CASH REVIEWS

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A cash review is a systematic method to follow cash. The methodical process provides an overview of the cash flow and alerts both the practice staff and the billing company that the numbers are reviewed. The reviews are not designed to find every mistake or discrepancy. Instead, they address the basic question: Are we being paid for the services we provide?

You can take three to four hours to conduct a cash review and find out if:

- Services are billed
- Posting is correct
- Money is lost
- Credits and refunds are accurate
- Aged receivables are reasonable
- Reports are valid

The size of the practice often guides the frequency of reviews and the size of the random sampling. For a small organization, quarterly cash reviews are probably sufficient. For medium to large organizations, monthly reviews—and in some cases, weekly reviews— should be conducted.

ARE SERVICES BILLED?

Enter **all** services provided to patients into the billing software program; it is the only way to establish a reliable audit trail. Depending upon your billing software capabilities, you may need to set up a "non-billable" holding folder or non-billable code that prevents incomplete accounts from being sent to insurance carriers.

Eliminate any procedure that holds incomplete accounts in a paper "to do" folder and bypasses computer entry. Temporary paper files are too easy to lose, impossible to track, and often result in missed filing dates.

Missed billing opportunities do not appear on billing software-generated reports when incomplete accounts are withheld from a computerized system. Consequently, the reports appear favorable because poor patient-receivables management is excluded.

A system that allows incomplete accounts and services withheld from computer entry also provides a means to withhold cash entries—making embezzlement difficult to find. For example, a patient (one usually on an initial visit who is not likely to return) pays $50 in cash—no receipt is given. Demographic and service information is not entered in the computer and the cash is pocketed.

SERVICE REVIEW

Select two or three days randomly from your schedule and run a list* of patients seen and services provided. Confirm that all services, demographics, and insurance information has been entered in the computerized billing program and billed.

*Alert: Verify the query documentation whenever requesting lists. Check the "filters" attached to the query. Adding or excluding information by filtering queries is one way of making the report appear favorable. In some cases, it can be very difficult to confirm filters. Whenever possible, sit at the computer and open the files yourself.

IS MONEY LOST FROM THE INCORRECT POSTING OF CONTRACTUAL AND BAD DEBT ADJUSTMENTS?

Have adjustment and bad debt policies in writing. Contractual adjustment is the difference between the actual fee and the insurance carrier's allowed fee. Generally, bad debt occurs when the insurance company has not paid its expected portion of the fee because of an error caused by the office staff, such as a missed filing date and/or incomplete claim submitted, etc., or when a patient refuses to pay their bill.

Reviews and audits are easier to conduct when gross numbers, rather than net, are used and when there are two adjustment accounts—contractual and bad debt. It is very easy to hide bad debt problems with "adjusted" totals because practices frequently overlook reviewing the reasons and documentation for adjustments.

The following is an example from a multi-site clinic that offered a sliding scale adjustment for financial hardship.

Fee:	$100
Hardship adjustment:	$ 65
Adjusted patient balance:	$ 35

If the patient did not pay the adjusted balance, only $35 was written to bad debt. Management thought that bad debt write offs were under control because the bad debt reports appeared reasonable. Financial adjustments usually are agreed upon at the time of the initial visits; however, hardship adjustments are frequently used to write off bad debt—without patients requesting assistance or completing any documentation.

CONTRACTUAL AND BAD DEBT ADJUSTMENTS REVIEW

Select four to five checks (from different insurance carriers) and corresponding EOBs (Explanation of Benefits). Run a list showing the patient's name, amount billed, amount paid, contractual adjustment, and bad debt adjustment.

- If an insurance company should have paid, but did not because of late filing, provider not credentialed, etc., confirm that the adjustment was posted as a bad debt.

