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DENTAL SOLUTIONS

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10 Ways

to Improve the Health of Your **Revenue Cycle**

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Providing excellent dental care that keeps patients coming back and referring others, and that attracts new patients will *always* be your number one priority, of course. If you're not sufficiently profitable, though, you won't be able to deliver the kind of experience your patients want. You, nor anyone on your team, should feel uncomfortable about wanting and expecting to collect all that is rightfully owed to you – by insurance companies *and* by your patients. When you don't, you will be under constant financial stress which will be woefully obvious to your team and your patients.

That's why we have compiled the 10 PROVEN STRATEGIES that will improve the health of your revenue cycle. Not by accident, the first one is not specific to money; it is specific to *your team.* That's because to run a thriving, financially-profitable practice, you and your staff must be working toward the same goals, and follow *proven practices* that will help you achieve them.

If you're not sufficiently profitable, you won't be able to deliver the kind of experience your patients want.

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10 Ways

to Improve the Health of Your **Revenue Cycle**

1. Hold morning huddles
2. Verify insurance plans and input accurately into Practice Management System
3. Implement financial protocols with patients
4. Offer patient payment options on day of service
5. Submit insurance claims within 24 hours of performing services
6. Accept Electronic Funds Transfer (EFT) payments from insurance companies
7. Follow up on outstanding insurance claims frequently
8. Offer electronic payment options for outstanding patient balances
9. Use data and reports to set financial goals and track performance
10. Create a strategy to decrease overhead

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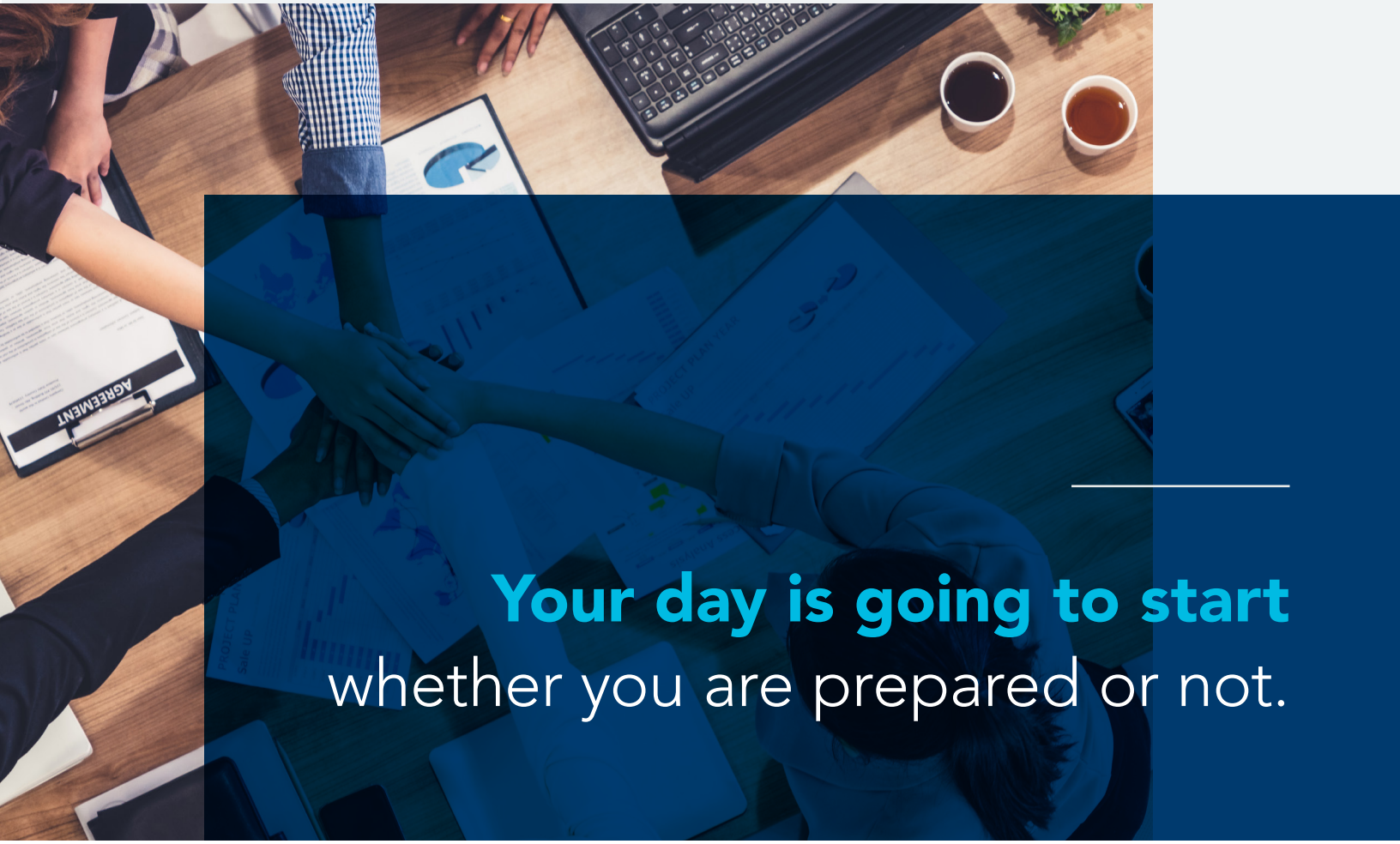
1 Hold morning huddles

