receivables—payment for services rendered—are the life blood of any medical practice. While dermatologists practice their specialty with the goal of helping patients, without a reasonable income they simply could not serve those in need of medical care. Plus, the reality of modern practice is that there are ample opportunities for dermatologists to apply their unique expertise and skill to provide elective services of interest to the general public.

Yet, despite their critical importance, “receivables” often receive insufficient attention from practices. In the worst instances practices never collect money owed them. In other cases, payments may be delayed or denied by many weeks or months, diminishing cash flow to a trickle, and making it difficult to keep up with even the most basic elements of the practice (such as payroll).

Improving practice cash flow requires timely and efficient collections. There are three key elements to managing receivables: (1) responsible personnel, (2) effective practice management software and billing practices, and (3) an appropriate practice philosophy and understanding of the “big picture” A/R process.

The discussion below focuses on item one and the role of specific staff members in maintaining a timely collections process. The emphasis is largely on third-party payers, though we’ll highlight some considerations regarding self-pay patients, as well.

The Front Line
The front desk is truly the front line in the fight for timely and accurate reimbursement.

Any individual who will schedule patients and check them in or out must be thoroughly trained on the proper procedures for gathering information and completing claims. This begins

When it comes to timely collection of payments, different staff members have important responsibilities.

By Susan Hirst
with the patient’s first call to the office. Every new patient must be pre-registered. That means that all relevant contact and insurance information is acquired during the initial phone call and verified shortly thereafter (sometimes while the patient is still on the line). If any problems with coverage, referrals, or authorizations are identified, these must be resolved in advance of the patient’s appointment.

Also at the time of the scheduling phone call, tell patients what materials to bring to the appointment—proof of insurance is most important—and inform them of any responsibilities for payment. Advise the patient of accepted forms of payment, including check and credit card, so that patients are prepared to pay co-pays, or deductibles or settle balances at the time of the visit.

On the day of the appointment, when any patient checks in, front desk personnel must capture and/or verify all personal contact information, including address and phone numbers, employer information and effective employment dates. Verify insurance coverage, ask specifically about changes in coverage, and ensure an up-to-date copy of the insurance card is on-file. For special considerations related to the self-pay patient, see the sidebar on the next page.

Before any encounters are sent on to the billing department, they should be spot-checked by the front office staff who should be trained to identify the common errors or omissions that waylay the payment of claims. They should also be well versed in compliance issues to ensure the encounters are not only valid for claims processing but compliant.

The Physician’s Responsibilities
If the front desk is the front line, then the physicians are like a tactical response team.

It’s essential that they have an overall sense of what makes a “clean claim,” but they are ultimately responsible for providing specific critical information; namely, proper coding and documentation. In addition, if your specialty requires a referral or authorization, a quick check to ensure coverage is handled prior to stepping into the exam room is highly recommended.

When the physician is aware of the billing process from beginning to end, he or she has a better understanding of the importance of his/her contribution. Put another way, a physician who is knowledgeable of the billing process is more likely to take ownership in the process and provide accurate and compliant data.

Documentation to support the level of E/M (evaluation and management) service is critical. Practices not currently using checklists should consider adopting them. Dermatologists become so adept at completing the review of systems and collecting histories that it becomes second nature to them. Without taking the time to document what they have done, physicians may not get full credit (or payment) for their efforts.

I encourage physicians to document each encounter in real time. Dictation remains a useful tool for documentation. By dictating a note immediately, the physician is able to capture pertinent information while it’s still fresh in the mind. Dictation can
be done in the presence of the patient to serve as a “recap” of the appointment. Physicians who record written notes should also complete these immediately after each encounter rather than allowing charts to collect until the end of the day.

Physicians have a third primary responsibility in regards to billing: the fee schedule. The physician (this responsibility can be delegated to or shared with a competent practice manager) must review new fee schedules when they are published each year and ensure fees are updated in the practice management software. Failure to update the system will lead to continual problems reconciling accounts, as the amount billed and amount paid will vary.

More importantly, the physician and/or the office manager must be actively involved in reviewing and negotiating contracts to ensure that fees are not being reduced. Even if a fee simply remains unchanged, that could spell a *de facto* cut to the physician, as the rate of inflation will minimize the value of that payment.

### The Physician and/or Practice Manager

The physician and/or the practice manager must also interact with representatives of their primary carriers on a consistent basis throughout the year. In many cases, the carrier will be content to publish the new fee schedule (not pointing out any fee cuts or freezes, of course) without offering to dialogue with the physician. However, pro-active practices can interact with carriers to discuss any recurring payment problems, clarify carrier policies, rectify payment problems, and otherwise address concerns that arise throughout the year.

### Receivables

**Special Considerations for Self-pay**

Patients today are used to having options to pay their various bills in a number of ways, ranging from traditional options like cash and money-order to more modern options like credit card installment charges or on-line bill pay. The greater variety a practice can offer, the better the likelihood of capturing payments in a timely manner.

