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The Strategy of Accounts Receivable

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A well-managed billing department is good for customer service and profit margins

FEW WOULD DISAGREE: The success of a home medical equipment or infusion business hinges on its ability to differentiate itself from the competition. Most providers also agree on one of the best strategies to do this: offering a better service than their competitors', from initial intake to product delivery and follow-up.

All too often, however, companies assessing their operations overlook a key service: efficient billing and collections. But a well-organized, well-managed billing and collections operation can make all the difference in the customers' experience, be they referral sources, patients or payers.

The role accounts receivable plays in an HME/IV company's financial well-being is more obvious. The efficient use of resources and close management of cash flow form a profit strategy that distinguishes top-notch home care companies from the rest.

Achieving this level of distinction, from customer service to financial stability, does have a cost: It takes work.

FROM THE GROUND UP

THE IMPORTANCE OF HAVING effective reimbursement protocols in place is reflected by the performance during the last four years of some of the larger industry players. Many leading providers have had to write off tens of millions of dollars because they failed to adequately qualify and bill and collect for the products and services they provided.

While the numbers are smaller for most providers in the industry, the need to evaluate and, as necessary, re-engineer reimbursement activities is critical to every HME/IV company.

To set up a reimbursement process that produces clean claims, collects timely payments and keeps costs down can require an overhaul of the entire operation, from design and structure to ongoing management.

Design considerations include departmentalization, specialization, chain of command and span of control. Structural issues revolve around the way jobs are divided, grouped and coordinated.

HME/IV providers commonly use several A/R models to establish the design and structure of their reimbursement activities. One of these models divides responsibilities into two departments, one that handles customer service and the other that deals with billing and collections.

A MODEL OF RESPONSIBILITY

THE SEPARATION OF customer service from claims processing generally produces superior results. It has a high degree of efficiency and helps maintain an acceptable days sales outstanding. Both functions can also achieve a good economy of scale, and employees in each department can more easily be held accountable for performance.

Generally, both departments report to a common manager but have separate supervisors. Functional responsibilities are divided as follows:

- Customer service representatives take calls for new orders, reorders and pickups. They qualify the orders, which includes obtaining complete information to meet reimbursement and compliance requirements, verifying insurance coverage and determining whether the insurance company or the patient is required to pay for the product or service. As needed, customer service reps also obtain prior authorization and perform case management functions.

- Employees in the billing department gather, submit and track any documentation required to bill for a product or service such as certificates of medical necessity, prescriptions and renewal prior authorization requests. As part of this responsibility, they must ensure that all documents are returned in a timely fashion with complete and correct information. The billing staff proofs all claims before submission and makes sure all necessary documentation is properly attached. Employees in this department are also responsible for generating renewal CMNs and prescriptions, following up on accounts receivable and resolving any denials and/or partial payments.

By separating responsibilities, this A/R model offers excellent efficiency because it limits the amount of telephone interruptions experienced by the billing/collection employees. On the flip side, it provides customer service employees the time they need to answer the telephone promptly, thus enhancing service to customers.

This model also takes advantage of the efficiencies that come when employees specialize and encompasses some of the total quality management principles required to establish ownership and accountability among employees. Roles are clear: The customer service department is responsible for all orders to the point of delivery, including the review and confirmation of the order ticket. The billing representatives then take over and retain responsibility until payment is made in full.

MASTER OF NONE

WITH VARYING DEGREES of success, many HME/IV providers handle their A/R functions differently. In the traditional TQM model, for example, each employee is responsible for all of his or her designated customers from initial intake to collection/cash application.

This model is inefficient and thus impractical for any company that has more than a couple of employees in the business office. Constant phone interruptions make it impossible for employees to concentrate on any one activity for an extended time, seriously hindering productivity.

Another office design separates the customer service intake and insurance verification functions, leading to a lack of continuity and loss of communication. This, in turn, results in errors and thus affects the company's ability to collect payment timely. Employers find it difficult to establish accountability, and employees have trouble taking ownership of their work.

These same problems exist at companies that go so far as to separate the billing and collection responsibilities into separate departments. Typically, this model results in a higher than average DSO because billers have less incentive to submit clean claims when they are not responsible for collecting those that are denied.

