

Organizing Staff in Your Office For Improved Cash Flow

By John B. Pinto

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Written protocols are a major determinant—perhaps THE determinant—of billing department success. These need frequent updating, and should form the core of your training program. Protocols should be in sufficient detail to outline specific keystrokes needed to accomplish various tasks. For example:

“To prepare an aging report, select ‘Menu 8,’ ‘option #2.’ Enter the desired fields according to the screen’s prompts. Enter ‘print.’ This will print a report with outstanding balances for all patients by payer....”

Your procedure manual should be sure to include daily, weekly and monthly checklists, which can also be extremely helpful. Even the best-trained pilots resort to written checklists without embarrassment before they take off. And flying the billing department of a modern ophthalmic clinic is vastly more complex than flying a Cessna.

The major secondary gain of checklists, from the perspective of the department manager and administrator, is that it vastly reduces the supervision time. Relevant staff, each with their own checklist to mark up and turn in, can more readily be left to their own self-supervision, with less frequent hovering and oversight.

Sample Daily Checklist Items:

- Did we post the day's charges by day's end?
- Did we submit electronically?
- Did the clinic run on time today?
- Have the next day's patients been called?
- Were all of today's no-shows called?

Sample Weekly Checklist Items:

- Have timecards been entered and payroll called in?
- Was an office supplies run made?
- Have this week's recall card's been mailed?
- Have caller logs been forwarded to marketing for tabulation?

Sample Monthly Checklist Items:

- Has the month been closed at the same time for both the patient accounts system and the general ledger?
- Has the appointment template been advanced another month?
- Are all of the end of the month reports printed and bound?

[] Has the aged trial balance report been reviewed with the doctor?

Checklists like this will keep important—but not urgent—items in your plain view. It's easy in small, harried departments to have a month slip by and forget to generate the month-ending aging report because you're full-up with other duties.

How about for those difficult patients who refuse to pay their patient-responsible/self-pay amounts? First, you need to have the doctors' permission to pursue deadbeats. You probably already have escalating dunning letters, leading to, "If this account is not paid or suitable payment arrangements made within the next 10 days your account will be referred to an outside agency for collections." Obviously, the longer you delay vigorous internal action, or sending patients to a collection agency, the lower your chances go for financial recovery.

Warm staff hearts are chilling as the economy softens and overall fees decline. If your doctor has been reticent to send patients to a collection agency in the past, ask again. At the very least, try one last annual shot at laggard patients with a year-end offer of amnesty from further pursuit if they'll write a check for 50% to 80% of their outstanding bill by the end of the year.

Simple human error, often starting first at the front desk, is the bane of every insurance clerk. Some of these clerks and their department heads hold their tongue and silently correct repeated front desk errors. This may help to keep the peace, but at a large cost in continued errors. It's much better to bring entry errors and other gaffs right back to the person who goofed and gently ask them to correct it personally. Their learning curve will accelerate, and billing staff frustrations will be reduced. The same approach works well, obviously, if the problem starts with doctors or technical staff. Always bring the error back to its source for correction.

The grossest kind of clinic floor errors lead to missing superbills, which should be traced at the end of every day with a missing ticket or unclosed encounter report. More commonly, scribes and providers simply forget to check off boxes. In the typical setting, \$3 to \$10 on average is dropped from the average patient visit...not much money when you think about a single patient. But this adds up to tens of thousands of dollars over the course of a year. You simply have to sweat the details.

Given what's at stake, and the complexities of coding, most advisors these days like to put the responsibility back on the doctors—and not the scribes—to fill out the superbill. As a backup, there should be at least one lay person in the practice who works themselves into the position of being the company's guru and troubleshooter. This person should supervisor regular audits, training and manual writing, and is most commonly the head of billing or the practice administrator or even a dedicated specialist who also handles the compliance program in larger practices.

Make sure that you are matching departmental resources to departmental standards. It would be unfair to task your billing staff with an exceptionally high level of reporting and oversight, while giving them an exceptionally low level of resources (staff, facilities, equipment, training, PRN overtime, etc.) Remember through all of this that the administrator is the *resource allocation authority* who needs to balance practice standards (as articulated by the board) with practical economic matters.

Too often, departments are segregated from each other in practices, and live in their own boxes. The technical staff never really develop an appreciation for the challenges in billing, and vice-versa. This leads to the development of competitive factions. You can break this down by

exposing every new staff member to each area of the practice...allowing a slated front desk clerk, for example, to see surgery, and observe patient encounters for a morning. Once they better understand the “product” you sell, they’ll do a much better job representing your services to the public *and helping you get paid for these valuable services.*

One problem we see a lot is that billing department goals are too diffuse, and amount to little more than, “You all try your best, and let’s see how much we can bring in this month.” It’s far more effective to set specific goals. Here’s an example: an agreed date in the calendar by which time total accounts receivable fall must below an agreed figure. Or a target figure for your accounts receivable ratio (A/R divided by average charges.) It’s especially helpful to designate the percentage of total A/R that should be out past 90-days...typically 18% or less is the performance target.

How can you detect if your patient accounts team is falling behind? There are several signals. Ask staff who are in the middle of posting charges or submitting claims what date of service they are posting for. If the answer is over 72 hours ago, someone is falling behind. Examine the frequency of patient refund checks—it should be monthly. Ask staff where they keep their rejected claims, and examine the file...a large collection of unworked rejections is a common sign of getting behind. Look at the aged trial balance (aging) report and ask at random for the status of larger/old open accounts. If staff don’t know the status of most such accounts by rote, they may be falling behind.

There are lots of effective sources for help with billing department problems. All serve a purpose. You can turn to your computer vendor. You can call on local and national billing consultants. One of the most overlooked, resources are the staff in other eye care practices just like yours. You and your colleague may compete vigorously for cataract cases, but it’s very useful to develop relationships between patient accounts departments. It may even be helpful to pull together formal site visits among collaborating practices and to hold periodic group meetings to compare billing notes.

With so much to learn to run even a modest practice , and so much to try to get done—precisely right—all at the same time, what are the odds of success? The frank answer, is that the odds of your practice achieving perfection are very low. Even in the most scrupulous settings, excessive charges are added and neglected charges are dropped. There is no way around the fact that patient accounts work is mind-numbingly dull. So how can we get doctors, techs and others in the practice who need to know coding and reimbursement details cold up to speed? While some advisors focus on the negative, and point out all of the adverse consequences of error, we like to concentrate on the positive results of getting it right: Peace of mind. Maximum compensation. A sense of mastery and control. There are no problems, just opportunities.

In summary, here are ten top “rules,” success factors for your reception and patient accounts management department

- 1. Make sure you have enough of the right staff to get the job done properly**
- 2. Make sure you have sufficient cross-coverage and cross-training to never have just one person who knows a critical job, no matter how small the practice**
- 3. Develop, update and refer often to clear, written protocols**
- 4. Make sure staff are training using the written protocols**
- 5. The administrator and at least one doctor need to be highly conversant with your computer system and your billing protocols**

- 6. Use the written protocols to periodically inspect accuracy and efficiency**
- 7. Employ graphs over 12-24 month or longer periods to track trends in the collection ratio, A/R ratio, collections per billing department FTE per month, etc.**
- 8. Visit successful reception and billing departments in other practices and copy all of the things that they do better than you**
- 9. Develop both internal and external sources of expertise for billing problems as they arise. A few dollars spent for expertise now can help you avoid under-billing, uncertainty and costly adverse audits**
- 10. Invest in at least bi-annual refresher training courses with your computer vendor**

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