No charges for a self-pay patient should be entered into the A/R system without a payment process in place. In other words, if the practice agrees to allow the patient to carry a balance (rather than pay for service in full at the time of the visit), the patient must at the time of service select how he or she will settle the balance, and this payment information must be duly recorded in the practice management system.

In this author’s experience, a patient unwilling to provide a payment method most likely will be unwilling to pay a statement balance.

Self-pay patients should be billed according to a reduced fee schedule relative to insured patients. Why? A self-pay discounted rate recognizes the fact that these patients are not costing the practice as much in terms of resources (staff hours spent submitting, tracking, and resubmitting claims) and are generally providing payment up-front versus the delayed payment inherent in the third-party system.

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**The Billing Department’s Daily To-Do List**

1. Collect and tally all encounter forms for the day.
2. Compare the encounter forms to the daily schedule. The goal is 100 percent capture or one encounter form for each patient seen.
3. Review the encounter forms to ensure they are complete and signed. All necessary information must be provided and the documentation must be complete.
4. Post into the system all claims detail, all charges, and payments received over the counter for the day (ie. Co-pays, deductible amounts or patient payment on account), including who paid them and how (cash, check, credit card).
5. Post all payments received with EOBs (Explanation of Benefits). When you run your pre-close for the day, all charges should balance with the encounters for the day, all monies received and cash, checks and credit card payments should match with deposits slips. Monies deposited in the bank for the day should match with the deposit receipts from the bank. When you “close” and print your daily report, your day is balanced and closed in your practice management system.
6. If all the numbers balance, close out the books for that day. Prepare the electronic claims and transmit them.
7. Correct and resubmit any rejected claim for the current day’s activity. Any denied claims worked that day should also be resubmitted.
8. Be sure to print out the confirmation report from your clearinghouse and include it in the daily activity.
9. Maintain billing files in day/date order with all activity documents attached to the daily close each day.
The Billing Staff

It goes without saying that billing staff must be intimately familiar with the billing process and thoroughly knowledgeable about what constitutes a “clean claim”—a complete claim that will sail quickly through the process—and adept at spotting common errors or “red flags” that may delay the payment process.

Prior to electronic submission or printing HCFA claims, a pre-billing worksheet should be printed and reviewed for claim errors that will result in a denied claim. The sidebar at left delineates the key responsibilities of the billing department. Once all claims for a given day have been transmitted, review the EMC confirmation report to ensure that all were received successfully. If rejected, immediately correct and re-send any claims that did not transmit successfully.

The 10-Day Plan

A 10-day claims tracking plan is crucial to identifying problem claims.

This tracking process is the responsibility of the billing department. After 10 working days, review worksheets created on a particular day. For example: On Wednesday, the 17th, review all claims submitted on Wednesday, the 3rd (10 working days prior). Work through patient claims, line by line, and mark out all claims that have been paid. For any remaining claims that have not been paid, go on-line to verify that the claim was received and determine if there is any identifiable reason the claim has not been paid. Take appropriate steps:

a) If there is an error or omission, correct this and resubmit the claim.

b) If there is no identifiable cause for delay, call the carrier. Have all pertinent information readily available. Identify the claim number, patient name, date of service, and date of claim. If the claim is deemed “in process,” ask if there is any problem with the claim. If the carrier requests documentation, get the fax number and immediately send the requested materials or, if needed, resubmit the claim.

c) If there is no identifiable cause for delay, simply ask when the practice can expect to receive payment. Record the anticipated date of payment, name of the person you have spoken to with their phone and extension number, and follow-up on the payment date if it is not received.

It is critical to be “proactive” and “courteous” with your carriers. Once they realize you are in control of your claims, denials will be less and cash flow will improve.

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Characteristics of a “Clean Claim”

1. **Patient information is complete:**
   - Name, address, phone number, social security number, date of birth matches the insurer’s records.
   - Group number and/or subscriber number is provided and correct.
   - Coverage dates of current insurance carrier / plan are active.
   - Employment has not changed in the last 24 hrs.

2. **Provider / Practice information is complete:**
   - Physician’s social security number, provider number (NPI) and tax identification number (EIN) is correct and complete.
   - Provider name / practice name accurate.
   - Provider signature (if required) is present.

3. **General claims information is complete:**
   - Authorization number is present for date of service.
   - All necessary dates are completed. (DOS, authorization dates approved.)
   - Dates for care given are chronological and complete.
   - Dates for care given are in agreement with the claims information from other providers such as the hospital, emergency room, or other.

4. **Coding information:**
   - ICD9 code(s) correct.
   - CPT codes match procedures provided with diagnosis.
   - Modifiers are used when applicable.
   - Diagnosis is coded using ICD-9-CM to the highest level of specificity.
   - Fee column is itemized and totaled.
   - Durable medical equipment prescribed by the physician is included.

5. **Include documentation if appropriate.**

6. **Other Items to check:**
   - The claim is signed by the physician. (the encounter form must also be signed).
   - Read through the documentation and ensure it matches the diagnosis and procedures done. In some cases, there will be a primary and secondary diagnosis, the documentation must match the claim being filed. If they do not, discuss this with the physician before sending the claim.

—Adapted and updated from Medical Group Management Assoc.