STRUCTURAL CHOICES

ONCE THE MOST appropriate A/R model is selected, it is time to decide how the work is to be divided within the billing/collection department. Most often, these functions are split by primary payer or by alphabet. Some companies with multiple branches also choose to divide responsibilities by location.

The responsibility structure that has consistently shown superior outcomes assigns responsibilities by payer and, if the company provides a combination of HME and infusion services by service type.

Working by payer and/or by service type results in increased proficiency and efficiency in part because reimbursement, regulatory and documentation requirements are not only complicated but also vary among payers. This makes it extremely difficult for individual employees to remember and be proficient on all coverage criteria, compliance and documentation requirements.

When a company establishes responsibilities for billing/collection activities by alphabet or location, individual employees sometimes called super billers are forced to handle the billing for all payers and therapies. This does not lend itself to efficient billing and collections.

Case in point: We once had a large hospital-based client that assigned billing tasks by an alphabetical split so that each reimbursement employee was responsible for all payers and services/products. The company's DSO was well over 200 days, and collections averaged approximately 60 percent of monthly revenue.

After some discussion, the company's management was persuaded to reassign the job responsibilities by payer and by product/service. A major factor in the company's original decision to establish responsibilities as they had been was the premise that a billing employee's leaving the company would have minimal effect on the operation.

Three months after job designations had been reassigned by payer and product by which time the company had implemented weekly processing schedules, provided training and performed minor clean-up of the software system control files cash collections were consistently 150-200 percent of the current monthly revenue. After seven months, the DSO was approximately 90 days.

What many managers fail to consider when setting up billing operations is that it takes considerable time and experience to become proficient with all payers and product lines. It is rare in this industry that one billing center has more than one or two individuals who ever obtain this level and when they do, they are often promoted to supervisor or manager and are thus removed from direct billing responsibilities.

A SUSTAINABLE LOAD

ANOTHER IMPORTANT consideration when developing your billing center model is how much work each staff member can handle. Workload assessments should depend on payer responsibility, product mix, the company's level of automation, its current DSO and the different abilities and knowledge of the employees.

When billing is submitted to payers electronically, the average billing/collection employee should be able to handle at least 150-200 accounts more than if claims are billed on paper. Other payer issues with substantial bearing on the employees' work capacity include the requirements and procedures surrounding prior authorizations.

Companies that have a computer system with automated claims tracking and follow-up and automatic claims resubmission also have a decided edge in the number of accounts a biller/collector can handle.

Finally, the ability of the department's personnel directly affects productivity. Just as in any other profession, not all employees are of equal ability. To ensure good customer service and a stable cash flow, each employee's responsibilities must be challenging but also attainable.

Each employee's patient load does not have to be equal, but factor in the payer, product/service, prior authorization/documentation requirements and the employee's ability.

TIME TO TAKE ACTION

AFTER ALL THIS, if your DSO exceeds 90, you should re-evaluate your staff's responsibilities and workload. Just make sure you determine the reason for the increase in DSO and see if changes in training, work flow or automation correct the problem before hiring additional employees.

But if you carefully follow these strategies and procedures, you will see a difference in your company's performance. And so will your customers.

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Ask Yourself This

Managing a successful reimbursement center requires knowledge of the quantity and quality of work performed by your staff. You need this information to determine employee efficiency and make informed decisions regarding your staffing needs.

When job designations have been defined properly and with an adequate software package, you can easily gather valuable, detailed information not just on the reimbursement department's performance but also on that of individual staff members.

Listed below are the key statistical indicators you should collect monthly.

- Days sales outstanding in accounts receivable: How fast or slow are you being paid for services you have provided?
- Aged trial balance: Is the percentage of revenue in the 120-day column acceptable? Is it increasing or decreasing?
- Bad debt expense. Is it at an acceptable level? Is it increasing or decreasing in relation to prior months?
- Unbilled revenue days outstanding: How long is it taking to receive completed certificates of medical necessity from physicians? Prior authorizations? What is the length of time from order to billing?
- Revenue per employee: What is your efficiency? Is it improving or declining?

Tracking these performance standards enables you to identify (and reward) top employees. Just as important, it also allows you to evaluate (and improve) the work of low performers.

Remember: When individual employees are held accountable, they usually strive to improve their performance. They also respond more positively to specific feedback regarding job performance than to general negative feedback.

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