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Billing Alert for Long-Term Care

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In this Issue

Five PDPM pointers and reimbursement opportunities you may have missed

The Patient-Driven Payment Model (PDPM) has so many nuances that can impact reimbursement that it is near impossible for SNFs to consider and capitalize on them all.

BALTC asked leading experts to share some of the lesser-known payment opportunities and challenges in PDPM. Check your processes and procedures to ensure you're taking advantage of or protecting against the following aspects of PDPM.

1: Capture reimbursement for physician utilization review

In RUG-IV and now PDPM, SNFs receive the majority of their payments from Medicare prospectively. However, filing a cost report also leads to reimbursement for a few specific items, including the Medicare utilization review.

"Many SNF providers do not know that if they have a physician who participates in their Medicare utilization review, they can get reimbursed for the Medicare portion of the cost of that," says **Lisa Trundy-Whitten CPA, FHFMA, CPC-A,** a principal for the healthcare and not-for-profit practice groups with the accounting firm, BerryDunn.

This is a reimbursement opportunity for SNFs, who may consider involving physicians in the Medicare utilization review meetings once PDPM goes into effect.

"Because reimbursement will be based on clinical characteristics, there will need to be more participation from providers to determine the primary diagnoses and comorbidities for residents," Trundy-Whitten says.

To ensure correct reimbursement, SNFs will need to ensure that they have documentation that the providers participated in the meetings and a process for ensuring that data pulls over into the cost report.

2. Submit accurate claims when interrupted stays occur

The introduction of the interrupted stay policy (ISP) is one of the biggest changes billers will have to contend with in PDPM, says **Rosana Benbow, RN, CCM, CIC, DNS-CT, RAC-CT**.

The ISP states that when a SNF discharges and readmits a patient within three consecutive calendar days or less, the SNF should consider the readmission a continuation of the previous Medicare Part A-covered stay, Benbow explains.

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"The ISP applies anytime they have a three-day gap in their Medicare coverage. This could be because they're in the hospital, they've changed payers, or even a leave of absence," Benbow says.

A discharge home for less than three days also meets the interrupted stay criteria.

Because it is a continuation of the stay, providers resume the assessment schedule and variable per diem schedule from the point just prior to the discharge. SNFs are not required to perform or submit a new 5-day assessment for patients who are subject to the ISP, says **Mary Jo Wilson,** client engagement specialist and consultant with SNF-Solutions, LLC.

Billing specialists must be aware of and consider the ISP's requirements when calculating beneficiary days.

"Instead of a one-day skip period, a resident can actually be in the hospital for up to three days and they can bill those days as skip days," Wilson says.

Additionally, billers need to understand how to submit claims if a patient returns to the SNF in the interruption window and the MDS/RAI coordinator determines that an interim payment assessment (IPA) is needed.

IPAs allow SNFs to capture the clinical conditions associated with the reasons for the patient's hospital or interrupted stay. The IPA can change all five case mix groups, so the MDS coordinator and billers should evaluate how the IPA will impact the overall daily rate before performing one.

Billers should submit one continued claim with the HCPCS codes generated by the current 5-day assessment. Billers should indicate that the hospital days or interrupted days are non-covered skip days by using revenue codes 0220, 0180, and ZZZZ0. This also requires billers to use span code 74 and dates of service to cover the skip days, Wilson says.

However, keep in mind that the ISP only applies if the resident leaves and returns to the same facility. It does not apply if the resident transfers in from another facility. When the SNF receives a transfer, the clinical team must complete a new 5-day assessment and billers must generate and submit a new claim, Wilson says.

Questions Comments & Ideas

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– Tami Swartz
Director,, AMBR for Long-Term Care

3. Get reimbursed for hospital-administered total parenteral nutrition (TPN)

In PDPM, TPN will impact the non-therapy ancillary (NTA) case-mix component, not just the nursing component which was the only category linked to TPN reimbursement in RUG-IV, says Benbow.

