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Better Business: Begin at the Beginning

Focusing on intake/customer service improves payment collection.

By Michael Barish

A key component of a successful HME company is an effective intake/customer service process. The front-end responsibilities, such as gathering complete patient demographics, insurance information, and documentation to show medical necessity, are critical to a company's service and collection performance. Combined with the appropriate software systems and accurate control files, claim errors are minimized and timely payment occurs with little follow-up, reducing days sales outstanding (DSO), bad debt, and labor costs.

Properly delegated responsibilities and an efficient workflow are crucial to the operation of a customer service department. Maximize efficiency by making customer service representatives responsible for taking referrals, obtaining complete information to meet reimbursement and compliance requirements, verifying insurance coverage, and determining financial responsibility for items or services ordered. A customer service representative must ensure that all required forms are completed, information is entered correctly into the computer system, and the service department is promptly notified of the pending order so that arrangements can be made for delivery or pickup. As necessary, the customer service staff is also responsible for collecting copies of test results, and obtaining prior authorizations, and physicians' written orders when required before delivery.

Companies often mistakenly divide the intake and insurance verification process between two or more staff members. With multiple managed care payors, each with different claims preparation and coding requirements, poor execution of the verification and authorization process increases the potential for bad debt. Many referral sources expect providers to make deliveries with little notice and only a portion of the necessary coverage information available. With one individual responsible for obtaining and documenting all of the necessary information pertaining to a specific order, the likelihood of mistakes is reduced, ensuring better customer service and less bad debt.

Qualify the Order

Verifying insurance benefits during the intake process helps ensure that charges for services provided are covered, the claim is sent to the correct address for processing, and accurate financial responsibility information is obtained and provided to the patient and/or caregivers. Informing customers of their financial responsibility improves service and collection rates of the private pay receivables, and is a Medicare and an accreditation compliance requirement.

Tell the customer service representative to indicate on every order whether it is new or an add-on. If the order is an add-on, the representative should review the customer/patient master record to ensure the qualifying diagnosis for the new equipment already appears on the patient record.

Remember to enter the ordering physician information at the order entry function to ensure that the prescription is sent to the correct physician. This reduces held revenue and decreases billing and collection costs.

Give Staff the Tools to Perform
No one can perform well without the proper tools and training. Staff members should have easy access to updated DMERC manuals and bulletins. Also provide Medicaid and third-party coverage criteria and documentation requirements. Hold regular in-services to update staff on the products and services your company provides, telephone etiquette, and using the company computer system.

Remember to give employees customer intake and insurance verification forms that are appropriate for all types of referrals. Give careful consideration to the sequence of these forms so that they flow logically. For oxygen and enteral therapies, I recommend using data collection sheets to gather information. I also recommend obtaining copies of the arterial blood gas or oxygen saturation tests performed.

In the case of Medicare enteral therapy, instruct the customer service representative to obtain swallowing tests whenever possible. If Medicare conducts a review to ensure that you meet certificate of medical necessity (CMN) and other documentation requirements (pre- or post-payment review), the clinical information submitted on the CMN must be substantiated by the physician's patient chart, the hospital's patient chart, or your own patient chart. You can also give copies of test results to physicians to use as reference when they complete CMNs.

Workflow Process
An efficient workflow controls staff and operating costs. The workflow process begins with the incoming telephone call. If your company receives a high call volume, a buffer (either an operator or an automated answering system) should be placed between the customer service representative and the caller to direct calls appropriately.

After the customer service representative completes the qualification and entry of the order, he or she should send a service ticket to the warehouse printer. Keep the completed paperwork in an alphabetical binder so it can easily be matched to paperwork turned in by the service department.

Quality Assurance
A key position in reducing DSO and bad debt is a detail-oriented quality assurance and confirmation staff member. This person reviews all orders and supporting documentation entered by customer service staff and confirms the order. He or she must be knowledgeable about coverage criteria and documentation requirements for all payors, and familiar with your products and services.

Your staff can review re-orders more quickly than new orders for common mistakes, such as failure to override the ordering physician information or to obtain additional diagnosis and medical information. They must review all orders to ensure they met the coverage criteria and documentation requirements for specific payors, and entered all demographic information correctly. Document an authorization number and the length and scope of the authorization in the customer notes file of the business software. In addition, make the order confirmation employee responsible for logging authorizations for all items.

Software Systems
Properly installed and used software helps keep staffing, operating cost, and DSO at acceptable levels. Most industry software systems have control files that determine how you should process CMNs/detailed written orders and claims. There is usually a notes feature that let your staff enter information. By using these notes to document insurance information, delivery instructions,

equipment settings and claims follow-up, you can deliver a higher level of service, as all activity concerning the care and follow-up of each customer is readily available.

Staff Evaluation

There are few reliable industry benchmarks for evaluating the performance of your customer service department. Therefore, it is important that managers closely monitor the quality and volume of work performed by their employees. The quality assurance and confirmation staff member(s) track the accuracy of customer service representatives, and should bring errors to the attention of a supervisor. You can also determine order volume per customer service employee using report writer software. Call volume tracking can determine how many calls each employee receives and how much time is spent on the telephone.

Stop Chasing Your Tail

When managers see their DSO climbing, their first reaction is typically to allocate additional resources to the accounts receivable department to work the accounts over 120 days. While this may be a necessary action, given the limited resources most companies with poor cash flow experience, a more logical first move is to re-engineer the intake customer service operation. When nonqualifying orders are taken, when prior authorization is required but not obtained, and when there is incorrect or nonexistent documentation, additional collection efforts will have poor results.

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