Special Article

Beyond All Measures: Criteria for the Use and Selection of a Collection Agency in a Medical Practice

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The need for protecting the accounts receivable of a medical practice by using collection agencies is well known. This paper provides background material and information necessary to establish criteria for placing accounts with a collection agency.

Key words. Accounting; accounts payable and receivable; patient credit and collection. (*J Fam Pract 1994; 38:514-520*)

Insurance provider bulletins, state medical association newsletters, and national publications all point to accounts receivable management as a top priority for the financial integrity of medical practices in the 1990s. In today's economy, the survival of medical practices can hinge on physician attention to the balance sheet. A practice not on sound business footing will not survive.

As credit manager for a medical practice, I began developing criteria for placing accounts receivable with a collection agency. In doing so, I was struck by the lack of guidelines available to the business office manager. A thorough search of the literature since 1973 produced not a single article or chapter on the subject—not even a letter to the editor. This shortage results from lack of expertise in this area coupled with the belief held in many medical practices that overdue accounts receivable are unworthy of a management strategy. As a result, placing accounts with collection agencies is commonly a willy-nilly, hit-or-miss proposition.

With over two decades of experience, I have developed criteria for the establishment of policy relating to the placement of accounts receivable with a collection agency and guidelines on the effective transfer of those accounts. A practice's credit policy and internal collection process establish the context for collection agency referral.

Credit Policy

A credit policy has two parts. The first one is the official "Credit Policy," which is provided in writing to the patient and outlines patient responsibility and physician expectations (Figure).

The second part of the credit policy is the business office operations manual, which outlines billing and collection procedures. This manual allows the business office staff to function autonomously, consulting the physician only for circumstances beyond its guidelines. There is no perfect operations manual: the "best" system is the one that works best for an individual practice.

When developing and implementing a credit policy, the first step is to determine who will set the policy. Foremost are the physicians or practice owners, who establish the ground rules. The business manager must know the myriad of governmental and insurance rules and regulations with which medical practices must comply. An administrator or manager who is responsible for adherence to these regulations disseminates the rules, and business office staffs oversee the daily operation of the credit policy.

A fair and effective credit policy accomplishes the following:

1. All accounts are billed in the same manner, and everyone is treated equally. Straying from this path will

Submitted, revised, March 4, 1994.

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ISSN 0094-3509

CREDIT POLICY
All charges are due and payable within thirty days of the date of service. If unable to pay the balance in full, please call the business office at (123) 456-7890 to arrange a payment plan.
You are responsible for payment.
Delayed payment by an insurance company is not considered an acceptable reason for nonpayment.

Figure. Sample credit policy for medical offices, which outlines patient responsibility and physician expectations.

likely lead to accusations of favoritism, allegations of unfairness, and exposure to needless risk.

2. Statements are accurate, easy to understand, and timely. Patients should receive statements on a regular basis until accounts are paid in full, written off, or placed with a collection agency.

3. Charges are not allowed to accumulate, and patients are informed of their financial obligations. Slow billing of a patient account encourages delinquent payment, and delayed billing of insurance companies encourages tardy reimbursement. Business office personnel should stay current on reforms affecting reimbursement, and depending on the practice size, should file insurance claims daily or weekly, never less frequently. Claims should be transmitted to insurance companies electronically whenever possible.

Payments at the Time of Service

The reason for collecting fees at the door is simple: the cost of billing often amounts to more than the payment is worth. Patients know their obligations: require them to tender copayments before seeing the physician. Generally, the copayment percentage is clearly indicated on the insurance identification card. Train the reception staff to inquire calmly and matter-of-factly about how the copayment is going to be paid. Never ask patients, "How do you wish to pay the copayment?" a question that often draws the response, "Bill me." Instead, ask, "Will you be paying the copayment by cash, check, or credit card?"

Have the person confirming appointments remind the patient that copayments are due before the appointment. Prompts printed on reminder cards are an effective reminder. If all patients are notified about payment policies beforehand, their appointments can be canceled if they arrive unprepared to pay.

Another method of collecting copayments at the time of appointment is to complete the billing sheet before the patient leaves the examination room. As the patient passes by the business office, a staff person simply poses the golden question, "Will you be paying your portion of the bill by cash, check, or credit card?" Patients will readily become familiar with your methods and comply.

If necessary, billing expenses related to patient copayments can be passed along to the patients not paying at the time of service. This policy encourages payment at the time of service and defers your expenses. Offering a small discount for up-front payments is an added incentive.

