report.



This sample report shows the amount owed for every revenue source divided into seven age ranges (or buckets) across the top of the spreadsheet, and the various TPPs are listed down the side. An A/R aging report can be set up using expected revenue.[[1]](#footnote-1) The top section of this report shows the age of reimbursements owed to the practice by each TPP and revenue source including patient fees at a certain point in time for two consecutive months. The bottom section of the sample report shows the aggregate amount per age bucket for each preceding month of a fiscal year. A report such as this one allows you to identify potential issues from a high level view, and identify where to prioritize your focused A/R work.

# Steps for Reviewing A/R aging report

* If starting with charges (this data is most easily accessible), first adjust the dollars owed to the amount you expect to receive.[[2]](#footnote-2)
	+ *TIP: Set up your system to compare payments to expected contractual amounts so you can easily determine when full payments versus partial payments are made.*
* Look at the aggregate report and identify what stands out. Compare months to determine trends such as if billing and collections are improving, getting worse or staying about the same. You are looking for steady, positive trends and correlations. As an example, if there was similar patient volume in two months, you would expect similar revenue.
* The largest A/R amount should be in the first age bucket as it will include current charges or claims most recently billed. This bucket will experience the highest amount of denials and unprocessed reimbursements.
	+ *TIP: The A/R amounts should decline in each subsequent age bucket. If there is a jump in amounts in any older age bucket this may be an issue to look into. An example of an issue would be Medicaid 1 and 2 in November in the 61-90 bucket in the sample monthly A/R report above.*
* If your charges and therefore expected revenue increase in one month, (review a **Charge Report**) your A/R should increase that month, and collections the following month. If charges increase one month but collections don’t increase in the subsequent month, this could be an issue. This would require more specific A/R work.
* An overall decrease in A/R is generally good. An exception would be when the decrease is due in large part to a decrease in the 0-30 age bucket. Another exception would be a significant write-off done for denial reasons you cannot overturn.
* If there are more work days in one month, revenues in the 0-30 age bucket should increase by approximately 5% in a 22 day month versus a 21 day month if visits/days were similar each month, assuming a relatively stable mix of services. An example of an issue can be observed in the August ($275,789) versus the September ($248,996) 0-30 bucket *in the sample monthly A/R report above*.
	+ Uncovering the reason for differences between months (an example might be that billing for one payer did not get processed during one month) is critical to develop strategies to avoid this issue in the future.
* In the *sample monthly A/R report above*, note the increase in the commercial 2 in the over 365 bucket. You will typically write off accounts after 365 days.
* *In the sample monthly A/R report above,* note that Patient Fees After Insurance is trending up. This category presents challenges as the fees are often generated after the patient has left the office.
	+ *TIP: Identify these amounts while the patient is still in the office, communicate the balance, and collect any portion you can are effective strategies to decrease the dollars in these buckets.*

# Ways to View the Detailed Data Needed to Work Specific A/R Issues

In general, you would like to see claims being paid within 42 days (benchmark in the Title X [Financial Dashboard, a free resource available on the Sustainability Community of Practice](http://fpntc.org/cop/sustainability)). If a claim isn’t paid or rejected within 42 days, there may be a problem. Utilize the methods below to identify common issues with claims being paid.

* Set up the monthly A/R aging report to allow you to view and access the detailed information that comprises any of the bucket totals (export data from your data system to an Excel spreadsheet to accomplish this). That detail would include site, encounter level data, procedures/codes, dates of service, etc. Sorting by any of these elements could allow you to identify trends in a bucket, such as a new denial on a specific code, partial payments of a particular service, etc.
* Review detailed reports from your PM/EHR system such as **Claims Receivable for all TPP** or **Insurance Payment Trend Report, or Denied Claims** showing information such as: date of service, date filed, services billed, dates monies posted, adjustments, what amounts were collected, or what was denied.
* TPP websites also will provide the information necessary to work A/R claims.

# Strategies to Resolve Unpaid or Rejected Claims

* Review the entire **Claims Receivable Report** and identify any claims where no payment has been received.
* Identify any repeating issues by payer such as multiple claims for the same dollar amount that have not been paid/partially paid, payers where little or no payment has occurred, and large dollar amount balance due claims regardless of the payer, and prioritize these.
	+ *TIP: Disregard this instruction for the charges/claims that have gone out in the current month.*
* Using this list, focus on those that are older than 90 days first. It is critical for you to get the claim/claim issues handled at this point as you might encounter filing deadlines. This will require going into each **Client Charge/Activity File** and specifically looking at details such as charges filed 6 months ago with no correspondence back from payers, charges filed, denial received, or no follow-up. Make sure to note the denial reason.
* When payments have been received but are not equal to the expected payment, investigate if it should be a write-off (compare payments to contractual amounts – or a rebill of the remaining amount (underpayment) either to the insurance company or to the client.
* Once the above work has been completed, rebill in the cases that it is clear you should do so. If notes/written documentation from the TPP don’t tell you why a particular claim was rejected, or if you are not sure how to correct the claim for resubmission, call the claims representative and ask specific questions for each of the specific claims. Make notes for yourself or other team members so that future errors of the type you just corrected are not made again.
	+ *TIP: Foster a good relationship with your TPP contact.*
* If you are a sub-recipient or grantee agency, consider comparing notes about issues with specific payers among clinics within your network.
	+ *TIP: Identify one person within your network to be the contact person with a specific payer.*
* When you note errors either from your clinicians or from other staff in the office, provide feedback to them (used wrong lab, provided service not covered, billed too late, etc.)
* Often claims will have more than one denial reason. A claim may require multiple corrections before it will be paid. Other Common denial reasons include:
	+ - Bundled/non-covered (ex: modifiers)
		- Charge entry issues: Invalid procedure or diagnosis code
		- Duplicate (2nd CPT on same date)
		- Past filing limits submission of claims
	+ *TIP: Customize your own* ***Common Denial list*** *and measure progress/assess trends on a monthly basis.*
1. Expected revenue is the negotiated third party payer contractual amounts for services. This amount would typically be less than the charge amount. [↑](#footnote-ref-1)
2. To calculate expected revenue, deduct the difference between the charge and the contractual amount, called the contractual adjustment or write-off for each TPP. [↑](#footnote-ref-2)