If the resident receives TPN while in the SNF, you will see higher NTA and nursing scores for that patient. The resident will either meet the criteria for TPN High Intensity or Low Intensity. According to Medicare, use Section K0710A2 to determine the resident's level. The criteria are:

- High intensity: If the proportion of total calories the resident received through TPN was 51% or more while a resident
- Low intensity: If the proportion of total calories the resident received through TPN was 26-50% and average fluid intake per day by IV or tube feeding was 501 cc per day or more while a resident

SNFs will continue to receive reimbursement under the nursing component for TPN administered in the hospital. Section K is a 7-day look back, which can include the hospital stay. Including the TPN in Section K can increase the patient's nursing score, which can result in a much higher nursing component case-mix grouping and bump the SNF's reimbursement for these patients.

The 7-day look back is measured by the assessment reference date (ARD) counting back 7 days, including the ARD. At times, it may benefit SNFs to use an earlier day in the stay.

SNFs risk missing out on reimbursement dollars associated with TPN if they do not gather complete documentation from the hospital during the pre-admissions process.

"Because we're now able to count back from the hospital administration of the TPN, admissions needs to gather that information so that we can set the reference date early enough to capture that hospital TPN," Benbow says.

4. Get to know the return to provider (RTP) codes

CMS identifies certain ICD-10-CM codes that will automatically trigger an RTP error if submitted on the MDS

or claim. ICD-10-CM codes listed on CMS's RTP list are not specific enough to map to a PDPM clinical category, so CMS will kick them back for nonpayment, says **Maureen McCarthy, RN, BS RAC-MT, QCP-MT, DNS-MT, RAC-MTA,** president and CEO of Celtic Consulting.

The RTP list includes many primary diagnoses accepted in the RUG-IV system, including:

- Muscle weakness
- Falls
- Unspecified diagnoses
- Failure to thrive
- Dehydration
- Unsteady gait/Abnormal gait/Difficulty walking
- Debility
- General weakness

Including RTP codes on MDSs and claims will cause delays in reimbursement and could ultimately lead to no reimbursement if you admit a patient who does not have a condition that maps to a PDPM clinical category, McCarthy says.

"In RUG-IV, we could cover patients with these conditions by providing therapy to get them to that skilled-level of care. But now, you do not have that safety net. Those diagnoses do not cross over to PDPM. If you have an RTP condition listed as the reason why you're skilling them, you will not get a case-mix grouping and the patient will not be covered," McCarthy says.

Consider admission staff as your first line of defense in guarding against patients with RTP conditions as their primary diagnosis. Savvy SNFs will screen for these conditions during the pre-admission process.

"If you have one open bed and three referrals, admission staff should look at the diagnosis codes provided in the admission documentation and compare it to the RTP list. You should choose the patient that you can cover—whose conditions are not on the RTP list," McCarthy says.

MDS coordinators should also know the codes that will trigger an RTP and avoid including them on the MDS. If the MDS sees an RTP, it may also be a sign that the clinical documentation is not strong enough to support a more accurate and higher-paying code. The MDS coordinator can go back to the clinical team and get a more accurate diagnosis that CMS will reimburse, McCarthy explains.

Billers are the SNF's last line of defense. During the triple check, the biller should confirm that the primary diagnosis listed does not appear on the RTP list, McCarthy says.

5. Prepare for a bumpy ride

Business office staff, MDS coordinators, and administration should expect technical issues when they submit MDSs and claims to Medicare or to other payers who have adjusted their systems for PDPM, McCarthy says.

"We saw this in 2010 when we went from MDS 2.0 to MDS 3.0. In some states, we couldn't even submit MDSs at all. They were being rejected,' McCarthy says. "There are probably going to be problems, and you're not just going to be able to push one button and be done."

In anticipation of technical problems, do not wait until the last minute to submit MDSs or claims. Give yourself extra time to troubleshoot any issues so that you're not late in submitting the MDS or claims.