- If the insurance carrier paid the contracted rate, confirm that the adjustment was posted to the contractual account, and if any balance remained, that the patient or secondary carrier was billed.
- Compare the names, dates, and services on the computer-generated printout to the EOBs. Do they match?
- Review bad debt adjustment accounts. According to policy: Were collection letters sent? Patients called? Accounts sent to a collection agency?

Usually, accounts sent to a collections agency are written off (a bad debt alert is attached to the account) and later—if payment is received—the amount is put back on the books. In *rare* cases, practices set up a new account such as "A/R to Collections" and transfer the bad debt from the current A/R to this account.

Adjustments Review *Individual* Accounts

Patient's Name	Charge	Payment	Contractual Adjustment
Benjamin	$125.00 (insurance)	$50.00	$75.00
Corey	$65.00 (insurance)	$23.40	$41.60
Jones	$45.00 (insurance)	$0	$45.00
Smith	$320.00 (private pay)	$250.00	$70.00

In the above chart, investigate the $45 and $70 adjustment. Initially, payment was expected from the insurance company—none received—why? The private pay individual has $70 adjusted. Why? Is there documentation?

Reminder: When reviewing reports and lists, always check the data filter specifications.

FEE ADJUSTMENTS

Granting fee adjustments, such as professional courtesies, financial hardship assistance (a sliding scale, etc.), and small automatic write-offs (too costly to bill), cause issues of concern—such as compliance (fraud and abuse), embezzlement, and the most favored nation clause that allows insurance companies or Federal agencies to pay rates based on the lowest charge that the practice bills to any patient (T.J. Kennedy v Connecticut General Life Insurance).

Note: Professional courtesies, financial hardship adjustments, and small automatic write-offs are posted under *contractual* adjustments.

PROFESSIONAL COURTESIES

Have a written policy describing who qualifies for professional courtesies. Generally, professional courtesies cause no problem as long as the courtesy **also extends to third party payers**—insurance companies and Federal and state agencies. Unfortunately, the term "professional courtesy" is often used indiscriminately to write off bad debt and other fee adjustments, which can prompt abuse and fraud charges if discovered during a Medicare audit.

FINANCIAL HARDSHIP ADJUSTMENTS

Many times, practices have a general policy that sliding scales and adjusted fees are not available. However, some practices recognize that a patient may experience temporary financial difficulty and will consider each request on a case-by-case basis. The request for aid may be as basic as a signed letter describing the financial circumstances or the completion of an application with copies of income documentation such as pay stubs or a recent tax return.

Financial adjustments can be a haven for embezzlers—especially when cash is accepted. Here is how it works: a self-pay patient pays $100 in cash. Financial hardship, or other adjustment reason, is noted and the service is adjusted for less than $100—the embezzler pockets the difference. This is particularly easy to accomplish when there is grant funding to offset the fee amount. Always review financial adjustments!

Have backup documentation for all patients who are granted a financial hardship adjustment and involve at least two people in the process—one obtaining the information and submitting the request for aid, and the second person authorizing the adjustment.

FEE ADJUSTMENT REVIEW

PROFESSIONAL COURTESY

Run a report showing the patient's name and occupation, the fee, and the financial amount of the professional courtesy adjustment. Does the patient's occupation qualify for a professional courtesy adjustment? Was the courtesy extended to all third-party payers involved? Do you consider the yearly total of professional courtesy adjustments reasonable or should you reconsider the policy?

SMALL AUTOMATIC WRITE-OFFS

Select a random sample, e.g. patients whose last name starts with E and P (because a complete list would likely give you a massive report). List the patient's last name and write-off adjustment amounts of less than $5.

- The adjustment amounts should be lower than the amounts that qualify for secondary insurance billing.
- Are "same last names" listed frequently? In some cases, the "small" write-offs could add up, but are automatically taken off the books. Consider purging the small amounts quarterly or yearly—*only if the "holding" process is cost effective.*

Watch for automatic writes-offs that may represent "old" $5 copays. Small copay write-offs provide an opportunity for embezzlers to pocket the cash for those who know that there is little

follow-up and that a policy is in place to write off small amounts.

