



# PMBA

PROFESSIONAL MEDICAL BILLERS ASSOCIATION  
"Certifying Excellence in Medical Billing."

## Accounts Receivable

# The Key to Healthcare Revenue Management



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# Introduction

In the intricate world of healthcare finance, accounts receivable (AR) plays a pivotal role in ensuring the financial stability of healthcare providers. Medical accounts receivable refers to the outstanding reimbursement owed to providers for the treatments and services they have rendered, whether the responsibility falls on the patient or their insurance company. It is crucial for healthcare providers to manage their accounts receivable effectively to maintain a healthy revenue cycle and ensure the financial viability of their practice. This essay explores the significance of accounts receivable in the healthcare industry, the challenges it poses, and the strategies to optimize revenue management.

**AR calling:** in medical billing refers to the process of contacting insurance companies, patients, or other payers to follow up on outstanding claims that have not been paid or have been denied. It is a crucial step in the revenue cycle management (RCM) process, occurring after the initial claim submission and processing.

When a claim remains unpaid or is denied, it becomes part of the accounts receivable (AR) of the medical practice. AR calling involves proactive efforts to resolve these outstanding claims and ensure timely and accurate reimbursement for the services rendered by the healthcare provider.

## The responsibilities of AR calling in medical billing include

**Claim Analysis:** AR specialists review the details of the denied or unpaid claim, verifying that all required information, including patient details, diagnosis codes, procedure codes, and supporting documentation, is correct and complete.

**Follow-up with Insurance Companies:** AR specialists contact insurance companies to inquire about the status of the claim and the reasons for the denial or non-payment. They may request additional information or clarification to address any discrepancies.

**Patient Communication:** In cases where the patient is responsible for a portion of the payment, AR calling may involve contacting the patient to discuss outstanding balances, co-pays, co-insurance, or deductibles. They provide information about the claim status and payment options to facilitate prompt settlement.

**Resolving Claim Issues:** Based on the information gathered during follow-up, AR specialists take appropriate actions to address claim issues. This may include resubmitting corrected claims, appealing denied claims, or addressing any other issues that are preventing timely payment.

**Documentation and Record-keeping:** Throughout the AR calling process, thorough documentation of all interactions with insurance companies, patients, and other payers is essential for accurate tracking and efficient resolution of claims.

**Reporting and Analysis:** AR specialists maintain records of AR aging, tracking the length of time each claim has been outstanding. They generate reports to analyze trends, identify recurring issues, and implement strategies for improving the overall AR performance.

## Understanding Medical Accounts Receivable

Accounts receivable in the medical context encompass the money owed to healthcare providers for the healthcare services they have provided to patients. When healthcare providers bill a patient or their insurance company for services rendered, it gives rise to an accounts receivable. It is important to note that although ARs represent outstanding payments, they do not qualify as assets in the traditional sense.

*The longer an account goes unpaid for services rendered, the more likely it is that an account will never be paid.*

Providers categorize accounts receivable based on their age, usually in the following time frames:

- ▶ 1-30 days,
- ▶ 31-60 days,
- ▶ 61-90 days, and
- ▶ 91-120 days.

Charge entry errors and patient information inaccuracies on submitted claims lead to claim denial and lengthened AR cycles.

# Challenges Faced by Healthcare Providers

One of the most significant challenges faced by healthcare providers is the collection of reimbursements within a reasonable time frame. The longer an AR goes unpaid, the higher the risk of non-payment altogether. **According to industry statistics, after 120 days, healthcare providers can expect to receive only ten cents per dollar owed.** This highlights the urgency for timely and efficient AR management to avoid revenue leakage and financial losses.

Moreover, managing accounts receivable can be complex and time-consuming for healthcare providers. The process involves dealing with insurance companies, claims denials, appeals, and patient billing inquiries. It requires constant monitoring and follow-up to ensure that outstanding payments are collected promptly.

## Optimizing Revenue Management

Effective management of medical accounts receivable is crucial for healthcare providers to maintain a steady cash flow and financial stability. To optimize revenue management, healthcare providers should implement the following strategies:

**Timely Billing:** Promptly bill patients and insurance companies after providing healthcare services to minimize delays in reimbursement.

**Clear Communication:** Ensure clear and transparent communication with patients regarding their financial responsibilities and payment options.

**Proactive Follow-Up:** Implement a systematic follow-up process to track unpaid claims and address any issues or denials promptly.

