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A NEWSLETTER FOR THE HEALTHCARE INDUSTRY

SUMMER 2009

Don't Be Denied Strategies for Winning the Claims Game

When it comes to submitting claims, it can feel like you're playing a game. You submit; they deny. You try another tack, and back it comes. And make no mistake: It's a high-stakes game. Make the wrong moves, and your collections rate drops (and your cash flow plummets). Claims denials also impact your patients. Charges not covered by insurance can quickly devastate a family's finances.

How Bad Is It?

Just look at Medicare denials, which top \$10 billion annually — 11 percent of claims. In most practices, an overall claims denial rate of 5 percent to 8 percent is typical, although it can easily jump to more than 20 percent. According to the Medical Group Management Association (MGMA), the five most common reasons for claim denial are:

1. Diagnosis is not coded to the highest level of specificity
2. Missing patient subscriber or ID number
3. Patient name and/or address doesn't match insurer's records
4. Missing physician information or ID number
5. Claim information is illegible or improperly entered

It's Your Move

Of course, the first move in the claims game is yours. Consider these steps for submitting timely, accurate claims:



Keep it clean. The denial reasons above are easy to avoid. Review your claims before submission to ensure that all required fields are complete, legible and correctly coded.

Staff up. Make sure you have enough trained billing staff on the job. If you don't have staff dedicated to billing and collections, don't be surprised to find them constantly being pulled to help out at the front desk, resulting in mistakes caused by distraction.

Play by the rules. Some practices are investing in software systems that help navigate insurers' payment systems and prevent denials. Others are using the

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Revenue Management: Tools for Putting Your Money to Work

It seems simple enough: You collect money from patients and payers, and then put it to work paying bills, covering salaries and funding the growth of your practice. That, in a nutshell, is your revenue cycle.



“Unfortunately, many practices remain woefully out of step with modern cash management procedures,” says Steven F. Lutz, partner-in-charge of the *Healthcare Services Group* at Wolf & Company LLP. “At these practices, manual processes keep staff tied up with mundane chores such as opening envelopes and filling out deposit slips. And outdated procedures keep cash tied up.”

What Does Big Business Know?

Manufacturers, retailers and others have been using basic revenue-cycle-management tools for years. Now, savvy practices are taking their cue. They’ve discovered how tools such as merchant services, lockbox processing and sweep accounts can automate payment processing and then put those funds quickly to work. And that is critical as reimbursement levels fall, credit tightens and it becomes more important than ever to focus on the bottom line.

Start by Streamlining Collections

The key to efficient collections is eliminating as many manual processes as possible.

- **Merchant Services** – Allowing patients to pay with a credit or debit card is a true win-win. Patients love the convenience and flexibility, and you eliminate billing costs and payment float. By pre-arranging

it with patients, you can even bill their credit card for deductibles, coinsurance and any outstanding balances due after the insurance company has processed the claim.

- **Remote Deposit** – With this technology, staff can scan checks into a desktop scanner and send the digitized checks directly to the bank via a secure Internet connection. This eliminates the time and expense of preparing deposits manually and making daily trips to the bank. Remote deposit also provides instant access to all your deposit information online and avoids the security risks entailed with making after-hours deposits.

- **Medical Lockbox** – Businesses with heavy payment volumes have long used lockboxes to speed the conversion of payments to cash. For a medical practice, lockboxes send patient and third party payments directly to the bank, where they are opened, scanned and processed, greatly reducing mail time and check float. Data files of checks and EOBs can then be downloaded to the practice’s computer for reconciliation. And, by removing payments from the office setting, lockbox services also help eliminate opportunities for fraud.

Put Money to Work

Collecting the money your practice is owed is certainly important, but putting those funds to work for the practice is also vital.

- **Healthcare Sweep Account** – Excess funds from the practice’s operating account are automatically transferred, or “swept,” into an interest-bearing investment account, generating a revenue stream. As funds are needed, they are automatically swept back into the checking account.

- **Zero Balance Accounts** – Accounts can add up quickly when

separate accounts are created for practice payroll, petty cash, expenses and other categories. This pool of non-earning funds can reduce margins when not managed efficiently. By contrast, a Zero Balance Account allows independent operating accounts, or sub accounts, to be funded from a single account. As checks clear the sub accounts, the bank automatically moves exactly that amount, thus returning the account balance to zero. ■

Our financial professionals can provide the guidance you need to improve your practice’s revenue cycle. For more information, contact Steve Lutz at 630-545-4550.

How Do Successful Practices Do It?

A revealing report from the Medical Group Management Association (MGMA) shows that successful practices have a solid handle on revenue management. The MGMA report, *Performance and Practices of Successful Medical Groups*, benchmarks performance among more than 1,200 responding medical practices.

It clearly shows that better-performing practices enjoy a higher percentage of 0-30 day accounts receivable than that of poorer-performing groups. Their gross and net collection percentages are higher, and their bad debt is lower.