Your day is going to start whether you are prepared or not.

The most synergized and successful dental practices utilize morning huddles to ensure everyone is prepared and motivated to work as a cohesive team to deliver the best patient experience possible, while also supporting the practice's financial goals. Huddles also give you the opportunity to learn from past hiccups, and anticipate and *plan ahead* for any that may arise that day, thereby setting everyone up for success.



Your day is going to start
whether you are prepared or not.

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Hold morning huddles 1

Following these best practices will help you design and run efficient, effective morning huddles:

- Schedule huddles early enough so they end at least five minutes before the first scheduled appointments of the day. Patients that schedule appointments first thing in the morning typically do so to avoid any delay, so it is important to respect that.

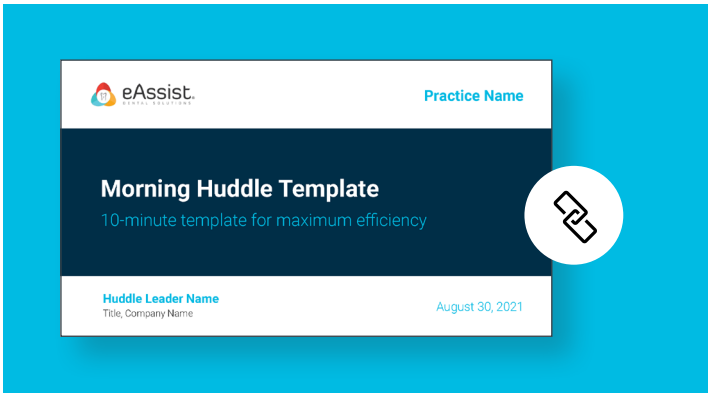
- Require attendance by the entire team, and that they be prepared with any necessary information they are responsible to know or provide. If a team member is running late or unable to attend, task another team member to catch them up, or give each team member one or more parts of the agenda to relay to them.

- Ensure focus and efficiency. This is not the time for eating breakfast or sipping coffee; people should be listening, participating, problem-solving, and taking notes (e.g., on a printout, calendar template, or dedicated notebook).

- Start on time, meet no more than 15 minutes, then end on time.

- Follow an agenda. Choose the topics that are most important and impactful for your specific practice and patients, and that can be covered in the recommended 15 minute timeframe.

- Foster team engagement and ownership by empowering *team members* to run huddles. The doctor can begin the huddle with a brief leadership remark – such as a motivational statement, inspirational quote, or positive patient review – then turn it over to the huddle leader to keep the session on time and running smoothly. Rotate the team member in charge each week.



When first implementing huddles, you may find yourself running out of time. Stick with it, as you and the whole team will get better with practice. As you're learning, though, don't give short-shrift to the agenda items that, over time, will make or break you financially.

