10 Ways to Reduce Your Urgent Care Center's Accounts Receivable

Alan A. Ayers, MBA, MAcc
Content Advisor, Urgent Care Association of America
Vice President of Strategy and Execution, Concentra Urgent Care
Dallas, Texas

Cash is the lifeblood of every business but the challenge with medical insurance billing is that it takes 30 to 90 days (or more) to be paid for patient visits that require immediate expenditures for staff, rent, equipment and supplies. Accounts receivable are expensive. Not only are there direct costs of documenting, submitting, following-up, and posting insurance claims—but when there is insufficient cash available to pay practice expenses, "working capital" must either be borrowed from the bank or retained from the owners.

Follows are 10 guidelines for reducing accounts receivable and improving profitability in urgent care:

1. **Financial Policy:** Before a patient visits an urgent care center, he should have a clear understanding of both the total expected cost of the visit as well as how much he will be required to pay at time of service. The financial policy should be clearly communicated on the center's website, verbally by the front office staff, and in materials provided at registration. It should detail which insurance plans are accepted, the cost of a cash visit for the uninsured, and whether the patient will be billed his deductible or required to put down a "deposit" at time of service.

2. **Insurance Verification**: Just because a patient presents an insurance card doesn't mean he is insured. In a recessed economy, people transitioning between jobs often forego COBRA coverage and some businesses reduce or drop employee benefits. Before the center treats any patient, the front desk should contact the insurance carrier to confirm enrollment, coverage levels, co-pays, and deductibles. Failure to verify insurance could result in a denied claim and a patient balance that never gets paid.

3. **Patient Registration:** When a patient arrives at the urgent care center, the front office should verify that all demographic information is complete and accurate in the billing system. Not only are many insurance claims rejected due to inaccurate information but incorrect addresses also lead to postal return of patient invoices. If the patient has been seen at the center before, it is inadequate to ask "whether any information has changed." Instead, the front desk should have the patient review and initial that his address, employment, and insurance information is correct. Patients should also receive a copy of the financial policy and sign that they understand their obligations. To save time by processing information before the patient arrives, many urgent care centers post registration forms on their website or offer Internet or telephone pre-registration services.

4. **Collect Co-payment, Deductible, and Patient Balances:** Prior to the visit, the patient should be required to make his insurance co-payment. Failure to collect the co-pay prior to service too often results in patients walking out without paying or "forgetting" their checkbook. If insurance verification shows a deductible, the policy at many centers is for the patient to pay a "deposit" (typically $100 to $150) prior to the visit and then settle any balances when charges are calculated after the visit. If it turns out after submitting an insurance claim that the patient had already met his deductible elsewhere, a refund check can always be mailed. It's also a good idea to review the patient's account and collect payment on any prior balances before the patient incurs additional charges.

5. **Provide Care and Document Services:** While the patient is still in the exam room, the provider should document the patient's history, physical findings, all diagnoses, services performed, supplies used, prescriptions or tests ordered, and patient instructions. Thorough documentation is necessary for accurate coding and charge entry and to support insurance claims. Charts should be regularly reviewed to assure the documentation supports the level of service and that no money is being left on the table by omitting billable codes.

6. **Generate and Submit Claim:** When a third-party payer rejects a claim, correcting and resubmitting can add two to three weeks to accounts receivable. Health insurance claims are most often rejected due to missing or inaccurate information including patient name, subscriber information and diagnosis and procedure codes. Using a good practice management software solution—or outsourcing to a medical billing company—can reduce errors by assuring claims are complete before submission. But because systems are only as good as the data they contain—following steps one through five above are essential in assuring accurate information on insurance claims.

7. **Monitor, Receive and Document Insurance Reimbursement:** When an insurance company processes a claim, it creates an Explanation of Benefits (EOB) detailing what services were billed and how much the insurance company and the patient is responsible for paying. To assure receivables are not carried on paid accounts, and to invoice patient balances in a timely manner, EOBs should be posted to the patient record immediately upon receipt. To expedite posting, many billing applications and insurance carriers offer electronic remittance services in which EOB data is sent digitally to the billing system.

8. **Invoice Patient:** When patients don't understand what they owe a provider, and the reasons why they owe it, they are less likely to pay their medical bills. Patient invoices should clearly explain the dates of service, services performed, insurance payments, payments collected at time of service, and the total amount due. To achieve a patient friendly look and feel—and scale economies in production and mailing—many centers utilize third parties to print and mail invoices. Patient invoices should be sent as soon as the EOB is posted because the sooner an invoice is received by the patient, the more likely and faster it is to be paid.

9. **Write-off or Third-Party Collections:** Written billing procedures should address handling of past-due accounts. Typically centers automatically write-off small balances less than $5 or $10 where billing costs exceed potential collections. The process for larger balances would designate time intervals for sending a second invoice, a warning letter, and then disposing the account to a third-party collections agency. More recent balances have a higher likelihood of collections success which results in lower fees charged by the collections agency.

10. **Close-out Charge:** Once final payment has been received, or the account has been written off to collections, the charge should be closed out. To improve management of receivables, records should be maintained including average accounts receivable days and write-offs by payer, provider, and service. Most practice management systems include standard reports for managing accounts receivable. Key is for everyone involved in patient service—from the front office to providers and billing—should understand the issues contributing to high receivables and their role in improving overall collections.

For more information on how to optimize cash in your urgent care center, including common drivers of accounts receivable balances, see "Playing to Win: Maximizing Profits in Urgent Care" in the April, 2008 *Journal of Urgent Care Medicine* at http://jucm.com/2008-apr/practicemanagement2.shtml