On the front end, better-performing groups are more likely to accept payment by credit card, and they file claims electronically. These groups include both patient account balance and pending insurance balance information on their billing statements. They are also more likely to verify patient insurance before services are rendered.

insurer's software, sometimes called a "rules engine" to identify billing errors and make corrections before submitting a claim.

Verify eligibility. There's no use appealing a denial for a non-eligible service or patient. The key is to pre-certify/verify eligibility upfront. Most payers allow you to determine eligibility online.

Don't under code. Surveys consistently find that physicians under code. Why? They think that coding at a lower level will help their claims get through. When you perform a service or procedure, report it according to the AMA CPT codes, guidelines and conventions.

Get it in on time. Be aware of submission deadlines. Timely filing can mean the difference between money in the bank and writing off a claim.

Get Your Claim Back on Track
Again, the move is yours when a claim comes back denied. The strategy here: Don't write it off –

appeal. In fact, the American Medical Association (<http://ama-assn.org>) encourages practices to audit and appeal all inappropriately paid or denied claims. The AMA has prepared several tools that explain the appeals process, including form letters that you can modify for your own use. **Prepare that Claim and Appeal that Claim** can be found on the AMA's website. Another educational resource on the site, **Is Your Practice Losing Revenue Through Inappropriate Health Plan Adjustments?**, provides tips for reviewing EOBs and RAs.

Audit the EOB. Practices should not rely on the health insurer to correctly process and pay the claims it receives. Audit each EOB/RA to determine the accuracy and appropriateness of the claim, making sure you understand exactly why the claim was denied.

Submit your appeal. After you've reviewed your claim and made sure all required fields are complete and correctly coded, submit a formal appeal of the denial. If you don't

receive a response in a timely manner, follow up by contacting the payer's office.

Learn from it. Create a concrete analysis of the denial codes the practice is getting. Watch for patterns (e.g., recurring denial codes, missing information, etc.). Address these deficiencies with staff and revise your processes and systems accordingly.

Speak up. By all means, address noncompliant payer behavior, such as violation of prompt payment statutes.

Look for the Game to Change

As healthcare inevitably moves toward a more wired, interconnected future, the claims game is sure to change. Physicians are focusing on claims denial management more keenly than ever before. At the same time, patients have been pressing for greater access to claims and insurance data. As patients, physicians and insurance providers find themselves more closely linked, the value of systems that submit and manage claims electronically is sure to increase. ■

Denial Management to the Rescue

As medical billing grows ever more complex (and payers seem to be finding new reasons to deny or underpay claims), an entire industry has emerged to assist medical practices in challenging claim denials and recovering revenue.

These "denial management" providers re-adjudicate EOBs to identify errors and missed revenue opportunities and to appeal denials/underpayments, typically taking a percentage of collections.

How It Works

Working in partnership with a denial management provider, you can increase collection rates and improve cash flow. Some vendors simply provide manual, claim-by-claim review of your denied claims. They dig through past claims in search of short-changed payments and go to bat for you over charges misadjudicated by payers.

Others provide software that integrates with your electronic medical record/billing system or offer a Web-based system that

With a claims denial rate of only 5 percent, a practice with five physicians generating \$500,000 each could be losing up to \$125,000 a year!

reviews claims. The idea here is to prevent denials from recurring by educating you on national and regional payer rules, and creating processes that lead to cleaner claims and fewer denials from insurers.

Wolf & Company LLP

Certified Public Accountants

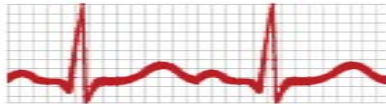
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Vital Signs



Restating Your Practice Retirement Plan

The IRS is requiring sponsors of qualified retirement plans to “restate” their plan documents, incorporating changes brought about by federal legislation. Here are answers to some common questions.

Q: What plans are affected?

A: Retirement plans subject to restatement include those typically used by medical practices, including 401(k), profit sharing, money purchase pension, employee stock ownership plans (ESOPs) and defined benefit pension plans.

Q: Why does our plan need to be restated?

A: As new legislation affecting

retirement plans is enacted, the IRS requires all plan sponsors to rewrite, or restate, their plans to conform to current law. This current restatement is designed to incorporate provisions of the Economic Growth and Tax Relief Reconciliation Act (EGTRRA) of 2001, which created numerous benefits, including increased contribution limits and a “catch-up” provision for workers age 50 and older.

Q: Is there a deadline for restating our plan?

A: Restatement has been ongoing, and the actual deadline depends on the type of plan, but all plans must be restated by April 30, 2010.

Q: What happens if we don't restate our plan?

A: If you don't meet the deadline, the IRS can disqualify your plan and take away all of its tax benefits.

Q: Can we make other changes?

A: Yes. In addition to legislated changes, you can also make changes to improve your retirement program. This is an excellent opportunity to review your plan and make sure it meets your goals. ■

Contact Ray McFaul at 630-545-4738 for prompt support of your practice's restatement needs. Ray is the vice president of Retirement Plan Services at Wolf Financial Management LLC.