Internal Collection Process

An inventory of unpaid accounts receivable will accumulate unless payment in full is required prior to services being rendered. The first step in the internal collection process (Table 1) for unpaid balances is to call the insurance company, worker's compensation carrier, or other insurer at 30 days. This is the course of least resistance, as it is easier to coax a patient to pay if the insurance company has remitted. Most states have laws requiring insurance companies to pay or deny claims within 30 days.

Typically, insurance companies pay claims within 15 to 45 days. Most conscientious patients have their accounts paid in full within 90 days. The remaining accounts are problems resulting from insurance carriers requiring unusual items, worker's compensation carriers denying liability, and patients flatly refusing to pay without basis.

During the billing process, various collection techniques come into play. After 30 days, patients begin receiving "billing messages," typically appearing at the bottom of a monthly statement. The messages indicate an aging account and request prompt payment. The real "collection" process begins with separate collection letters mailed directly to the guarantor. For each overdue

Table 1. Guidelines for the Internal Collection of Delinquent Accounts

• Begin insurance follow-up by telephone at 30 days
• Print billing messages on patient statements after 30 days
• Use collection calls and letters from 60 to 150 days
• Be creative to catch the patient's attention

balance, only one "final demand" collection letter should be sent, after which decisive action should be taken.

Collection calls should begin in conjunction with the collection letters. The caller charged with this task should politely but firmly request payment or ascertain the reason for nonpayment. Any legitimate reasons for nonpayment should be addressed. Accounts should be carried for the shortest possible time. The value of a service begins to decline at 30 days. Five years after service, an account due is worth only one cent on the dollar.

Physicians in a practice should determine the length of time they are willing to carry an unpaid balance and should set limits accordingly. Statement billing is costly—between $2 and $5 per bill, per account. Cost variables include (1) billing technology, (2) administrative overhead, and (3) number of times billed. In any case, each statement mailed costs more than postage.

Most legitimate problems can be resolved within an additional 30 to 60 days, with the oldest accounts receivable approaching 120 to 150 days. Continuing to collect accounts older than 150 days quickly accrues excessive costs. For example, an account with a $10 balance is billed for 6 months at a cost of $2 per monthly bill. It does not take a rocket scientist to figure out that the business is already $2 in the hole after only 6 months.

By the time 150 days comes around, the hard-core collection account becomes difficult to salvage. The physician's office staff may assume the collector's position by default, but with little training and experience, they are not the most effective. A cutoff point should be set that is agreeable to both the physicians and the staff members who collect the accounts. I recommend 150 days.

When a physician's business office encounters a backlog of accounts 150 days or older, effective stop-gap measures should be employed. Short, direct messages handwritten in eye-catching colors on the patient's statement are effective: for example, "Your account is delinquent, please pay!" or "Is there a problem we are unaware of?" Special mailings also attract attention and produce excellent results. One of my favorite collection methods is to mail obnoxious-colored stationery (pea green, shocking pink, or phosphorescent yellow) with hand-addressed envelopes. The text on such correspondence should be short and simple: "This account is long overdue. Make payment by return mail, or I shall be forced to meet with you before your next appointment." A little intimidating perhaps, but very effective. Another successful method of handling problem accounts is to vary the times of collection calls. Saturday mornings, right after school, the dinner hour, or during a highly publicized television program are effective times to call about an overdue account. Your contact may be in a hurry, but then again, so are you.

Many collection agencies have "rent-a-collector" programs through which collectors are placed right in your office. "Rented" at an hourly rate over a specified period, these highly skilled, capable individuals function as part of your staff under your guidelines and control. The advantage is that professional results are realized at fixed rates that are less than normal collection agency commissions. This option can be used as a one-time "clean-up" method or as a periodic review before collection agency placement. Be creative, but set limits.

When an account reaches the billing cutoff point, you have three options: keep the account, write it off, or send it to a collection agency. Only after going beyond all measures should you consider turning to a collection agency.

Costs and Potential Return

Estimating costs and potential return rate is a tricky business because sources such as the US Department of Commerce, accounting texts, and collection agencies each advise from their particular vantage point.

Business costs vary dramatically from practice to practice. Solo practitioners sustain all business expenses, whereas a group practice spreads administrative and business expenses over larger aggregations. Typically, collection agencies charge 20% to 50% of the gross as a commission, depending on the contract, account age, and work performed. Another variable is the actual number of accounts the agency collects. Some agencies collect 10% or less, whereas others garner 60% to 70%. Why? The age at which the account is placed, the skills of the physician's collector, the dollar amount, and the agency's professionalism all have an impact on results. In 1993, our practice wrote off only 1%. Naturally, since the accounts placed had already been worked assiduously, the agency's recovery rate was not high. Costs and recovery rates are highly individual because account age, effort expended, and commission rate all affect the net result.

