

Valuation of Physician Accounts Receivable
Avoiding the Five Most Common Pitfalls

Jeffrey Bettinger, MD, FACEP
Bettinger, Stimler, Schultz & Associates



Valuation of Physician Accounts Receivable

Avoiding the Five Most Common Pitfalls

Valuation of physician accounts receivable is necessary as a prerequisite for various financial transactions and agreements. Examples include sale or purchase of physician practices, institution of buy/sell agreements, and borrowing of funds or establishment of lines of credit where the accounts receivable serve as collateral. Unfortunately, unlike other types of accounts receivable (AR), the variables that affect the amount of eventual collections from physician accounts receivable pools are protean. Possessing a thorough understanding of these variables, and then asking the right questions, will allow a valuator to more accurately predict the true value of the AR pool. Conversely, lack of appreciation of these variables may lead to significant valuation errors.

Following is a discussion of five mistakes that are commonly made when valuing physician AR. The first three mistakes deal with lack of understanding of the reports generated by the billing system on which the AR resides. The remaining two address misinterpretation of the governmental and payer rules that apply to physician billing. Understanding these common pitfalls will allow an AR reviewer to ask the right questions and greatly increase the valuation accuracy.

Five Pitfalls all Valuators Should Avoid

1. Over/under valuation of current AR by not applying historic collection rates.

As the “current” period (0-30 days after claim generation) typically accounts for the largest component of AR on an Aging Report, accurately predicting eventual collections from this AR subset is crucial. Often, the starting point for this subset calculation is a contrived collection rate based on an artificial timeframe where charges are divided by collections to yield a “collection rate.” This methodology is fraught with inaccuracy caused by periodic aberrancies in charges and collections. For example, if the timeframe selected has elevated charges due to a one-time influx of patients (bad flu season), the collection rate may be artificially reduced, especially if payments for the patient influx have not yet been collected from the payers.

To avoid the error of assigning inaccurate payment rates, the valuator should use reports that track payments back to original charges in order to provide an accurate historical baseline for collection percentages. Most modern billing software systems can produce this report for charges as old as 24 months. This methodology

allows an accurate depiction of the eventual collections for an historic month of charges, thus allowing the valuator to have an excellent baseline in valuing the “current” AR.

2. Using Aging Reports that allow for re-aging of AR to “current” after there is a change in the financial class of an account.

As mentioned above, the current aging category is usually the largest category of AR on an Aging Report; however, the current category can be artificially inflated by billing systems that re-age accounts to current after the primary insurer only partially pays (or fails to pay). An example is an account with a balance that is determined to be patient responsible after the payer has denied payment due to lack of eligibility. Systems that re-age the account to current may have a certain logic as far as dunning the patient, as the argument can be made that the account should be treated as current in the new financial class (self-pay).

The problem that arises with re-aging the account to current is that these re-aged balances often have different eventual collection rates, usually lower, than they would have if collected

from the payer. Inflating the current AR with re-aged AR may lead to overvaluation of the current AR and, therefore, the total AR. Whenever possible, the valuator should request Aging Reports that do not re-age accounts to current after partial payment or denial by the payer.

3. Relying on AR Aging Reports that do not change the financial class of an account when partial payment occurs.

Some aging reports allow the account to remain in the original financial class despite partial payment or denial of payment, thus artificially inflating the true amount of AR that remains in the original financial class. Typical examples include patient-responsible co-pays and deductibles that remain in the primary insurance class after partial payment has been made by the insurer.

The problem that arises when the account financial class remains unchanged after partial payment is that these accounts often have different eventual collection rates, usually lower, than non-adjudicated accounts in the same financial class. Solutions to this problem include transfer of the partially paid account balance to a new financial class that includes a separate financial class for patient responsible account balances due to denials, co-pays and deductibles. These changes will allow the valuator to accurately apply expected payment rates to the remaining AR.

