

The Business of Psychology

Collecting All You Earn: How to Get the Money in the Door

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As the owner of a mental health billing service, I've spent a lot of time contemplating and designing systems to get all your money in the door. And as the owner of a mental health collection agency, I've had the opportunity to observe many things that haven't worked for psychologists. In this article, I'll discuss some of the do's and don'ts of getting paid for your work.

I'm not clinically trained. Nonetheless, I've developed some strong opinions about how clinical and financial matters intersect and impact each other in a psychology practice. Let me begin by telling you some of my biases.

- You deserve to be paid for all of your work promptly and in full. Your fees and your financial policies and practices should reflect that belief.
- Nothing depreciates faster than fifty minutes of therapy or a completed evaluation. Getting paid in full in cash at the beginning of each appointment is the only sure way to get paid.
- Patients who don't pay for their therapy don't "own" the results. Neither the patient nor the psychologist, is helped by a huge unpaid bill for services the patient couldn't realistically afford. Good therapy requires affordable treatment planning.
- A serious collection problem in a single ongoing case can signal that clinical consultation is in order. More frequent serious collection problems can indicate that business consultation is in order or sometimes that psychotherapy is needed to address some issues that are interfering with a psychologist's prosperity.
- A good billing and collection system is worth its weight in gold — literally.

Financial Policies

The cornerstone to a financially successful practice is to have clear policies about the financial part of your relationship with your patients. Choose ones that fit you and your practice, then articulate them clearly in writing and adhere to them. These policies should address specific issues such as: What is your fee? What does it cover? For what kinds of things do you charge (phone calls, consultation with other professionals, test scoring, report and letter writing, court appearances, etc)? Do you charge the same rate for all your services? What is your policy about payments for no shows or late cancellations? Under what conditions will you make exceptions to these policies? Whose responsibility is it to track insurance coverage, payments, limitations,

authorizations? Whose responsibility is it to bill insurance if any? Must patients pay in full at the time of service? If not, what is due and when is payment due? When is payment late? Do you charge a rebilling fee or late fee for patients who don't pay their portion each month? Do you use a billing service? If so, name them. Do you use a collection agency? If so, warn patients.

Fees In the last issue, I discussed fees, how to set them, when, if and how to raise or lower them and how to set clear limits for yourself about reduced fees in your practice. For a review of that information, if you don't have last issue available, e-mail or call me and I'll get you a copy of that article.

Payment The best time to collect your fee, strategically, is the moment a patient sinks into the chair in your office. A simple line like "Let's get the business part out of the way" can take care of getting payment up front. You will need to decide whether you will require patients to pay in full at the time of service, whether the patient will pay only deductible and copay at the time of service, or whether there will be some other payment arrangement. If you have managed care contracts, for those patients, you will be contractually prohibited from collecting anything other than deductible and copay at the time of service. In any event, be clear in your own mind and with your patient about payment policies, and apply them consistently.

Rebilling Charges I say "rebilling charges" rather than "interest" because charging interest, a percentage of the balance owed, subjects you to the provisions of the Federal Truth in Lending Act, a level of bureaucracy easily avoided by charging a flat fee rebilling charge. It's common to impose a rebilling charge (\$5-\$25) on any account where the patient has a personal balance and has made no payment on that balance during the billing cycle. This rebilling charge serves both as an impetus to pay something (even if the patient can't afford to pay the full amount) and a consequence for not paying anything. It also serves to offset the cost of repeat billing and your decreased cash flow.

Billing Service Versus Do-It-Yourself You're the best one to do your own billing if: (1) You have the desire, (2) You have the time (and are prepared to spend it that way), (3) You have the talent (detail orientation, numbers person, persistent to the nth degree), (4) You have the technology (computer, fax, good billing software), (5) You can afford it (if you couldn't or wouldn't be earning more money in the time you spend billing than it costs to have it done for you). If any one of these does not apply, then you're better off hiring a billing service. Be sure to check their average collection ratios and collection periods and get references from business-savvy colleagues. A good billing service is worth its weight in gold. A bad billing service can put you out of business.

Collection of Delinquent Accounts With a good billing and collection system, delinquent accounts should be infrequent occurrences. However, they do still happen. You will need to decide whether and under what conditions you will refer a delinquent account to a collection agency and whether you will refer to an agency that sends a collection letter series only or to a full service collection agency that will phone patients, report them to credit bureaus and ultimately sue them. Keep in mind that some patients can become litigious when pressed for

payment. Weigh the risks versus benefits in each case, especially before referring an account to a full service collection agency. Whatever your policy, articulate it clearly for yourself and your patients and adhere to it.

Preparing to Get Paid

Having made decisions about your financial policies and practices, the key to getting paid is in the details. If I dotting and T crossing are not your forté, get help.

Intake and Office Policy Forms You will need an intake form for the patient to fill out and sign that provides you and/or your billing service with all the demographic and insurance information necessary to do the patient's billing and authorizing that billing and payment to you by the insurance company. It is crucial as well to have written office policy forms that articulate clearly and concisely the business policies and practices you will follow with your patients. This works best if printed separately from informed consent and HIPAA documents. A single sheet should suffice. Be sure to give each patient his/her own copy of the policy form and get a signed copy for your records. The signature will acknowledge the patient understands and agrees to the policies and can also serve as acknowledgment of HIPAA privacy documents. If you're not contracted with a patient's insurance company and if the patient is not paying in full at each visit, it's wise to have a written fee agreement about when and how much they will pay. If you would like a sample of the forms we use at Professional Practice Management, just call or e-mail and I'll happily share a copy with you.