For each patient scheduled that day, review their treatment plan, *and* (a) status of insurance, e.g., eligibility, use against maximum, deductibles; (b) outstanding insurance claims; (c) outstanding patient balance; and (d) continuing care visits. During morning huddles everyone should be made aware of patients that need to be handed off by the clinical team to the front desk team (or whomever you have collect patient payments) so you can collect copays and patient portion *that day*.

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2 Verify insurance plans and input accurately into the Practice Management System

Insurance verification (IV) determines a patient's eligibility for services.

IV requires an understanding of the many and ever-changing dental and medical codes, as well as the intricacies and nuances of the *many* dental plans you may accept. Timely, accurate IV helps you:

- Plan and present the *best treatment plan* for the patient;
- Confidently explain copays and covered/non-covered portions so you can collect the proper patient portion *at time of service;*
- Submit a complete and accurate insurance claim *that gets paid in a timely manner;* and
- Invoice the patient for any remaining balance, confident they will not be surprised or upset, and will therefore be willing to pay *in a timely manner.*

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Verify insurance plans and input accurately into the Practice Management System

2

Being diligent about IV but then less diligent about timely, accurate entry of insurance and personal information into your Practice Management System (PMS) makes no sense. Your PMS is your go-to for "all things dental practice." Having inaccurate or outdated information in the PMS hinders your ability to provide the best treatment plans to your patients, severely impacting your cash flow and adversely affecting the trust your patients have in you and your practice.

Get any detail wrong on insurance claims and you'll suffer a potentially lengthy delay in payment due to returns requiring resubmission, or denials requiring appeals – all of which require time and aggravation on the part of your staff. After all that you may *still* never get paid. In fact, insurance denials due to incorrect or incomplete information are the #1 cause of lost profits for a dental practice. Getting insurance claims right *the first time* is crucial to consistent and predictable cash flow, and to collecting all that's rightfully owed to you.

In addition to the clinical portion of the claim being complete and accurate, all of the patient's personal information must match *exactly* to that which the insurance company has on file. Have a disciplined process in place to regularly confirm every patient's plan (i.e., every 6 months minimum, and before the start of a new year), and current personal data. Save yourself the time, energy and aggravation of submitting and then following up on claims with the wrong company, or finding out the patient was no longer covered as of a certain date.

No matter how diligently you pursue accurate information you may still get surprised by such things as: retroactive insurance termination due to non-payment of premiums or job loss; use of an abbreviated or middle name with your office instead of their legal name as on an insurance policy; maximum use and frequency of treatment exceeded because they've also used other providers during the year. Keep your PMS as up-to-date and accurate as possible so these surprises are the exceptions instead of the norm.

Most Common Reasons Claims are Denied *(all of which are preventable!)*

- Insufficient / incorrect information
- Coverage limitations
- Internal data entry errors
- Coordination of benefits
- Pre-authorization not obtained per plan guidelines

> Your PMS is your go-to for **"all things dental practice."**

3 Implement financial protocols with patients

Financial controls are essential to any business. Especially for dental and *any* type of medical practice, finesse is required in order to preserve the patient relationship while also being clear about payment expectations. Having well-defined protocols and processes in place – and following them *consistently* – alleviates pain points for patients and staff while keeping your cash flowing.

- **Know why the patient is seeking treatment,** e.g., why they came to see you today, why dental health is important to them, why they would limit treatment to only what insurance covers. Seek first to understand before being understood so you build trust, which makes patients more receptive to expectations of the office.

- **Use a Financial Agreement form** that clearly states how outstanding balances and credits are handled. For example: in the case of outstanding balances, how you will initiate contact; and how long before you involve a collection agency. For credit balances, many states set a legal time limit for how long unused credits may be kept on an account. Leverage credit balances as an ideal marketing opportunity to reach out to patients to get them back for follow-up treatments, and include marketing materials with refund checks.

alleviate pain points + keep your cash flowing.

Click here for a Sample Financial Agreement

> **Finesse is required in order to preserve the patient relationship** while also being clear about payment expectations.