**Denials Management:** Invest in denials management software or services to identify and address claim denials efficiently, reducing the risk of revenue loss.

**Patient Engagement:** Engage with patients to educate them about their insurance coverage, co-pays, and deductibles, fostering a better understanding of their financial responsibilities.

**Regular Reporting:** Generate regular reports to analyze the aging of accounts receivable and identify areas for improvement in the revenue cycle.



Medical accounts receivable forms the backbone of healthcare revenue management, representing the outstanding reimbursements owed to healthcare providers for the services they deliver. Efficient management of accounts receivable is essential to maintain a healthy revenue cycle, avoid revenue leakage, and ensure the financial viability of healthcare practices. By implementing proactive strategies, engaging patients, and maintaining clear communication with payers, healthcare providers can optimize their revenue management and continue providing quality care to their patients. It is through effective accounts receivable management that the healthcare industry can maintain its financial health and continue serving the needs of patients worldwide.

**The AR cycle is the final segment of the revenue cycle. Issues that may occur throughout the revenue cycle, even as early as collecting patients' personal and insurance information, threaten the success of both.**

## Reason

Since the enactment of the Affordable Care Act (ACA) in 2010, many Americans have opted for high-deductible health insurance plans as a means to lower their monthly premiums. While this choice has provided cost-saving benefits for policyholders, it has also resulted in an increase in out-of-pocket expenses for patients when they seek medical care. As a consequence, medical providers have experienced a surge in patients responsible for a higher percentage of their medical bills.

For healthcare providers, this shift in patient insurance coverage has led to significant challenges in managing their accounts receivable (AR) processes. In the past, when patients had lower deductibles and insurance covered a larger portion of the medical expenses, providers could more readily rely on timely reimbursements from insurance companies. However, with the rise in high-deductible plans, the burden of recouping reimbursements has shifted from insurance companies to individual patients, placing additional strain on providers' revenue management systems.

# Challenges

- ▶ High deductibles
- ▶ Shortage of Certified Medical Billers
- ▶ submitting incomplete insurance information
- ▶ Unverified insurance
- ▶ Errors on bills and invoices
- ▶ Missed follow-ups
- ▶ Disorganized collection process

## Calculating - “Days in AR”

Calculating Days in Accounts Receivable (AR) is a vital financial metric for healthcare providers, helping them assess the efficiency of their revenue cycle and understand the average time it takes to collect outstanding payments from patients and insurance companies. To calculate Days in AR, follow these steps:

### **Step 1:** Compute the Average Daily Charges for the Past Several Months

To begin, add up the total charges posted for the last six months. For example, let's assume the sum of charges for the past six months is \$180,000. Next, determine the total number of days in those six months. If each month had 30 days, then the total number of days would be 180 (6 months \* 30 days per month).

Now, divide the total charges (\$180,000) by the total number of days (180) to calculate the average daily charges. In this case, the average daily charges would be \$1,000 (\$180,000 / 180 days).

### **Step 2:** Divide the Total Accounts Receivable by the Average Daily Charges

Next, determine the total accounts receivable balance at a specific point in time. Let's assume the total accounts receivable is \$60,000.

Now, divide the total accounts receivable (\$60,000) by the average daily charges (\$1,000) to calculate the Days in AR. In this example, the Days in AR would be 60 days (\$60,000 / \$1,000).

# Interpreting the Result

The calculated Days in AR (60 days) represents the average number of days it takes for the healthcare provider to collect outstanding payments from patients and insurance companies. In this case, the provider takes an average of 60 days to receive payment for services rendered.

A lower number of Days in AR indicates that the provider's revenue cycle is efficient, and outstanding payments are being collected promptly. Conversely, a higher number of Days in AR suggests that the revenue cycle may be experiencing delays in payment collection, potentially leading to cash flow challenges and impacting the financial health of the healthcare practice.

Monitoring Days in AR regularly enables healthcare providers to identify areas for improvement in their revenue management processes, enhance collection efforts, and maintain a financially stable practice. By implementing effective accounts receivable management strategies, providers can strive to reduce Days in AR and optimize their revenue cycle for sustainable financial success.

- ▶ 30 days or less for a High performing Medical Billing Department- Good or High Performance
- ▶ 40-50 days for an Average performing Medical Billing Department.
- ▶ 60 days or more for a Below Average Medical Billing Department- Good or High Performance

Monitoring the percentage of A/R that has aged beyond 90 and 120 days is a fundamental component of effective revenue cycle management for medical practices. It provides key insights into the aging of outstanding receivables and helps assess the practice's ability to collect payments in a timely manner.