4. Failing to incorporate delays in obtaining a Provider Identification Number (PIN) into the valuation process.

In order to receive payment from many payers - including Medicare, Medicaid, and Blue Cross Blue Shield - physicians are required to have previously issued Provider Identification Numbers (PINs). Because of the often prolonged timeframe involved in obtaining these PINs, physician often render medical services before their PINs have been issued. After they obtain their PINs, physicians may retroactively submit claims for professional services rendered during these interim periods. Usually, the involved payers allow retroactive submission of claims; however, many Medicaid plans only allow payment for services rendered

after the PIN application packet is received at its credentialing office.

Representation of non-submitted claims (due to lack of PINs) varies widely on AR Aging Reports. It is critical that a valuator clearly understands how the Aging Reports treat non-submitted claims. The three most common methods of representing non-submitted claims on AR Aging Reports are as follows:

- Allowing the non-submitted claim to age as if the claim was actually submitted
- Maintaining the non-submitted claim in the “current” aging category
- Leaving non-submitted claims off the aging report entirely.

Each of these three methods has its own unique formula that will allow a valuator to correctly value non-submitted claims. Failure to account for the non-submitted AR will cause errors in valuation. For example, deeply discounting 6-month old Medicare AR may be incorrect as Medicare accounts are often fully reimbursable as long as the claim is submitted within one year of the date of service. Alternatively, claims that remain in the current category may actually exceed timely filing limits depending on the individual payer, and will need to be fully discounted in order for an accurate valuation to occur.

5. Failure to consider the various state laws that adversely affect the ability to balance bill patients.

The regulations that govern submission and payment of physician claims are promulgated by each State. Most states have regulations that govern areas such as assignment of benefits, timeliness of claims submission, and timeliness of payments by the insurer. Some states - notably Florida and Maryland - have statutes that often prohibit balance billing to managed care beneficiaries, even when the physician is a non-contracted provider. In these states, older AR may be inflated by uncollectible accounts due to prohibition of balance billing. In order to achieve an accurate valuation, these uncollectible balances may need to be fully discounted.

***Visit www.bsanda.com
for more industry insights
on healthcare finance.***



Valuation of physician accounts receivables is a complex exercise and involves many variables that often times are overlooked. As the volume of financial transactions involving physician practices continues to grow, it will be critical for valuers to make sure that their efforts are as accurate as possible. Awareness of the common pitfalls that are unique to physician AR valuation, and the enlistment of outside assistance when appropriate will effectively reduce the likelihood of costly errors and ensure more accurate valuations. §

Jeffrey Bettinger, MD, FACEP

Dr. Jeffrey Bettinger is a founder, and managing member, of ***Bettinger, Stimler, Schultz & Associates, L.L.C. (BS&A)***. He has been involved in all aspects of billing and reimbursement for large medical groups for more than twenty years.

A graduate of Hahnemann Medical College in Philadelphia, Dr. Bettinger completed his residency in internal medicine and served as a staff physician and later, as emergency department medical director for the Emergency Medical Group of Miami (EMG). He is board certified in both internal medicine and emergency medicine. In the mid-1980s, Dr. Bettinger built a billing and accounts receivable management system for EMG, which later merged with EMSA, the forerunner of InPhyNet Medical Management, Inc. In 1997, InPhyNet merged with MedPartners, and Dr. Bettinger assumed the role of executive vice president of billing and reimbursement for Team Health, the hospital-based physician subsidiary of MedPartners. He remained in this role until February 2000. As vice president of billing and reimbursement for Team Health, Dr. Bettinger directed a billing and accounts receivable operation that billed for over four million encounters annually. Dr. Bettinger is a member of the Florida College of Emergency Physician's Medical Economic Committee, and a member of the American College of Emergency Physician's Reimbursement Committee.

Bettinger, Stimler, Schultz & Associates, L.L.C. is a physician-owned firm that specializes in helping healthcare providers and organizations improve quality and enhance revenue and practice management capabilities. For additional information about ***BS&A***'s physician AR Valuation Services, or any of the services provided by ***BS&A***, please visit www.bsanda.com, or call 1-888-568-4993.