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- **Understand that the office is not a bank, and adhere to regulatory requirements.** Establish clear internal processes for patient payments and refunds that comply with regulations for third party or in-house financing. For example, if a patient paid by credit card but then requests a check for an overpayment, that may be a problem, especially in the case of third-party financing. Adhere to the rules and ensure your office is not being used as a bank.

- **Establish clear verbiage around payment at time of service.** As a team, establish appropriate verbiage that lets the patient know your office cares, and also sets reasonable expectations for payments at time of service. Telling a patient "It's our office policy" can come across as abrasive or uncaring. Conversely, excessive leniency on copayments and patient portions can give the impression your business is not as professional as it should be.

> **The office is not a bank —** adhere to regulatory requirements.

- **Establish a threshold for when a signed financial agreement is necessary**. Set a minimum threshold for treatment amount that requires a financial agreement. Anticipate if treatment may exceed that threshold and initiate a written commitment for how the patient will handle their financial obligation prior to scheduling the appointment.

- **Be consistent and accurate.** Financial processes and protocols must be applied consistently by all team members and for *all* patients. And accuracy is critical. That said, to err is human. For example, humans transpose figures, occasionally post patient payments to the wrong account, and insurance companies have been known to deposit funds into the wrong bank account.

  Verification and reconciliation protocols ensure mistakes are caught and corrected as quickly as possible. Financial conversations go more smoothly with patients when you're confident in the information. Following these key protocols will also help protect your practice against the unlikely but all-too-real possibility of theft or fraud.

  — Daily verification and reconciliation of your PMS with your bank account to ensure all accounts receivable are posted timely and correctly, i.e., insurance checks, EFT payments, and patient payments

  — Daily verification and reconciliation of all expenditures and accounts payable

4 Offer patient payment options on day of service

Having a variety of payment and financing options when shopping has become an expectation in our society, and going to the dentist is no different.

Offering your patients the convenience and control of deciding how to purchase your products and services benefits your practice in important ways:

- *More immediate cash flow* from copays and patient portions collected at time of service
- *More predictable ongoing cashflow and revenue* from agreed-upon payments over time
- *Improved patient care* by enabling patients to afford the treatment they need and want

Offer Patients the Convenience of Payment Options on Day of Service

- Cash*
- Credit/debit card*
- Auto-pay on pre-set dates
- Financing options – 3rd party and/or in-house

(Consider offering a discount for payment in full)*

For lower-cost treatments, such as cleanings and exams, patients are likely to use a credit card or auto-pay as a way of self-financing by being able to pay over time, if they need or prefer to. That may not be an option for some, especially for higher-cost treatments. If you don't offer financing options, the patient may quickly decide they can't afford it.

More costly and/or lengthy treatment plans that might require a patient to finance the cost must be presented correctly. Whether it's your office manager, treatment coordinator, financial coordinator, or other team member who discusses the treatment plan and payment options, they must have the proper skill set. In addition to fully understanding what they are presenting, that person must be able to explain the benefits and value in terms of what is important to the patient, e.g., they will no longer suffer pain and discomfort, or be embarrassed by their smile, or be unable to eat certain foods they love.

Do your homework to identify reputable third party financing companies so you can make recommendations. If the patient is told they have to figure that out on their own, they won't be able to agree to the treatment that day… and likely never will. If you offer in-house financing or membership plans, have a formal professional financial agreement (in addition to the one used for all patients) that spells out precise payment terms over time (e.g., auto-pay, or due dates), just as any third party company would. And, of course, be knowledgeable about any state regulations involved with in-house financing.

5 Submit insurance claims within 24 hours of performing services

The longer you wait to submit claims to insurance companies, the longer it will be before you get paid.

As obvious as that is, too many offices put off this task even though insurance payments may account for 50-60% of total cash flow. A definitive, proven best practice is to submit insurance claims within 24 business hours of performing the service. But not just a claim – a *clean* claim.