## Example-2: AR Days

**A/R Days = (Accounts receivable ÷ Annual revenue) x Number of days in the year**

Accounts receivable for a pediatric clinic is \$100,000 and its (Account receivable/total charges) X 365 days is \$600,000. Then the A/R days for this clinic will be:

A/R Days = (\$100,000 accounts receivable ÷ \$600,000) x 365 days = 60.8 Accounts Receivable Days

# Calculating - “Aging Buckets”

The percent of accounts receivable in each "aging bucket" is a crucial metric used by healthcare providers to assess the efficiency of their billing departments and the effectiveness of their accounts receivable management. Aging buckets typically categorize outstanding accounts receivable based on the number of days since the invoice or claim was issued. The standard aging buckets are often segmented as follows: 0-30 days, 31-60 days, 61-90 days, 91-120 days, and over 120 days.

To calculate the percent of accounts receivable in each aging bucket, healthcare providers generate a report that shows the dollar amount of outstanding AR in each bucket. This report helps them visualize the distribution of outstanding payments across different timeframes.

To convert each aging bucket to a percentage of the total accounts receivable, follow these steps:

Sum up the dollar amounts of AR in each aging bucket. For example, let's assume the total AR in each aging bucket is as follows:

- ▶ 0-30 days: \$50,000
- ▶ 31-60 days: \$20,000
- ▶ 61-90 days: \$15,000
- ▶ 91-120 days: \$10,000
- ▶ Over 120 days: \$5,000

Calculate the total accounts receivable by adding up the AR amounts in all aging buckets:

Total AR = \$50,000 + \$20,000 + \$15,000 + \$10,000 + \$5,000 = \$100,000

Convert each aging bucket to a percentage of the total AR:

- ▶ Percent in 0-30 days bucket =  $(\$50,000 / \$100,000) * 100\% = 50\%$
- ▶ Percent in 31-60 days bucket =  $(\$20,000 / \$100,000) * 100\% = 20\%$
- ▶ Percent in 61-90 days bucket =  $(\$15,000 / \$100,000) * 100\% = 15\%$
- ▶ Percent in 91-120 days bucket =  $(\$10,000 / \$100,000) * 100\% = 10\%$
- ▶ Percent in Over 120 days bucket =  $(\$5,000 / \$100,000) * 100\% = 5\%$

# Denial Rate

Total Dollar Amount of Denied Claims ÷ Total Dollar Amount of Submitted Claims

**FPRR:** The First Pass Resolution Rate (FPRR) is a critical performance metric used to assess the efficiency and effectiveness of a medical practice's Revenue Cycle Management (RCM) process. It measures the percentage of claims that are successfully paid by the insurance company on the first submission, without the need for resubmission or appeal.

A high FPRR indicates that the RCM process is streamlined, accurate, and well-managed, resulting in a higher proportion of claims being paid promptly and correctly. On the other hand, a low FPRR suggests inefficiencies or errors in the billing, coding, or claims submission process, leading to claim denials or delays in reimbursement.

## FPRR Calculation

To calculate the First Pass Resolution Rate, use the following formula:

$$\text{FPRR} = (\text{Number of claims paid on the first pass} / \text{Total number of claims submitted}) * 100$$

For example, if a medical practice submitted 100 claims to insurance companies, and 85 of those claims were successfully paid on the first submission without any need for resubmission, the FPRR would be:

$$\text{FPRR} = (85 / 100) * 100 = 85\%$$

## Interpreting FPRR

A high-performance FPRR is typically considered to be 90% or higher. This means that 90% or more of the claims are successfully paid on the first submission. Achieving a high FPRR is crucial for optimizing revenue cycle operations and ensuring prompt reimbursement for services provided.

## Importance of FPRR

A higher FPRR signifies a well-organized and efficient RCM process, leading to several benefits for the medical practice:



**Reduced Accounts Receivable (AR):** A higher FPRR means fewer claims are pending, leading to a decrease in the number of outstanding accounts receivable. This, in turn, improves cash flow and financial stability.

**Faster Payments:** When claims are paid on the first pass, payment turnaround times are significantly reduced, providing the practice with more timely revenue.

**Lower Administrative Costs:** Rejected or denied claims require additional administrative efforts and resources for resubmission and appeals. A higher FPRR helps minimize these extra costs.

