The Right Way to Do Write-offs

A write-off is an amount that a practice deducts from a charge and does not expect to collect, thereby “writing it off” the accounts receivable or list of monies owed them by payers or patients.

There are lots of reasons why write-offs are taken, and it is common practice to divide write-offs into two major categories.

Necessary or Approved Write-offs

These are write-offs that you have agreed to, either in the context of a contract, or in terms of your practice philosophy.

Contractual write-offs are the difference between the practice fee schedule and the allowable fee schedule you’ve agreed to accept.

Charity write-offs are the difference between the practice fee schedule and anything collected. Charity write-offs may be in accordance with a community indigent care effort, a policy adhered to in a faith-led healthcare system, or a financial assistance program.

Small balance write-offs are amounts left on the patient’s account that may not warrant the cost of sending a bill, which has been estimated to cost about $12.00 each, taking into account the statement process, as well as the cost to receive the check, post it, and deposit it. Many practices write off the small balance (usually $15 or less) and collect it when the patient returns. Others run a special small balance statement run once a quarter.

Prompt payment discounts and **self-pay (no insurance) discounts** are write-offs for patients paying in full at time of service, and/or patients who receive a discount off the retail price because they do not have insurance coverage.

Unnecessary Write-offs

These are write-offs that you have not agreed to and you reluctantly reduce the charge based on billing mistakes or situations that you should have been able to control, but were not.

Timely filing write-offs are caused by filing the claim past the date required by the payer. Medicare requires that claims be filed no later than 12 months after the date of service to be paid. Medicaid varies from state-to-state. Commercial payers usually have very tight timely filing limits and most average three months. (Make sure you know your timely filing limits for each payer.)

Uncredentialed provider write-offs are those caused by filing a claim for a provider before they are credentialed with the payer.

Administrative write-offs are those approved by the manager based on service issues. For instance, if the practice assures the patient that they are participating with the patient's insurance, then it turns out that the practice is not in-network, the manager may approve a write-off based on the practice's error. If the patient has a very bad experience in the practice, the manager may want to discount the service or to write-off the charge completely. If you do discount the service, remember to submit the claim for the altered fee, as you cannot discount the fee to patient and charge the payer the full fee.

Bad debt write-offs are balances that you have decided to write-off and not pursue further. These are balances that for whatever reason, you are forgiving forever.

Collection agency write-offs are those that are written off the main A/R (accounts receivable) and transferred to a third-party collection agency to collect on your behalf. These balances are not forgiven. Some PM (practice management) systems maintain a separate collection bucket or A/R and others do not maintain collection accounts in the system. Most practices do not schedule appointments with patients that have a collection balance until that balance is satisfied or the patient is committed to a reasonable payment plan.

Some guidelines for managing write-offs

1. Start with the basic write-offs but add write-off categories as the need arises.
2. Decide which write-offs require managerial approval. Do not make staff get approval for routine write-offs, but do not completely relinquish approval for all write-offs as this is one place where staff could abuse their authority. Make sure write-offs are addressed in your compliance plan so staff understand their responsibilities.
3. Review all write-off categories monthly and pay attention to unusual spikes as well as creeping trends. Keep in mind that if you raise your fees and don’t renegotiate your contracts, your contractual write-offs are going to escalate, and you’ll need to account for that difference in your evaluation.
4. Audit write-offs periodically to make sure that they are being done correctly. Staff will know that their work is being checked and you can be sure the numbers you are

making business decisions on are sound.
5. Best practices for unnecessary write-offs are no more than 5% of your total expected collections. The formula for expected collections is gross charges minus necessary/approved write-offs.

There is No Such Thing as a 10-Minute Office Visit

I sat at the checkout desk in my practice last week for the first time and as always, it was a revelation. If you haven't worked your check-in and check-out desks recently, I highly recommend it.

An insured patient that I checked out was shocked when I said the charge for her visit was $100. She said, "But he was only in the room for ten minutes!" I was briefly at a loss for words. I recovered, we agreed on a payment plan, I made a note on her encounter form for the billing office and she left.

I've been thinking about our conversation, and thinking about what that $100 is supposed to cover…

1. First, we **scheduled** the appointment, which was a work-in, so it took several people to **take the message**, **pull the medical record** (paper charts), **call the patient to assess the problem**, determine the need for the appointment and schedule it.
2. When the patient arrived, we checked to make sure her address and phone were the same, quickly checked her **eligibility** to make sure the insurance on file was still in force, and asked for a photo ID for **red flags**. An

encounter form was generated at the nurse's station to notify her of the patient's arrival.

3. The nurse called her from the reception area, **weighed her**, and took her into an exam room to take her **vitals**, take a brief **chief complaint**, **review the medications** she is taking and check to see if she needed any chronic **medication refills** while she was there.
4. The physician came in to see her, asked about any **changes** since she'd last been seen, reviewed her **history of present illness** and **examined her**. He talked to her about her illness and described a **treatment plan** for her upper respiratory infection given her chronic health problems.
5. He **prescribed a medication** for her problem, **updated her medication list** and **made a copy** for her to take with her.
6. He marked the **encounter form** with the level of service and her diagnoses and gave her the form to take to the check-out desk.
7. He **refiled the medication reconciliation** in the chart, finished **documenting the visit**, and placed the chart in the bin to be refiled. The **chart was filed**, and the **encounter form was sent to the billing office**.
8. At the billing office the **charges and any payment was posted** and the **claim was filed**. If there was no problem with the claim, it electronically passed through two scrubs and a final one at the payer.
9. If payment was not denied for any of a dozen reasons, the **payment would arrive at the billing office and would be posted**.
10. Since the patient did not pay at the check-out desk, the **patient-responsible balance is billed to the patient**. If the patient pays on the first statement, it has taken 45 to 60 days to receive complete payment. Since the patient has BCBS, there is a negotiated rate, so the payment will not even total $100.

I know that patients often say “But he only spent 10 minutes with me.” Checking back with the provider, I find it was typically longer. Patients tend to underestimate the time as it goes very fast.

The total visit encompassed the work of the phone operator, the medical records clerk, the triage nurse, the check-in person, the nurse, the doctor, the check-out person and the biller. It took 8 people, and at least 45 minutes of work to make that appointment happen. Plus, that visit had to help pay the expenses for the rent, the utilities, malpractice insurance, medical supplies, computers, phones and janitorial services.

The practice, the patients and the overseers of healthcare want each visit to be non-rationed, safe, high-quality, error-free, holistic, pleasant, clean, accurate, efficient and reimbursable. It’s what we all want. And it ain’t cheap.

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