Proper preparation can ward off major cashflow issues for the SNF.

"It can cause huge problems. For example, administrators may need to request interim rate relief because they can't make payroll because they cannot get their Medicare money," McCarthy says.

MDS coordinators and billers should also check their software for accuracy during the first several months that PDPM is in effect, says **Jennifer LaBay, RN, RAC-MT, RAC-MTA,CRC,** a MDS and policy consultant with Triad Health Care.

"Most of the bigger integrated software systems have a sequencing component or a list of diagnoses managed by the clinical team that carries over to the bill. Double check that information flows over correctly," LaBay says.

In PDPM, ICD-10 codes take on an entirely new level of importance for reimbursement. The interdisciplinary team (IDT) must ensure that the codes not only accurately reflect the patient's conditions but are sequenced properly.

Do not assume that the software sequenced the codes properly. The IDT should review and confirm the sequencing during regular Medicare meetings and during the triple check to ensure that the codes are correct, LaBay says.

A tale of two reimbursement models

Juggling PDPM and managed care billing

Preparing for and implementing the new Patient-Driven Payment Model (PDPM) was a momentous task for the skilled nursing industry. However, in many ways, the transition is not complete.

"CMS does not require Medicare Advantage Plans (Medicare Part C plans) and other managed care plans to adopt the new payment model at this time," says **Stacy Baker, OTR/L, CHC, RAC-CT,** director of audit services for Proactive Medical Review & Consulting, LLC.

Medicare Part-C plans can determine their own timelines for transitioning to PDPM. In the meantime, they will continue to pay SNFs based on Resource Utilization Group (RUG) levels or negotiated rates.

Now that PDPM is in effect, that leaves billing specialists and clinical staff to juggle the clinical and reimbursement requirements for both the PDPM and RUG-IV systems, Baker explains.

In fact, even though the industry has recently focused largely on the transition to PDPM, national data indicate SNF billers may submit the majority of their claims using RUG-IV, depending on the number of Medicare Part-C patients they care for and their payer mix trends.

"More consumers are electing one of these plans. Back in 2010, 25% of those eligible elected a Medicare Advantage Plan. Now that's grown to 34%, Baker says.

Additionally, accounting firm *Plante Moran* published a benchmarking report earlier this year looking at payer mix trends. Medicare makes up only 15% of SNFs' payer mix whereas Medicaid represents 54%, and other payor sources account for 31%.

"We're going to have to have our RUG-IV hats on, and we're going to have to have our PDPM hats on. With these two payment models and the various state Medicaid reimbursement rules, everyone will have to clearly understand the requirements to get reimbursed for services provided," Baker says.

Although billing specialists are adept at managing the requirements of different payers, operating in multiple reimbursement systems and keeping up with Medicare Advantage Plan's gradual transitions into PDPM opens SNFs up to financial risk, says **Stefanie Corbett, DHA,** post-acute regulatory specialists for HCPro, Inc.

For billing specialists, keeping the SNF's cashflow healthy will require careful tracking of which payers are paying based on negotiated levels, PDPM or RUG-IV categories, Corbett says.

As providers juggle residents covered by Medicare Part-A and RUG-IV, billing specialists will play a vital role in making the team aware of residents' payer type, ensuring a thorough triple check process, and mitigating the risk for improper payments.

Understand what is at risk

It will be critical for billers to communicate residents' exact payers to the interdisciplinary team (IDT). MDS coordinators and the IDT will also have to manage the disparate financial inducements offered by PDPM and RUG-IV. Medicare Advantage Plans that reimburse based on RUG-IV will continue to financially incentivize SNFs for providing therapy to patients, says **Robin Hillier, CPA, STNA, LNHA, RAC-MT,** president of RLH Consulting.

Meanwhile, in PDPM, CMS has shifted away from therapy minutes. Instead, the clinical characteristics and acuity of patients drives PDPM payment.