MISCELLANEOUS PROCEDURE FEE ADJUSTMENTS

Select two or three procedure codes (specify a timeframe, e.g. one month, a quarter, or YTD) and run a list to include: patient's last name, procedure code, amount charged, payment received, amount billed to secondary payer or patient, and adjusted amount.

- Confirm that the charge is the same for all patients.
- Investigate any variances in charges. (Note: Adjustments are separately noted—the fee schedule is the same for all patients.)

FINANCIAL HARDSHIP ADJUSTMENTS

Select a random sample of patients receiving financial aid. Confirm the following:

- Financial hardship application is complete and on file.
- Authorized person granted the aid and signed the application.
- If there is an expiration date on the application, is the aid still in effect? Should the patient reapply?
- Is there income back-up, such as a tax return or pay stubs?
  - Check the pay stubs.
    - Is there any deduction for medical insurance that signifies the patient has insurance coverage?
  - Check the tax return.
    - Is the patient claiming a large amount of interest income that indicates a large savings account?
    - Is the patient receiving alimony, signifying that there may be medical coverage under an ex-spouse?
    - Is "other income" listed?
    - Did the patient receive earned income credit—a good indicator of the patient's financial status?
- Does the income level qualify for Federal or state aid? (If yes, has the patient applied for aid?)
- Has the patient been paying the adjusted fee on a timely basis?

If unusual circumstances (other than income) qualify the need for aid, is there documentation?

REFUNDS

Refunds are required for overpayments—a patient overpaid the copay, two insurance companies paid as a primary provider, insurance carrier paid for the incorrect service or date of service, a service was billed by mistake, etc.

Require all refunds to have documentation attached to the request. Confirm the following: services were rendered and billed and overpayment or payment was received from the patient or insurance company in error. Checkpoints confirm that refunds are justified and that no refunds are being diverted for personal use, e.g., insurance premiums or cash to friends.

REFUNDS REVIEW

Select five or six refund requests. Review backup documentation. Confirm that the refunds were justified.

Randomly select a timeframe and print a list of refunds—names (patients and insurance carriers), the reason for the refund (such as duplicate payment or billed in error), and the amount of the refund. Investigate any unusual "patterns" such as overbilling, same name frequently appearing on the list, etc.

ABANDONED PROPERTY REVIEW

Check the abandoned property listing yearly (online or published in the newspaper) to see if your practice is owed money for services provided. (Note: Credit balances over three years old must be sent to your state's treasury department. Check with your state treasury department regarding filing requirements.)

ANALYZING REPORTS

Review Gross Collections, Net Collections, Contractual Adjustments (previously discussed) Aged Accounts Receivables, and EOBs (Explanation of Benefits).

Unless otherwise requested, the collections and adjustment reports generally show the activity for the month—meaning that payments do not match the charges. The reports provide you with a "feel" of your collections. You can measure collections by insurance carriers and/or procedures. At least once a year, run a report that shows percentages that match charges and payments.

The collection percentages alert you to the following:

- A shift in the practice's payer mix
- Failure to follow up on unpaid insurance claims
- Failure to collect co-pays and co-insurances
- Patient statements sent out late
- Change in reimbursement rates
- Poor patient-receivables management
- Possible embezzlement

The following are examples of collections reports. The charts below are report examples—not benchmarking guides. Medical

$$\text{Gross collection percentage} = \frac{\text{Collections}}{\text{Gross Charges}}$$

Charges and Payments

Insurance Company (or procedures)	Charges	Payments	%
Blue Shield	122,732	48,681	40
Blue Choice	21,962	7,861	36
Harvard Pilgrim	58,667	19,212	33
HMO Blue	104,032	33,925	33
Medicare	617,184	186,174	30
Self-Pay	82,320	30,449	37
Total:	1,006,897	326,302	32

associations can often provide you with benchmarking data.