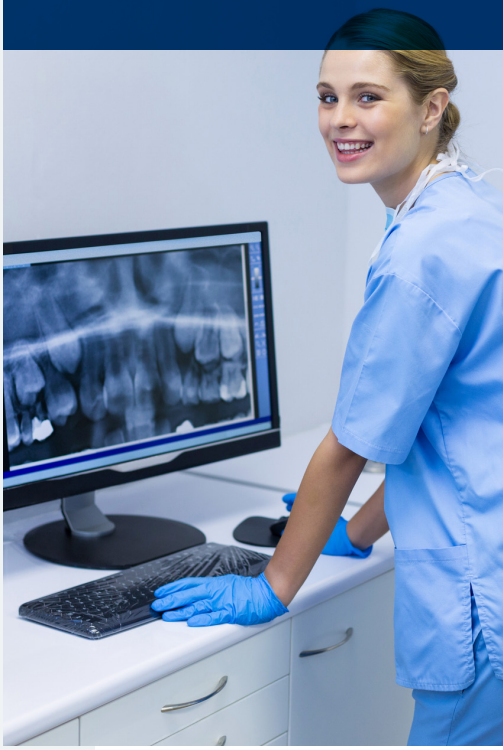
A clean claim submission is *100% complete and accurate* – including patient information, procedure codes, clinical notes, radiographs, intra-oral photos, and any other required or beneficial supporting documentation. As one example of the latter, if a pre-authorization was obtained (also a best practice for large procedures), include it as proof of approved estimated benefits in case provisions for a certain procedure changed in the meantime.

The specific information required (or often requested) differs by type of service, and is typically spelled out in the explanation of benefits (EOB). Including everything the insurance carrier needs and wants as part of the initial claim package will greatly increase the chances that the claim will be processed quickly the *first* time, so you get paid faster. The alternative is that the claim gets stalled, returned or denied due to incorrect or missing information – which means you're not getting paid in a timely manner… and maybe not at all.

Time spent preparing anything less than a clean claim will result in more time and aggravation being spent later to prepare a resubmission or appeal. If details were not properly documented in the patient's chart so they could be included on the initial claim, the provider won't accurately recall those details weeks later. Avoid doing your practice and your patients a disservice by doing what's necessary to collect all that is rightfully owed to you from their insurance company by submitting clean claims ASAP.

Clean Claim =

- All procedures properly coded
- Accurate patient demographic information
- Accurate benefits carrier information
- All necessary documentation attached



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6 Accept Electronic Funds Transfer (EFT) payments from insurance companies

Payments from insurance companies made via electronic funds transfer (EFT) land in your bank account *much* sooner than paper checks. That alone should make you want to accept EFT payments.

Practices that haven't switched either; (a) don't understand what EFT is, (b) don't trust the technology, (c) believe high fees are involved, and/or (b) think it would be a hassle and time-consuming to make the change and learn new processes. Let's tackle these one at a time:

a) EFT is the process of electronically moving funds from one bank account (from the insurance carrier) to another (the practice account). EFTs usually include ACH (automated clearinghouse) payments, wire transfers, and other types of digital payments.

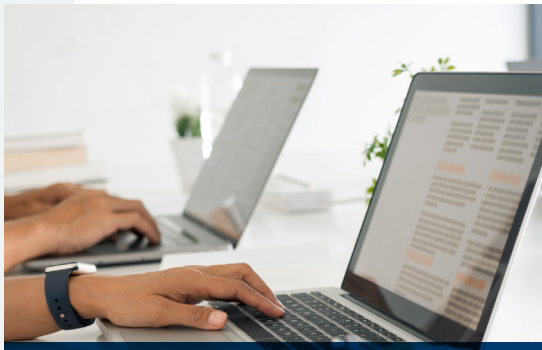
b) EFTs have been around for more than 35 years. Any kinks in the technology have *long* since been worked out and EFT has been an accepted method of banking worldwide for decades.

c) Insurance carriers are legally precluded from charging excessive fees for EFT services.

d) As far as being too time-consuming to make the switch, your staff spends far more time *on an ongoing basis* having to follow up on status of outstanding payments and process paper checks that could have been in your bank account much earlier.

Making the switch is easy. To securely opt into EFT payments with individual carriers, follow the simple steps listed. If you ever wish to discontinue EFTs, you may opt out at any time by contacting the company and letting them know you prefer to go back to receiving paper checks.