"If MDS nurses and therapists are unclear about a resident's payor, they could miss therapy targets critical to payment under RUGs, or they could fail to capture clinical information critical to payment under PDPM," says Hillier.

Mismanaging residents will not only result in the loss of reimbursement dollars, but it also causes denials, Baker says. Medicare Advantage Plans and Medicare will deny payment if providers do not have the proper documentation in place. This is complicated as each payer's requirements differ as do the requirements for RUG-IV vs. PDPM, Baker says.

Know your payment arrangements

Navigating between the requirements for different payers will not be easy.

"This is especially going to be a headache for billers because they will have to know how to bill each of the Medicare Part-C plans in addition to Medicare Part A and B, Medicaid, managed care, and private pay. If you are preparing a claim under the retired payment model and not the newly introduced model or under the terms

of a revised Medicare Part-C plan that has been updated since the implementation of PDPM, you will not be reimbursed," Corbett says.

Avoid confusion by reviewing and understanding the terms of your facility's agreements with each managed care organization, Corbett says. In addition to listing payment rates for services provided to Medicare Part-C beneficiaries, these contracts outline how billers submit claims to the Medicare Advantage Plan and reimbursement terms.

Billers should know the ins and outs of these agreements.

"When you understand the terms of your agreements with those providers, then you can mitigate risk for collection issues with Medicare Part C because the agreements will tell you exactly what they require, which is especially important as Medicare Advantage Plan convert to PDPM," Corbett says.

If you have not done so already, check with each Medicare Advantage Plan to confirm whether they want you to bill using negotiated rates, the RUG-IV or PDPM model. If they will continue to pay under RUG-IV, ask them to share their timeline for converting to PDPM, says **Jennifer Matoushek, MBA/HCM, CPC,** senior consultant with LW Consulting Inc.

Knowing the PDPM transition plan mitigates financial risk by ensuring your billing office is prepared to submit the correct information on the claims during the correct billing cycle. Otherwise, you will receive a denial, Matoushek explains.

Additionally, billing specialists should confirm when their facilities will renew their payment arrangements with each Medicare Advantage Plan.

"Many SNFs and Medicare Part-C plans renegotiate their rates in September or October when Medicare adjusts their rates or in January," Matoushek says.

Reviewing and noting updates to these agreements ensures that billers are informed of any new claim submission or payment protocols—not just those related to PDPM. Billing specialists can then update their processes accordingly, Corbett says.

Implement triple check for all payers

Submitting a clean claim really begins with your month-end triple check process. It may be tempting not to perform triple checks on claims submitted to Medicare Advantage Plans because nothing has changed in the RUG-IV system, but IDTs must recall the original intent of triple checks: To ensure clean claims, no matter the payment model.

"I'm often surprised by how many facilities only perform the triple check for claims going to traditional Medicare payers. You should apply the same process to your managed care claims, too," Baker says.

Triple checks are an industry best practice. Every facility should have a triple check process in place where key personnel come together to review and validate the information on the claim.

"During the triple check, billers should verify all information that supports Medicare Advantage plan claims as well as claims billed to any other payor," Hillier says.

For Medicare Advantage Plans that have not switched to PDPM, the triple check should confirm therapy delivery and minutes.

Know the common reasons for Medicare Part-C denials

Managed care post pay reviews are at an exponential high, and they just keep coming, Baker says. As such, it's critical for billers to know the common reasons for denials so that they can protect their payments.

The following are some of the denials Baker most commonly sees:

- **Therapy minutes documentation.** Therapy minutes will continue to generate denials for those managed care plans that stick with the RUG-IV payment model, Baker says. Medicare Advantage Plans frequently deny payment due to a lack of daily therapy documentation. There is room for error in this two-payment situation because Medicare rules do not require therapists to write a daily treatment note but most managed care plans do require that. It will be critical for billers to ensure MDS coordinators know if a resident is a Medicare Part-C beneficiary that requires this documentation, Baker says.