Alert: If the majority of your market mix is in managed care and you have a high gross collection percentage, it is an indication that your fee schedule may be too low. A large market mix of indemnity patients should expect a higher gross collection rate.

$$\text{Net collection percentage} = \frac{\text{Collections}}{\text{Production minus contractual adjustments}}$$

Charges and Payments
Expected Collections based on 40% of Gross Charges

Insurance Company (or procedures)	Charges	Payments	%
Blue Shield	49,092	48,681	99
Blue Choice	8,785	7,861	89
Harvard Pilgrim	23,468	19,212	82
HMO Blue	41,613	33,925	82
Medicare	246,874	186,174	75
Self-Pay	32,928	30,449	92
Total:	402,759	326,302	81

(For demonstration purposes, charges are calculated at 40 percent of the charges noted in the above gross chart. Your software program would provide you with the actual expected numbers.)

Alert: The percentage for expected collections (also known as net collections) should be greater than 90%.

ACCOUNTS RECEIVABLE ANALYSIS

Accounts receivables reports are separated into timeframes, such as 0-30 days, 31-60 days, etc. Keep receivables more than 90 days old at less than 15-20 percent of the total amount of accounts receivable.

Run the aged reports by Date of Service (DOS) and Date of Billing (DOB) for comparison. An aged accounts receivable analysis reviews the following:

- Are filing dates met?
- Are private pays collected?
- Are statements timely?
- Are billing delays justifiable?
- Are the A/R ratios reasonable?
- Are bad debts written off or turned over to a collections agency?

The following charts represent the same accounts receivable information, except the data is sorted differently—date of service and date of billing. When sorted by date of billing, the data shows the percentage of total receivables over 90 days at 11%; when sorted by date of service, the report shows the actual percentage at 27%. For review purposes, totals are illustrated. A complete aged accounts receivable report will show all payers or groupings, such as Medicare, Medicaid, Managed Care, Commercial, and Self-Pay.

Aged Accounts Receivables
Date of Billing vs Date of Service

Date of Billing Percent of total receivables over 90 days: 11%
Note: Generally, this report is aged by each payer.

Payers or procedures	0-30 days	31-60 days	61-90 days	91-120 days	120+
Total:	612,214	141,290	37,410	37,927	57,996

Date of Service Percentage of total receivables over 90 days: 27%

Payers or procedures	0-30 days	31-60 days	61-90 days	91-120 days	120+
Total:	222,271	339,951	83,575	43,154	197,886

PRIVATE/SELF-PAY

The combination of consumer demand for fewer restrictions and the employers' need to cut costs has resulted in revisiting the indemnity plans as solutions. Coinsurance and deductibles lower insurance premiums and increase the patient's financial responsibility when services are rendered.

PRIVATE PAY REVIEWS

- Review documentation for write-offs and financial hardship adjustments.
- Confirm that Medicare, commercial, deductible, and indemnity claims are submitted on a timely basis.
- Check the patient correspondence and statement process. Are patients kept informed—in writing or verbally? Do they know that a claim was sent to the insurance carrier? Do they have an estimate of their responsibility?
- Review the collections policy. Is the staff dedicating time and effort toward collecting past-due accounts? Are past-due accounts sent to a collections agency, or are they adjusted off?
- Is the fee for services the same for all patients?

EOB REVIEWS

Compare the date of service to the date of the EOB—if greater than 45 days, investigate the cause of the delay. Check amounts charged and allowed—if equal (or close) to the amount allowed, fees are too low. Review denial codes to locate problems. Correct the source of problems. Compare payment postings with patient accounts, as previously mentioned.

SUMMARY

Initial cash reviews require preparation, such as customizing reports and setting benchmarks for collection, adjustments, A/R, and write-offs ratios. Once the benchmarks and reports are in queue, cash reviews should generally take less than four hours.

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