As reliable as EFT technology is, human error can still be a factor. Insurance companies can make EFT deposits into the wrong account, and payments received can be incorrectly applied to the wrong patient account. As discussed under Financial Protocols, verification and reconciliation on a daily basis will ensure these errors are detected and corrected in a timely manner.



Making the Switch to EFT

1. Contact the insurance carrier's Provider Relations department
2. Tell them you want to utilize the EFT payment option
3. Provide your bank's information for electronic payment (bank name, routing and account numbers

7 Follow up on outstanding insurance claims frequently

Discussing outstanding balances with patients is difficult and stressful for even the most experienced team member.

When payment and balance due information is incorrect or not up-to-date, the conversation goes poorly, and negatively impacts the patient's trust in your practice. Following up on outstanding insurance claims frequently helps minimize pending claims and payments so you're working with the best possible information, instead of trying to collect an "alleged" balance that may surprise and aggravate your patient.

Track every claim from start to finish to ensure payment is received and applied correctly in the PMS. Reconcile the patient's account by verifying the following:

- Were all claims for services rendered created, batched, and sent to the correct insurance company?
- Did the patient pay their estimated copay at time of service?
- Were line-item payments posted to the correct providers?
- Are there any credits on the account? Are they accurate?

Frequent follow up also alerts you ASAP if a claim has been denied so you can prepare an appeal (or a second or third) within deadlines. When discussing an outstanding balance with a patient, you can let them know you're continuing to work hard on their behalf, and may even suggest they call their insurance company to protest the denial.

Track every claim
from start to finish

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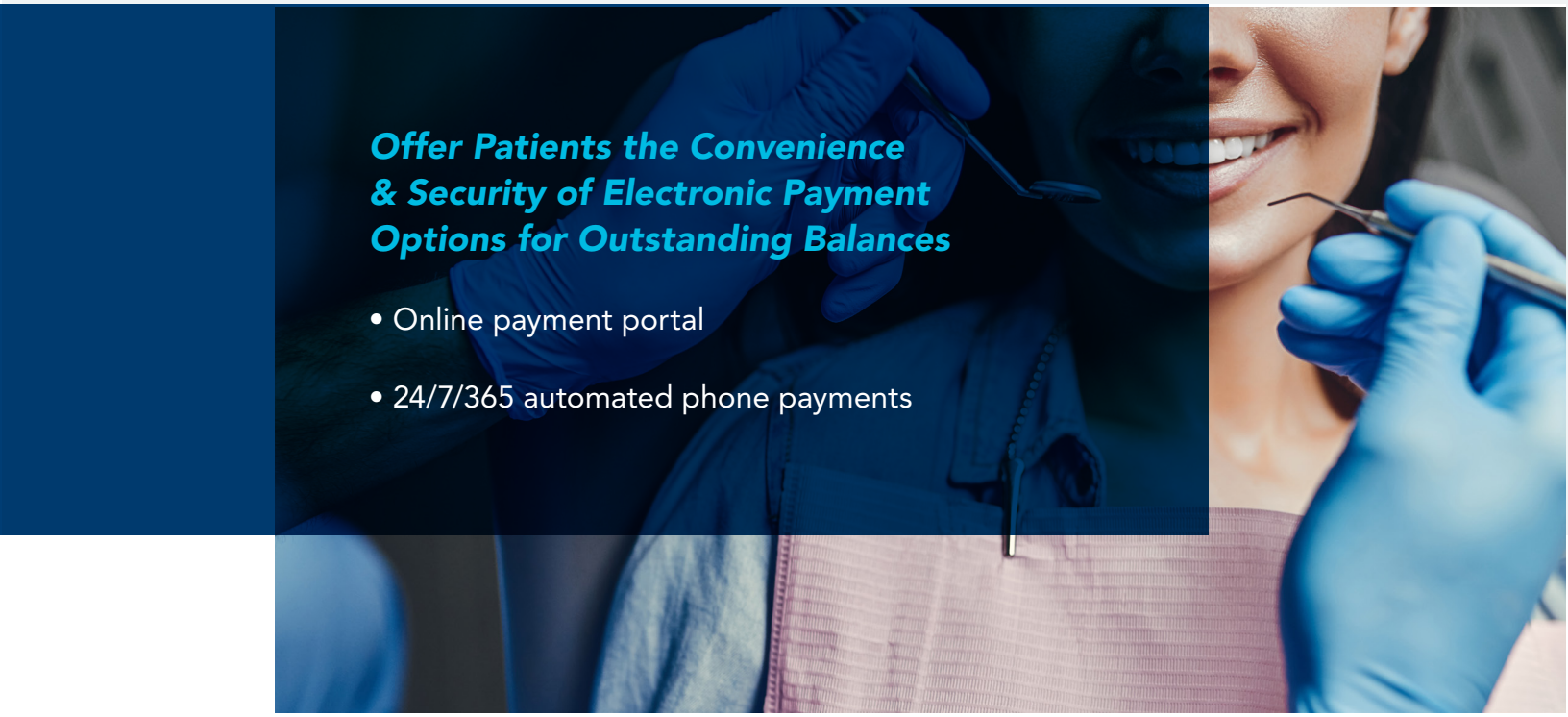
8 Offer electronic payment options for outstanding patient balances