  However, therapy minutes will not be a concern from the technical review or denial standpoint for those plans that switch to PDPM, Baker says.
- **Nursing documentation.** Inadequate or incomplete nursing documentation can also cause a denial, especially if a patient has a severe condition that requires

extensive nursing services, such as isolation. In that case, the Medicare Advantage Plan will want to see very technical documentation showing the patient is in a private room, lab documentation, etc.

Modifier-59. Managed care plans also do not like to see Modifier -59. They traditionally do not accept services billed together on the same date and will issue a technical denial. They tend to prefer that providers bill for each distinct service using the appropriate CPT code, Baker says.

- **Certifications and recertifications.** SNFs often receive denials from Medicare Part-C because they do not have the physician certifications and recertifications documented.

  "Many facilities I work with do not think Medicare Advantage Plans require those certifications, but most do," Baker says.

- Prevent denials by applying your process for obtaining physician certifications and recertifications for Medicare beneficiaries to managed care beneficiaries.

Will they or won't they? Manage care plans diverge on PDPM adoption plans

The Patient-Driven Payment Model (PDPM) is in effect for all Medicare Part A residents. However, CMS does not require Medicare Advantage Plans (Medicare Part-C plans) to reimburse SNFs based on the new payment model. As such each plan will determine when and if they will adopt PDPM.

Billers will need to be aware of when Medicare Advantage Plans will switch systems but should expect each plan to be on a different timeline as they weigh the pros and cons of making the switch.

Although many managed care plans have already announced their intent to transition to PDPM this year along with Medicare Part A, some Medicare Advantage Plans will wait and see how PDPM goes before making a decision about changing their payment methodology, says **Robin Hillier, CPA, STNA, LNHA, RAC-MT,** president of RLH Consulting.

Reasons for sticking with RUG-IV will vary, but some Medicare Part-C plans may prefer to continue using a levels-based system because it is less administratively complex, Hillier says.

Of course, Medicare Part-C plans will also consider the impact switching to PDPM may have on their bottom lines.

"There's the possibility for higher reimbursement under PDPM and a levels approach is more predictable and has a payment cap," Hillier says.

Conversely, managed care organizations and Medicaid have traditionally followed Medicare's lead on payment methodology and will likely align their rate calculations with PDPM with time, says **Stefanie Corbett, DBA,** post-acute regulatory specialist for HCPro, Inc.

In addition to aligning on rates, putting similar processes in place for billing creates consistency in practices across all commercial insurers. This ultimately makes submitting and paying out claims easier, say Corbett.

"If I were a managed care organization, I would be looking over time, ways to develop alignment because the last thing you want is for facility not to know how to bill. That creates a headache, not just the facility but also for the managed care organization," Corbett says.

Unfortunately for billers, there's really no predicting what Medicare Advantage Plans will do or when. The best advice is to monitor communications from these plans and establish connections at each organization that you can call and speak with if you have questions, Corbett says.

How billers can support revenue cycle management in PDPM

With the implementation of the Patient-Driven Payment Model (PDPM), SNF's bottom lines are more at risk than ever before.

In these early days of PDPM, SNFs may find it difficult to project revenue and profitability for their Medicare Part A covered patients because so many factors, (e.g., patient acuity, clinical documentation, accurate ICD-10 coding) impact payment, says **Kim Cusson, CCS, CPC,** a consultant with Crowe Healthcare Risk Consulting, LLC.

SNFs must protect their financial stability by maximizing their revenue cycle management (RCM) practices. Well-run revenue cycles increase margins and mitigate debt, Cusson says.

Billing specialists play a key role in the facility's revenue cycle. How you manage revenue cycle processes can impact cashflow, which is critical for SNFs, says **Erin Shvetzoff Hennessey,** CEO of Health Dimensions Group.