Insurance Verification If you are billing insurance for a patient and if you are not collecting in full at the time of service, the most important step you can take is a thorough insurance verification, to discover in advance, with as much certainty as possible, what the insurance will pay and what the patient will need to pay. This allows you to know what the patient's portion is so you can collect it at each visit. Insurance verification is both an art and a science and one's ability to predict accurately what an insurance company will pay increases with years of experience. An entire, very tedious, column could be written on the subject, but I'll spare you that. Be sure to keep written notes of every contact with insurance company personnel, including the date and name of the person you spoke with. The essentials are these:

- Verify insurance company name, billing address, ID # and group number
- Ask if there is a specific provider panel or MCO associated with the patient's group
- If yes, and you're not on that panel, ask if there are out of network benefits
- Check the effective date of the coverage and whether pre-existing conditions are covered. If not, when will the excluded conditions be covered?
- Is there an annual deductible? If yes, how much of it has been met? And when will a new deductible period begin?
- Is there an out of pocket maximum or stop loss? If yes, how much of it has been met? And when will a new period begin?
- If checking outpatient mental health benefits, what is the limitation on those benefits? How much of the benefit has been used? When will the benefit period renew?
- If checking evaluation benefits, will the testing be covered under medical or mental health? Is there a limit to the number of hours available with or without authorization?

- Are there any excluded diagnoses or procedure codes for the patient's particular group?
- Is an authorization or referral required? If so, is one in place? If not yet in place, can you do initiate it or must the patient or someone else initiate it?
- What will they pay? If they tell you a percentage, be sure to ask "percentage of what?" If they said "percentage of contracted amount", consult the fee scale on your contract with them. If you are not contracted with them and they say "percentage of usual and customary rate", see if they will quote their UCR for the procedure codes you intend to use.

Managed Care Authorizations

Very few clinicians enjoy managed care paperwork. You can't avoid it by not joining managed care panels, because a number of insurance companies require authorizations and treatment plans even for out of network providers. The only way to avoid it is not to work with insurance companies who require it. The most important thing is to know yourself. If you're a person who procrastinates on tasks of this sort, don't put yourself in the position to have to do them. You will lose money or patients or both. Some of you have structured your practices so you don't have to do work with managed care companies. Hooray for you! For the rest of you, managed care paperwork is a reality. It is crucial to create double check systems for tracking authorizations so you don't end up writing off unauthorized visits.

Getting the Money in the Door

Unless you're operating a cash practice where each patient pays in full at the beginning of every visit, you will have payment and collection challenges. I cannot emphasize enough that **SUCCESS IS IN THE DETAILS**.

Collecting from Patients

If your policy is to collect in full from patients at the time of service, do that at the beginning of each session. If you choose to collect only what their insurance won't cover, then your insurance verification process should tell you exactly what the patient owes each time and your billing process should tell you if he or she has a balance carried over. Becoming a VISA merchant so you can accept credit card payments can improve collection considerably and make payment plans possible for patients without your having to carry the financial burden. Be sure each patient gets a statement each month, whether they owe a personal balance or not — it's good business.

Collecting from Insurance Companies and Other Third Party Payers

Send HCFAs or other billing forms at least monthly, on a regular schedule and have a good system for checking patient accounts to be sure all payments are up to date. When the insurance company is slow to pay, call to find out why. Oregon law (for Oregon employers) requires clean claims to be processed within thirty days of receipt. Pay particular attention to how claims are paid. If they're paid differently than the insurance verification indicated, be sure to follow up. Insurance companies make frequent errors and if they are paying correctly, then your understanding of the patient's benefits needs updating. You should do a complete check of each patient's account at least monthly to be sure all payments are on track. Then

follow up promptly, if needed.

Analyzing Your Collection Results

So you've followed all the "rules" and now you're wondering how to assess your results. Here are three simple statistics you can calculate on a monthly and annual basis to make sure your practice's billing and collection system is working.

GROSS COLLECTION RATIO (Payments/Charges)

This measures how much of the money you earned you actually received. For those of you with moderate or higher fees who are contracted with managed care companies, this figure may be considerably less than 100%, depending on how your fees compare to the contracted rates. For a point of reference, the average Gross Collection Ratio for PPMI's billing clients in 2004 was 90.2%

NET COLLECTION RATIO (Payments - Adjustments)/Charges

This measures how much of the money you earned, minus adjustments, you actually received. This number should be close to 100%. The difference between the Gross and Net Collection Ratios is a measure of voluntary write-offs in your practice (managed care and other voluntary write offs). For a point of reference, the average net collection ratio for PPMI's billing clients in 2004 was 99.6%, the lowest it's been in five years.

COLLECTION PERIOD $$\frac{[(\text{Beginning Balance} + \text{Ending Balance})/2] \times \text{number of days in period}}{\text{Charges for the Period}}$$

This measures the average number of days it takes to collect each dollar you earn. If a significant amount of your income results from billing insurance companies and waiting for their payments, this number can get as high as 50 days in a healthy practice, depending on the insurance companies involved. If you're collecting most of your income from patients as they come in, the number will be in the single digits. For a point of reference, the average collection period for PPMI's billing clients was 39.1 days. If you'd like the formula for calculating the value of a difference in cash flow that can be obtained from collecting money sooner, e-mail or call me. You'll be amazed!

Next issue I'll talk about practice building at various stages of practice. If you have questions or particular topics you would like me to address, please let me know. I hope that in some small way I have helped you create a more rewarding psychology "business" that serves not only your patients, but also the psychologist who owns it!

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