Despite the most diligent of insurance verifications, pre-authorizations, and collection of copays and patient portions on the day of service, there will always be patients with outstanding balances after insurance payments have been received and posted. Having good financial protocols in place helps ensure expectations were communicated and understood up-front, so patients aren't surprised or angered when they receive an invoice for a balance due.

As with time-of-service payments, give your patients the convenience and control of deciding how to pay, but this time from their home or office. Some will still prefer to write and mail checks, but that is by far the slowest, most labor-intensive, and most unreliable way for you to get paid. Offer options that generate cash flow faster and more reliably, and that are more convenient for your patients and their hectic lives. With online shopping becoming increasingly popular, more and more adults are paying bills and invoices online, and you can have that option for your patients too.



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9 Use data and reports to set financial goals and track performance

As a business owner, you have a responsibility to know where your business stands at all times, based on facts. Data lets you understand how your practice is actually performing, instead of how you think (or hope) it is. As the saying goes, "What gets measured gets managed." Your PMS, and perhaps other financial software you use, are rife with data and reports you should be leveraging to help you set reasonable, achievable goals; plan strategies; and track performance.

Practice owners who look exclusively at gross production often don't understand how they can be making so much money, and yet be under constant financial stress because they never seem to have enough money. In reality, gross production tells you what the practice has earned for all the products and services provided, but not what it has made by being paid for those services, and after covering all expenses.

To know and improve upon what you're actually making (aka net profit), monitor and manage performance in these four key areas. They reflect the overall health of your practice, and where you and the team need to focus to drive improvement, growth and profitability.

1. Number of visits

You should always be working to fill your chairs with new patients and referrals, but your existing patients provide your best and fastest opportunities to increase the number of visits. Patient recall and scheduling is easier than ever with the use of texting and email. Let patients know you care about them and their health by reminding them they are overdue for a cleaning or exam, or have missed a step in their treatment plan.

Data lets you understand how your practice is actually performing, instead of how you think (or hope) it is.

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2. Production per visit

Your systems should allow you to pull a variety of production reports, e.g., by provider, by type of service, for different time frames, and many more. Increase your profitability in this area by improving on everyone's ability to make effective treatment plan presentations, and letting patients know about ancillary products and services that would be of benefit.

3. Collection percentage

Use collection and A/R reports to track performance against two key goals. Know where your office stands now, regardless of industry stats. If necessary, set goals for continuous improvement as you work toward the ideal result.

— **Zero dollars past 30 days** for both insurance and patient Accounts Receivables. You can quickly get closer to this goal by: switching to EFT payments from insurance companies so you get the money faster; working your aging report almost daily; and being assertive with insurance representatives so you get paid all the practice is owed.

— **98-100% collection ratio.** Due to adjustments and write-offs, this will never be 100% of *gross* revenue. Know how much of your gross revenue should be collectable (e.g., 80%) and how much of that 80% you actually collect, on average (e.g., the industry average of 91%). If you're already at that level, go for the gold by setting a goal of at least 98%. But let's say you're at 70% now; start with a goal that's more attainable. Achieve it, then set a higher one. Your best tool is your A/R report, and your best strategies are to submit accurate and complete insurance claims daily, and consistently and assertively follow up on outstanding claims.