**Improved Patient Satisfaction:** A streamlined billing process resulting in faster reimbursement can lead to improved patient satisfaction and trust in the medical practice.

**Enhanced Revenue Performance:** An efficient RCM process with a higher FPRR contributes to overall revenue optimization and financial success.

## GCR

The Gross Collection Ratio (GCR) is a significant financial metric used in medical billing to assess the efficiency and profitability of a healthcare practice. It measures the percentage of total payments received by the practice relative to the total charge amount allowed for the services rendered during a specific time period.

GCR is a critical indicator of how effectively the practice is able to collect the fees it is entitled to receive from insurance companies and patients. It helps identify how well the practice is performing in terms of revenue generation and collection efforts.

## GCR Calculation

To calculate the Gross Collection Ratio, use the following formula:

$$\text{GCR} = (\text{Total Payment amount} / \text{Total Charge Amount}) * 100\%$$

For example, if a practice billed a total of \$100,000 for services rendered during a specific time period, and they received \$80,000 in payments from insurance companies and patients, the GCR would be:

$$\text{GCR} = (\$80,000 / \$100,000) * 100\% = 80\%$$

# Interpreting GCR

A higher GCR indicates that the practice is able to collect a larger percentage of the fees it is allowed to charge for services. This suggests that the practice is performing well in terms of reimbursement and revenue collection.

On the other hand, a lower GCR may indicate potential issues in the revenue cycle, such as claim denials, delayed payments, or write-offs. A lower GCR could also be a result of contracted fee schedules with insurance companies that allow for lower reimbursement rates.

It is important to note that GCR can vary among different healthcare practices due to factors such as the type of services offered, insurance contracts, fee schedules, patient demographics, and billing practices. Therefore, GCR is best used as an internal benchmark to monitor the practice's financial performance over time, rather than comparing it with industry benchmarks or other practices.

## Importance of GCR

Monitoring the Gross Collection Ratio is crucial for medical practices to understand their financial health and the effectiveness of their revenue collection efforts. A high GCR indicates that the practice is successful in obtaining reimbursement for the services it provides, contributing to better financial stability and profitability.

By regularly tracking GCR, medical practices can identify trends and areas for improvement in their revenue cycle management. Analyzing GCR alongside other financial metrics allows practices to implement strategies to optimize revenue collection, improve the efficiency of billing processes, and enhance overall financial performance.

## NCR

Net Collection Ratio helps to measure the overall health of the billing and collection process.

It is helpful to determine the efficiency of the practice by measuring reimbursement amount over the allowed amount.

To calculate the Net Collection Ratio (NCR), follow these steps:

- Step 1:** Determine the Total Charge Amount - This is the total amount that the medical practice has billed for the services rendered during a specific time period.

**Step 2:** Calculate the Contractual Adjustments - Contractual adjustments are the reductions in the total charge amount that result from contractual agreements with insurance companies or other adjustments made during the billing process.

**Step 3:** Subtract Contractual Adjustments from Total Charge Amount - Subtract the contractual adjustments from the total charge amount to get the adjusted charge amount.

**Step 4:** Determine the Total Payment Amount - This is the total amount that the medical practice has received in payments from insurance companies and patients for the services rendered during the same time period.

**Step 5:** Calculate the Net Collection Ratio - Divide the total payment amount by the adjusted charge amount and multiply by 100 to get the NCR as a percentage.

**NCR Calculation:**  $(\text{Total Payment Amount} / (\text{Total Charge Amount} - \text{Contractual Adjustments})) * 100$

**For example:**

Total Charge Amount: \$100,000

Contractual Adjustments: \$20,000

Total Payment Amount: \$78,000

Adjusted Charge Amount = Total Charge Amount - Contractual Adjustments

= \$100,000 - \$20,000

= \$80,000

Net Collection Ratio =  $(\text{Total Payment Amount} / \text{Adjusted Charge Amount}) * 100$

=  $(\$78,000 / \$80,000) * 100$

= 97.5%

In this example, the Net Collection Ratio is 97.5%, which indicates that the medical practice is collecting 97.5% of the total allowed amount for services rendered. An NCR of 98% or greater is considered a high-performance level, while an NCR below 90% is indicative of poor performance in terms of revenue collection efficiency.

# CPV

Collection Per Visit (CPV) for a specific time period, follow these steps:

**Step 1:** Determine the Total Reimbursements - This is the total amount of money the medical practice has received in reimbursements from insurance companies and patients for all the services rendered during the specified time period.

