

## The Never Ending Battle for Timely Reimbursement

By Caryl Serbin, *Surgery Consultants of America*

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The procedure is over. The operative note dictated. The claim sent electronically within 48 hours of the procedure. Everything seems to be moving toward collecting the reimbursement in a timely manner. Then it happens!

An Explanation of Benefits is received with NO CHECK ATTACHED. The third-party payer tells us they can find no patient with this identification number in their data base. In most cases, this means you must refile your claim. This is just one example of what most billers and collectors deal with on a daily basis.

We've all heard the term "Days in A/R". This is a measurement of the average amount of time a billed charge remains in A/R before it's collected. Every day that a claim sits uncollected in your receivables your center is losing money. Every collection attempt that has to be made because of errors made by your center's billing department or the payer's reimbursement division costs you money.

Let's use an example of a claim sent to a payer whose contract indicates they are to pay 80% of billed charges. Billed charges were \$5,000 - this means the payer owes the center \$4,000 (provided the patient has paid co-payment and deductible).

Average hourly wages, benefits, and supplies cost the center approximately \$5.59 per 15 minute interval x each person working the claim.

In this example, the payer waits the full time allowed by the contract to send a denial (45 days). This means that the collector has already followed up 1 to 2 times before the denial is received. Whatever is needed is corrected and the claim is resubmitted. Another 45 days and two more follow-ups go by before payment is received. This means that there were 5 or 6 attempts at collecting this reimbursement at a total approximate cost of \$27.95. This does not include the 45 days of lost interest in your money market account which amounts to approximately \$12.54.

This total expenditure for ONE overdue claim amounted to over \$40. This claim was only 45 days late. Think about how much a claim that is still outstanding after 90 days or 120 days has cost the center. Multiply that by an average of 50 denials per month. The cost of collections is significant.

To try and make collections a shorter and more economic process, we have compiled a collection of collection hints - some are pre-surgery or pre-billing, others are post-billing and still others are post-denial.

1. Financial education or counseling of patient's pre-surgery, including collection of co-payments and deductibles is an important part of the collection process. All collectors know it's usually easier to collect these monies up-front than it is after the fact.

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2. Check and recheck the following before sending your claim:
  - a. Proper spelling of the patient's name
  - b. Name on claim is the same format as on insurance card, including middle initial
  - c. Accuracy of identification number including prefix, suffix, etc.
  - d. Correct claim address
  - e. All necessary information included on claim, including special payer-specific requests
  - f. Invoice or operative note is attached, if applicable
3. Start follow-up process 15 to 30 days after claim submission. Use a manual or computer "tickler" system. During first 60 days, follow up twice per month.
4. When following up, try to reach a "real person" and request reason for delay, request processing time, get a definite payment date.
5. Know your state's rules on prompt payments - remind the payer when necessary.
6. Touch all accounts at least every 30 days.
7. Call delinquent accounts by payer. This allows the collector to make one phone call to discuss all outstanding claims with that payer regardless of age.
8. Promptly send additional information if requested.
9. Document in detail for all to see.

One of the most important tools in collections is a denial log (see sample form). Every denial received should be recorded in the log in the appropriate category. This helps you determine trends, either yours or the payers, and make corrections. It also allows you to pinpoint where employees may need reinforcement or education. Some categories you may want to include are:

- **Wrong patient information - name, ID, date of birth**
- **Form errors - insurance company or ASC**
- **Clearinghouse errors**
- **Wrong insurance, network, claim office**
- **No pre-authorization**
- **Non-ASC procedure**
- **Non-coverage, benefits expired**
- **Coding error**
- **No accident information**
- **Additional information**

Every collector is aware of the importance of reports on your accounts receivable. Measure the A/R by payer, physician provider, specialties, age - analyze for trends

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such as timely filing, timely reimbursement, etc.. These reports can point out areas where you may not realize you are having problems. For instance, increased non-payment by a specific payer may reveal they are having computer problems; non-payment of implants may be carrier-specific or procedure-specific and indicates an area that needs to be followed up.

There are so many reasons and non-reasons for non-payment or wrong payments on claims, the list is almost endless. However, as shown above, the cost of collection is a formidable one and every effort must be made to try and curtail these expenses. Hopefully these hints will assist you in this endeavor.

DOWNLOAD EXAMPLE OF DENIAL FORM  
[CLICK HERE TO VIEW OR SAVE EXCEL FILE](#)

Caryl A. Serbin, RN, BSN, LHRM  
President and Founder  
Surgery Consultants of America, Inc.  
Surgery Center Billing, LLC

12670 CREEKSIDE LN. SUITE 401  
FORT MYERS, FL 33919

Toll Free: 1-866-889-7722

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