4. Overhead

Large or small, multi-location or single-office, you should be maintaining a complete and accurate Profit & Loss (P&L) statement. Your P&L tells you where you stand on all the elements of the business that you need to be monitoring and controlling to ensure profitability, especially overhead costs.

Break out overhead into numerous categories specific to a dental practice so you can be proactive about addressing anomalies and negative trends, finding ways to reduce costs (without adversely impacting patient care and service), and optimizing total overhead percentage.

A widely-accepted goal for a general dental practice is 59% total overhead (not factoring in write offs and adjustments), although 50% or less is proving to be an attainable goal by the most successful dental practices.

Dental Practice P&L Overhead Chart of Accounts (minimum)

- Staff wages
- Lab costs
- Supplies
- Equipment
- Rent/mortgage
- Marketing
- Business office
- Miscellaneous

> A widely-accepted goal for a general dental practice is **59% total overhead**

10 Create a strategy to decrease overhead

Along with production and collections, overhead is a critical factor when it comes to profitability. In fact, if your practice is not as profitable as you need or want it to be, overhead is almost always the best place to look for opportunities.

Knowing total overhead percentage tells you if there's an overall problem, and your detailed P&L tells you where to look to solve the underlying root causes. Monitoring expenses by category lets you see adverse trends such as rising lab costs, increasing credit card fees, and anomalous supply or business office expenses.

Practice Overhead =
Every cost not associated with dentist income

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Create a strategy to decrease overhead 10

Based on the generally accepted goal of 59% total overhead (for a general dental practice), these are good line-item goals. If you're a long way from these currently, set more achievable short-term goals and work toward these in the longer term.

Breaking down the 59% for General Dentists:

25%	Staff wages
8%	Lab
6%	Supplies
3%	Equipment
7%	Rent/Mortgage
4%	Marketing
3%	Business Office
3%	Miscellaneous

Your strategy to decrease overhead should include these best practices:

- **Negotiate *everything.*** Don't assume any of your costs or contracts are non-negotiable. You won't know if you don't ask, and if the answer is no, you're no worse off. Where possible, strengthen your position by negotiating package deals or bundles instead of individual line item purchases.

  Things you should absolutely negotiate:

  - **Lease**
  - **Supplies**
  - **Lab fees**
  - **Marketing**
  - **PPO Contacts**
  - **Staff**
  - **Utilities**
  - **Software**
  - **Real estate & practice loan**
  - **Equipment**
  - **Patients**
  - **Yourself**

- **Implement the $100 Rule.** Finding small savings here and there adds up to big savings overall. Sit down with your P&L and your office manager and go through every line item with the goal of finding five $100 monthly savings opportunities. It's easier than you might expect, and becomes almost addictive. Over the course of a year small savings add up to big expense reductions.

The higher your overhead, the more opportunity you have to drive it down, and drive profits up. Intensively controlling expenses, reducing costs, and managing margins on all the individual components that comprise total overhead lets you manage overhead and profit on a small scale… which leads to large-scale bottom line improvements.

Streamline the processes that drive your dental practice revenue

The more eyes on your revenue cycle, the quicker you will catch roadblocks and errors. Streamlining processes to remote team members alleviates the tedious tasks from your in-office team, and keeps cash flow consistent no matter what. Streamlining these processes is important whether you accept the assignment of benefits for twenty insurances, or none at all. But who can you trust with these processes?

At eAssist Dental Solutions, we're proud to say we have collected more money for more dentists for longer than any other dental billing company. That's why we are the LEADING DENTAL BILLING COMPANY IN THE NATION. We invented and perfected the dental billing process, and know the dental practice revenue cycle pipeline forward and backward. We work with you and your team as an EXTENSION of your staff — a trusted and reliable business partner dedicated to maximizing your income. We fight for all that is rightfully owed to you while you and your staff focus on serving your patients.

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