**Step 2:** Determine the Total Visits - This is the total number of patient visits or appointments the medical practice has had during the same time period.

**Step 3:** Calculate the Collection Per Visit - Divide the total reimbursements by the total visits to get the Collection Per Visit.

Collection Per Visit Calculation: Total Reimbursements / Total Visits

## For example:

Total Reimbursements: \$50,000

Total Visits: 500

Collection Per Visit = Total Reimbursements / Total Visits

= \$50,000 / 500

= \$100 per visit

In this example, the Collection Per Visit is \$100, which means that on average, the medical practice collects \$100 for each patient visit or appointment during the specified time period.

Analyzing the Collection Per Visit helps the medical practice in the following ways:

**Measuring Profitability:** CPV allows the practice to determine how much revenue is generated per patient visit, helping to assess the financial health of the practice.

**Benchmarking Against Industry Standards:** By comparing the CPV with industry standards and other same-specialty practices in the same area, the practice can gauge its financial performance and identify areas for improvement.

**Identifying Profitable Appointments:** CPV helps in determining the most profitable appointments or cases, enabling the practice to prioritize similar cases to generate more profit.

**Strategic Decision-Making:** Analyzing CPV helps in making informed decisions on how to increase revenue, such as focusing on high-profit appointments or identifying areas where efficiency can be improved.

Monitoring CPV regularly and striving to increase it can lead to improved financial performance and increased profitability for the medical practice.

Please note that the accuracy and relevance of the Collection Per Visit metric depend on the completeness and accuracy of the data used for calculation. It is essential to ensure that the data used in the calculation is reliable and up-to-date to get meaningful insights into the practice's financial performance.

## Contractual Variance

Contractual Variance is the amount that is paid less by the insurance company as per the contract.

**Contractual Variance Calculation:** Contracted Rate - Insurance Allowed Amount

**For example:**

Contracted Rate: \$50.00

Insurance Allowed Amount: \$35.00

Contractual Variance = Contracted Rate - Insurance Allowed Amount

= \$50.00 - \$35.00

= \$15.00

## Key Reasons Medical Practices Lose Money

Medical practices can experience financial losses due to several key reasons that hinder their revenue cycle management (RCM) process. These reasons highlight the importance of implementing comprehensive policies, procedures, and internal oversight controls to ensure efficient and effective financial operations. Some of the key reasons medical practices lose money include:

**Failure to Collect Patient Co-pay and Co-insurance:** When medical practices do not prioritize or effectively collect patient co-pays and co-insurance at the time of service, it can lead to a significant revenue leak. Neglecting to collect these payments upfront can result in delayed or missed payments, impacting the practice's cash flow.



**Not Having the Right Team to Manage the RCM Process:** Inadequate staffing or lack of expertise in revenue cycle management can lead to inefficiencies, errors, and delayed reimbursement. A well-trained and experienced team is essential for effective billing, coding, claims submission, and follow-up, maximizing revenue collection.

**Failure to Manage Denials Effectively:** Denials from insurance companies can occur for various reasons, such as incomplete or incorrect information on claims. Failing to address and appeal denials in a timely manner can result in lost revenue and increased administrative costs.

**Unnecessary Write-offs:** Incorrectly writing off patient balances without thorough investigation or attempts at collection can lead to unnecessary revenue loss. Proper tracking and follow-up on outstanding balances are crucial to avoid unjustified write-offs.

**Insufficient Focus on Patient Collections:** Medical practices must proactively address patient collections by establishing clear and transparent financial policies, providing payment options, and offering financial assistance when needed. Failure to prioritize patient collections can lead to significant outstanding balances.

**Not Having a Proper Insurance Eligibility Verification Process:** Lack of a robust insurance eligibility verification process can result in billing errors, claim rejections, and delayed payments. Verifying patients' insurance coverage before providing services helps avoid potential denials and financial losses.

**Not Using a Claims Edits System:** A claims edits system can identify coding errors, missing information, or billing discrepancies before claims are submitted. Without such a system, practices risk increased claim rejections and delayed reimbursements.

**Inaccurate Coding:** Coding errors, whether undercoding or overcoding, can lead to claim denials and potential compliance issues. Accurate and precise coding is essential for proper reimbursement and revenue optimization.