"The margins in skilled nursing and senior living are low, and we often have to wait a long time to receive payments. Billers constantly look at cashflow to ensure the facility is getting enough cash in the door to pay all the vendors that are critical for us to continue providing care to patients," Hennessey says.

As facilities navigate PDPM, billers can help safeguard cashflow by supporting accurate completion of the MDS, utilizing their software to its fullest potential, and implementing process improvements when issues arise.

Defining revenue cycle management

Before diving into how billers can enable a healthy revenue cycle, it's important to understand what RCM is.

"I describe RCM as the process we use to make sure we get paid for the great care we give patients, but also making sure we do not get a dollar more," says Hennessey.

RCM centralizes these often-fragmented activities and pulls them together as one integrated process that follows revenue from pre-admission to payment. This wholistic viewpoint allows SNFs to align and streamline processes, which reduces debt and increases profitability, says **Barbara Reimer,** consultant with the Fox Group.

RCM encompasses functions integral to receiving reimbursement dollars in a timely manner and protecting those payments, including denials management, revenue integrity, and chargemaster processes. Components of the revenue cycle include:

- Preadmission screening
- Point-of-service registration
- Utilization review
- Charge capturing and coding
- Claim submission
- Payer processing
- Remittance processing
- Denials
- Payment posting
- Appeals
- Collections

To make each of these RCM processes as efficient as possible, billers should review several key performance indicators (KPIs), says Cusson.

Common KPIs include:

- Accounts receivable (A/R)
- Accounts aging comparisons
- Days in A/R
- Collections as a percentage of revenue

Benchmark current performance for each KPI currently and monitor it overtime. If you notice delays or slowdowns, determine what processes the appropriate department (e.g., admissions, clinical team, billing) can modify or overhaul to bring cash in more quickly, Cusson says.

Tip: Billers should also compare the KPIs pre- and post-PDPM to identify how the new payment model affects the SNF's cashflow.

Understand how the MDS can impact RCM

PDPM links the MDS to the revenue cycle in a way that SNFs never experienced in the RUG-IV payment methodology.

"When you think about the revenue cycle, you tend to focus on A/Rs, but in PDPM, the MDS plays a big role in your revenue cycle," says Reimer.

The new PDPM assessment schedule creates an opportunity for SNFs to bring reimbursement monies in more quickly. Because PDPM only requires a 5-day initial assessment and discharge assessment, billing specialists should be able to turn claims over more quickly

"I'm sure there will be a lot of patients only requiring only 5-day and discharge assessments, so claims submission can happen [faster] because we will not have to wait for so many MDSs to be transmitted," Reimer says.

However, SNFs will only realize this benefit if they have strong clinical documentation and accurate ICD-10 coding.

The number of MDS sections that impact reimbursement increases significantly in PDPM. Patients' clinical characteristics and outcomes as captured on the MDS drive PDPM reimbursement. This makes capturing coded revenue on the MDS an essential part of your revenue cycle in PDPM.

"Medicare says that PDPM is budget neutral, but if we're not getting the full clinical picture or the right diagnoses, then patients will fall into lower clinical categories, which means lower reimbursement rates. In that way, PDPM may not be budget neutral for some facilities," Cusson says.

The MDS coordinator and interdisciplinary team (IDT) must ensure the documentation fully reflects

patients' conditions and comorbidities and the ICD-10 codes on the MDS most accurately reflect those clinical characteristics.

However, billing specialists are a great line of defense to ensuring the claims do not get kicked back for partial or non-payment. Actively communicate with the MDS coordinator and IDT and flag return-to-provider codes (RTP) that will automatically generate an error if included on the MDS or claim, Reimer says.

Billers also know better than anyone else in the facility what causes payers to issue denials. During regular Medicare meetings, billing specialists should not hesitate to speak up if they notice the primary diagnosis, the projected HIPPS code, documentation, certifications, or other items are not in order, Cusson says.