Criteria for Collection Agency Placement

Several issues should be examined before a decision is made to place an account with a collection agency (Table 2):

Are you certain you want to place an account with an agency? The relationship between physician and patient is altered permanently when a collection agency takes over an account. Does this outcome matter to you?

Table 2. Questions That Help Physicians Evaluate Whether a Delinquent Account Should Be Referred to a Collection Agency

- Are you certain about collection agency placement?
- Is the balance worth the expense?
- Can the bill be collected?
- Are you flexible?

Is the unpaid balance worth the expense of collections? Keeping an account with a collection agency costs money over and above its contingency fee. The account will continue to be carried on your books as either an active or inactive account. Office staff will monitor the progress at the agency. When the collection agency makes a payment, someone will post it. Correspondence, reports, phone calls, and so forth all require internal attention.

Can the bill be collected? If a patient has been unemployed for a long time, owns no real property, and has no assets, collection may be impossible. How about the elderly patient living on social security benefits with a remaining unpaid balance after Medicare's payment? In this case, no agency can force collection because the income is protected. These accounts are uncollectible. If you have such examples, do not waste your time and money. Certainly, a collection agency would not.

Does your policy allow for flexibility? If, for instance, a patient states on a current account, "I'm not going to pay," and the business office personnel can find no reason the patient cannot, the account should be shipped to a collection agency after the established 120 or 150 day cutoff point. On the other hand, if a farmer promises payment in full with cash from his crops, keep the account even though it will be over 150 days old at the time of promised payment.

Seriously delinquent accounts fall into three broad categories: accounts that should never be sent to a collection agency; accounts that should always be sent to a collection agency; and accounts that require individual decisions based on circumstances (Table 3).

Table 3. Collection Agency Referral Categories for Various Types of Delinquent Accounts

Accounts that should never be placed
- Accounts in litigation
- Workers' compensation cases
- Cases involving quality-of-care issues

Accounts that should be placed
- Accounts with small balances
- "Skip" accounts
- Patient fraud and abuse cases

Accounts That Should Never Go to an Agency

Never send to a collection agency (1) accounts in litigation, (2) worker's compensation cases, (3) accounts about which there are questions regarding quality of care, and (4) accounts involving sensitive issues.

The reason for not sending an account involved in litigation to a collection agency is simply to avoid adding fuel to the fire. Patients suing for damages, insurance coverage, and so forth, usually have an attorney advising them not to pay the medical bills. In most cases, the attorney sends a "letter of protection," which merely states that, in the event of a favorable settlement, you may get your fee after the lawyer has been paid. The point here is that if the account is turned over to a collection agency, the agency will bump the commission rate up to the "legal" level.

Let me explain. Collection agencies generally work on the basis of a contingency fee. For normal, run-of-the-mill accounts, this fee generally is about one third of the amount placed for collection. For accounts requiring legal action, however, the fee is at least one half. An account that is already in litigation and subsequently placed for collection will automatically be billed at the higher rate.

Never send worker's compensation accounts to an agency. These either are paid promptly or produce an enormous amount of work for the entire staff. When worker's compensation accounts are sent to a collection agency, physicians are called for depositions, and the business office repeatedly checks on the status of the claim, only to learn that the claimant is going through the appellate process, which sometimes takes years. Once in the appellate process, the patient's attorney again is likely to advise the client not to pay. From this point on, worker's compensation cases are like any other account in litigation. Once taken in by the collection agency, the account is commissioned at the highest rate and then put on the back burner while the agency's attorney presumably gathers information from the patient's attorney, the worker's compensation carrier's attorney, and so on, ad nauseam. By the time accounts in litigation are settled, the payment to a medical provider is startlingly reduced because of either the settlement or the costs involved.

Quality-of-care concerns range from petty complaints about bungling on the part of a laboratory technician, nurse, or receptionist to full-blown malpractice. The offended, mistreated, or poorly managed patient may have a basis for complaint. However, no matter what is done or whether the allegations are real or spurious, motivating the patient to pay is always very difficult. If the business office staff or administrator of your practice cannot placate the patient, the agency will not be

able to either. When questions about quality of care surface, the agency will back away, taking a hands-off attitude. In such cases, the agency will likely either shift the burden of proof back to your office or close the account, citing one of a variety of reasons, such as "all efforts exhausted." The bottom line is that the unpaid account lands back in your office.