**Failure to Keep Pace with Patient Consumerism Demands:** As patients become more informed and proactive in managing their healthcare expenses, medical practices must adapt to meet their demands. Practices that do not provide transparent pricing, patient portals for billing inquiries, or convenient payment options may lose patients and revenue.

**Failure to Measure Key Performance Indicators (KPIs) Consistently:** Regularly monitoring and analyzing financial performance through KPIs is crucial for identifying

areas of improvement in the revenue cycle. Practices that do not consistently measure and act upon KPIs may miss opportunities to optimize revenue and reduce losses.

Addressing the key reasons medical practices lose money requires a proactive and systematic approach to revenue cycle management. By implementing comprehensive policies, efficient internal controls, and a dedicated team, practices can optimize their revenue cycle, minimize financial losses, and ensure a sustainable financial future. Regularly evaluating performance metrics and adapting to patient consumerism demands are also vital for staying financially viable in the ever-evolving healthcare landscape.

## The Differences Between Denied, Pended, and Paid.

### Denied Claims

Some common reasons for claim denials include:

**Service Not Covered:** The insurance program may not cover the specific service or treatment rendered to the patient. In such cases, the claim will be denied as the insurance policy does not provide reimbursement for that particular service.

**Coding Errors:** Coding to the highest level of specificity is the best way to reduce denials. A diagnosis must be coded to the absolute highest level for that code the maximum number of digits for the code being used

**Duplicate Claim:** If a claim is submitted for the same service or treatment more than once, it will be considered a duplicate claim and will be denied by the insurance company.

**Lack of Prior Approval:** Certain medical services or procedures require prior approval from the insurance company before they can be covered. If the required prior approval is not obtained, the claim will be denied.

**Invalid or Inconsistent Data:** If the information provided in the claim is incorrect, incomplete, or inconsistent, the insurance company may deny the claim. This can include errors in patient demographics, diagnosis codes, procedure codes, or billing codes.

**Timely Filing Limit Exceeded:** Insurance companies often have specific timeframes within which claims must be submitted. If the claim is not filed within the allowed time limit, it will be denied as untimely.

**Non-Covered Diagnosis or Procedure:** Certain diagnoses or procedures may not be covered under the patient's insurance policy. If the claim is related to a non-covered diagnosis or procedure, it will be denied.

**Coordination of Benefits (COB) Issues:** If the patient has multiple insurance policies, the claim may be denied due to coordination of benefits issues. This occurs when the primary insurance has not been billed first, or the secondary insurance information is incorrect.

**Missing or Inadequate Documentation:** If the claim lacks the necessary supporting documentation, such as medical records or evidence of medical necessity, it may be denied.

**Lapsed or Inactive Insurance Policy:** If the patient's insurance policy has lapsed or become inactive, the claim will be denied as there is no active coverage for the services provided.

When a claim is denied, the medical billing team must review the reason for denial and take appropriate actions to rectify the issue. This may involve appealing the denial with additional documentation, correcting errors, obtaining prior approvals, or resubmitting the claim with the correct information. Effective denial management is crucial for medical practices to optimize revenue and ensure proper reimbursement for the services they provide to patients.

## Pended Claim

A claim may be pended if it contains erroneous information, does not match requires manual review to be resolved.

Some common reasons to pend a claim are:

- ▶ Recipient Number invalid
- ▶ Medical Review required
- ▶ Procedure requires manual pricing
- ▶ No Service Authorization on file

# Improve

- ▶ Implementing comprehensive patient communication and education programs to help patients better understand their insurance coverage, deductibles, and financial responsibilities.
- ▶ Investing in modern revenue cycle management tools and technology can also prove beneficial for healthcare providers.
- ▶ Streamline Claims Submissions – Hire certified professional medical billers
- ▶ Offering flexible payment options and financial assistance programs can ease the burden on patients experiencing financial difficulties.
- ▶ Implementing clear and compassionate financial policies can enhance patient satisfaction while supporting a higher rate of successful collections for medical providers.
- ▶ Evaluating process inefficiencies and oversights
- ▶ NRFT- Not right first time - collect patient information and submit correct claims on their first attempt
- ▶ Unverified insurance poses the biggest threat to medical claim reimbursement.
- ▶ Payment strategies for deductibles, copays
- ▶ Certified staff for charge entry, EOB postings
- ▶ Consistently Run A/R Reports-analyse the reports. Implement predictive analysis
- ▶ Increase the Frequency of Billing Cycles

## Disclaimer

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