Additionally, if your facility does not do so already, billers should advocate that the IDT participate in a triple check process. Because PDPM has so many more complexities than RUG-IV, the triple check is essential to ensuring the claim is clean. The IDT should meet and verify all the information on the claim one final time before you submit it. The triple check reduces errors that lead to denials, which cause your cashflow to take a hit, Cusson says.

Get the most out of your software

Clinical and billing software—whether they are the same system or not—should make your revenue cycle function more efficiently.

Many vendors released new features or functionality in preparation for PDPM. Get the most out of your software by participating in training opportunities, such as webinars or onsite education, and learning how to use programs to their fullest capabilities. Take the time to read the guides that vendors send out because they offer lots of time-saving tips, Reimer says.

Additionally, vendors will continue to update their systems to further optimize PDPM-related functions over the next several months. Establish an open line of communication and relationship with internal IT staff and the vendor. This way you will be aware of new feature releases and can ensure they're integrated into your system without issue, Reimer adds.

A word of caution. Your software systems also have the potential to hinder or slow your revenue cycle. As some billers experience in the transition to PDPM, new software features can also cause headaches for billers. You must confirm that information pulls over correctly either from one part of the system to another or between systems. Incorrect information flow can lead to incorrect data on the MDS and/or claim.

Whenever a vendor rolls out something new, perform regular audits to verify that the information populated onto both the MDS and claim is correct, Reimer suggests.

Conduct post-mortems

Learning from mistakes will help you strengthen the processes that make up the revenue cycle.

If you receive a denial or partial payment, billing specialists need to find out why.

"For example, if you're looking for a $5000 payment when the EOB comes through, and it's not there or not what you were expecting, you have to research to determine whether something was miscoded on the claim, if the data in the software was incorrect, if revenue, co-pay, or co-insurance calculations were incorrect," Reimer says.

Billers will often find that the issue is a one-off or related just to one patient. However, errors caused by a systematic issue have the potential to devastate your profitability. In these cases, billers should share their findings with a manager to take it through the proper channels for resolution, Reimer says.

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Do not lose sight of how billing basics can enhance the revenue cycle

"We've all been so focused on PDPM implementation, but you really need to go back to business basics and make sure your systems are strong and your billers are submitting claims and getting those payments in so that there are no cashflow issues," says **Barbara Reimer,** consultant with The Fox Group.

In many facilities billers wear several different hats, so following up on claims can sometimes take second priority. However, tracking down payments can make a sizeable difference in your cashflow.

Use the monthly aging review to identify long-term outstanding balances. The definition of long-term will vary, so only focus on claims that reach a threshold level of tardiness for that payer type. For example, HMOs and worker compensation payers will likely not pay in 30 days, but billers should flag them for review at the 60-day mark. Consult your contracts for the agreed upon payment turnaround time, Reimer says.

Additionally, align your efforts against what accounts will yield the highest return.

"We overlook the small balances that we know will be paid off when various contractors catch up on their payments. We spend way more time on bigger balances," Reimer says.

Contact the payer to confirm they received the batch of claims and continue to follow up with them.

"Reach out to the insurance company and find out what the problem is," Reimer says.

It is helpful for billers to know whether a payer is experiencing a system issue or has a large backlog and how delayed payment will be so that they can manage the cashflow accordingly.

Manage your calendar to manage your cashflow

Sync your tasks so that they support cashflow needs at various points in the month.

For example, to maximize cash in the bank at the end of the month, Reimer's team dedicates the 12th of each month to submitting Medicare bills.

"As long as your claim is correct, you will receive payment in 16 days—there's a 14-day turnaround time from Medicare plus two days for the deposit to go through to the bank," Reimer says.

Take advantage of any opportunity payers give you to bill more frequently than once per month.

"Why bill once a month if you can bill once a week or every other week to keep cash coming in," Reimer asks.

Billing specialists may also find it helpful to dedicate a certain day of the week to processing claims for a specific payer. That way staff will not miss any due dates.

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