Sensitive issues range from sexual harassment to physician's lack of interest. Some complaints have legal ramifications, but others are raised only to escape payment. Unless the unpaid balance on the account is substantial, it is not worth the time and trouble to collect. If the account is placed with an agency, clearly define the position of the practice, and document all activities related to the account before referral. The best rule of thumb is to write off accounts of this nature as not being worth the energy involved.

Accounts That Should Be Forwarded to an Agency

Refer to a collection agency (1) small-balance accounts, (2) uncontested accounts over 150 days past due, (3) "skip" accounts, and (4) accounts involving patient fraud and abuse of medical services.

Accounts for which internal billing costs exceed the unpaid balance should always be referred to a collection agency. Generally, small-balance accounts fall into this category. Remember, the cost of billing an account is between $2 and $5 each for each billing. Before going in the hole with an account, send it to the collection agency and pay the one-third commission. This allows the business office staff to spend their time more productively on large account balances with a greater return. Your business operations manual should designate which unpaid balances should be written off (for example, those of less than $10) and which should be referred to the agency.

I strongly advise that uncontested accounts more than 150 days overdue be placed with an agency. Once beyond the previously set aging cutoff, the account should be sent to an agency, unless unusual circumstances requiring higher-level decision-making exist.

"Skip" accounts should always be referred. A "skip" is a person who owes you money but whose whereabouts cannot be immediately ascertained. It is worthwhile to send these accounts to a collection agency that has sophisticated equipment and personnel trained in locating "skips." Most "skips" are unintentional. Many people neglect to notify interested parties when they relocate. These people do not move for the purpose of escaping; they are just careless. A small percentage, however, relocate fully intending to evade the past and its obligations. This type of "skip" usually acquires an unlisted phone number, an anonymous post office box, and so on. These rootless semicriminals have a vested interest in remaining undercover and are usually difficult to work with if found.

The computer-generated "skip" comes into existence when someone at the terminal miskeys a name, address, or telephone number. Because these "skips" often can be found in the telephone book, the business office should be able to locate them relatively easily. The others, however, require a certain degree of skill and are best placed with a collection agency.

Keep in mind that, with sufficient time and information, most "skips" can be found. Instead of writing off these accounts, use the skills of a collection agency.

The last class of accounts that should always be placed with an agency involve patient fraud and patient abuse of medical services. Remarkable as it may seem, some patients get insurance benefit payments, spend the money, and then refuse to pay the medical provider. Other patients present at clinics and hospitals with no intention of ever paying. Regardless of whether the patients have insurance or private means with which to make payment, the point is that they have no intention of paying even one penny. For the purpose of long-term protection, these accounts should be pursued aggressively. If you personally or professionally allow others to take advantage of you financially, they will do so repeatedly. Understandably, the physician has a need to treat, and the question of abandonment looms threateningly, but these concerns are easily addressed by requiring up-front cash payment for further care.

If a patient complains because of how a collection agency handles the account, it can be closed and returned with apology. In the meantime, the bill is paid or other appropriate action has taken place.

Accounts Requiring Special Decision-making

The last broad category of accounts requires decisions based on special circumstances. In such instances, the attending physician should advise. Consider, for example, the case of a patient who alleges a work-related injury. The injury is uncontested, but a worker's compensation carrier denies liability. The patient has no health insurance and is underemployed yet has a large, seriously delinquent account resulting from the injury. The business office in pursuit of collecting learns that the patient owns a home, a car, and other limited assets, including a wife's salary. This account is collectible. The wages can be garnished, and a lien can be placed on the home and car to protect assets for later disbursement. In this case, the staff still should seek the physician's advice. Perhaps the physician knows something that would pre-

Table 4. Guidelines for the Selection of a Collection Agency to Handle Delinquent Accounts

- Use agencies specializing in medical account management
- Use local firms
- Use well-known, reputable firms
- Confirm staff compatibility
- Investigate the firm's background

clude turning the account over to a collection agency (for example, the patient's wife is scheduled to be laid off the following day). Because special circumstances can make a difference in collection decisions, the attending physician should review all such accounts. All decisions should follow business principles, however, so that patients in like circumstances are all treated equally. In the absence of any business reason to keep the account, it should go to an agency.

Another consideration is the balance due. The business office staff should be given a threshold under which they may make discretionary decisions and set a limit up to which they can write off an account. Higher levels of management should make the greater financial decisions. For instance, the business office staff should have the authority to write off amounts between $100 and $500, and a clinic business manager or administrator should be able to write off amounts between $500 and $1000. Most certainly, physicians should be involved in determining disposition of balances above this amount. The practice takes a loss by writing off amounts over $1000, whereas writing off smaller balances can be cost-effective. Today more than ever, medical practices should be run like businesses.

General Principles of Agency Selection

There may be good reasons to use a collection attorney, but for our purposes, let us assume an agency is used instead. A reputable agency has legal counsel capable of obtaining judgments, filing liens, garnisheeing wages, and so forth.

There are five fundamental factors to consider in selecting a collection agency: (1) use an agency specializing in medical account management or having a high percentage of medical accounts; (2) choose a small local firm; (3) select a firm known to be reputable; (4) select a firm compatible with your staff, and (5) investigate the agency's background (Table 4).

An agency dealing with mostly medical accounts is sensitive to the physician-patient relationship and understands medical financial obligations. Such agencies are concerned about their reputation, and the community they serve usually knows their reputation.

Generally, small local firms produce better results. They work accounts aggressively because they need the business. Because of name recognition, Dun and Bradstreet is the exception, but I prefer to stick with small local firms.

Well-known firms belong to professional societies, such as the American Collectors Association, and participate in professional medical management organizations, such as the American Guild of Patient Account Managers or the Medical Group Managers Association. Alliance with such organizations provides the agency with insight into contemporary movements within medicine and local and national sensitivities.

Compatibility cannot be stressed enough. Communication is a critical factor. Without easy and frequent dialogue between the physician's office and the collection agency, success is unattainable.

Never rely solely on a colleague's casual reference. Personally investigate the agency before engaging it. Check with the Better Business Bureau to expose consumer complaints, the Chamber of Commerce to verify respectability and community involvement, and the state attorney general to document high-level complaints. Determine if the agency is a member of the American Collectors Association, a respected organization endorsing only the highest standards and to which all reputable collection agencies belong.

Negotiate a contract with the agency. Collection agencies generally do not admit to a dollar balance limit under which aggressive, labor-intensive pursuit of payment is avoided. Obtain this limit in the selection process. If it is an amount you cannot live with, include clauses in contract negotiations requiring a uniform level of performance regardless of the balance size. If an agency refuses to negotiate on this amount, select another or write off the account.

The person assigned the task of dealing with the collection agency should be watchful. Collection agencies will not fraudulently process commissions, but if you have negotiated a tough contract, your accounts will fall outside the normal agency work pattern.

Collection activity should be monitored to ensure contractual compliance. Make sure the agency is really working all accounts and not just letting them pass through the system, collecting only what the patient wants to pay. Questions such as, "When has the patient last been contacted?" or "What is the status of this legal account?" should be asked.

Summary

Each practice should establish a credit policy and a policy by which accounts are placed with a collection agency. Ask basic questions: Can the practice sustain having the physician-patient relationship altered? Is the bill worth the effort? Can the account be collected? Policies should allow for exceptions, using a fair, business-oriented approach.

Essentially, accounts receivable can be divided into three large categories: (1) accounts that should never be placed; (2) accounts that should always be placed; and (3) accounts where individual decisions are dependent on special circumstances.

Accounts that should never be placed include those involving litigation, worker's compensation, quality of care, and sensitive issues. Accounts that should always be placed include those in which the billing costs exceed the balance, accounts past the established aging limits, and those involving "skips," patient fraud, and abuse. Accounts handled on an individual basis are those for which placement is predicated on unusual circumstances. Finally, dollar thresholds under which lower-level employees can exercise discretion should be set.

Acknowledgments

The author wishes to thank Doris E. Husbyn for advice, support, and encouragement; and Alice J. Schmidt for editorial assistance.

CONSORTIUM ON RARE DISEASES

The Consortium on Rare Diseases (CORD) was formed in 1991 by a number of public and private groups concerned with furthering the interests of people with rare diseases. The CORD is made up of representatives from academia, lay voluntary organizations, pharmaceutical companies, trade associations, professional medical organizations and Government. The CORD is hosted by the Orphan Products Board, which is an interagency Federal board chaired by the Assistant Secretary for Health.

The CORD's first project was the creation and dissemination of a *Rare Disease Information Directory*. This project was chosen because the CORD feels that while there is a lot of information available about various rare disease topics, interested consumers don't always know where to find it. The directory is extremely short (one page front and back) so that it can be readily revised and can be disseminated easily and inexpensively. Only the most general sources of information are included; however, with a few phone calls an inquirer should be able to locate the desired information. The CORD believes that this document will be valuable for rare disease sufferers, families, physicians and other providers, researchers and policy makers.

The Consortium on Rare Diseases meets three times a year in Washington, D.C. If you have comments or questions about the *Rare Disease Information Directory* or the CORD, call the Office of Orphan Products Development, Food and Drug Administration at (301) 443-4903.