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MEET THE PRESENTER

Rhonda Granja
On the topic:
Patient and Payer Collections
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THE PHYSICIAN’S ROLE IN BILLING and COLLECTIONS

- There are several factors that are now shifting more of the costs of healthcare to the patients.
- Patients from certain plans can end up costing the practice 40 cent on the dollar if coinsurance/deductibles and co pays are not collected.
  - This makes accounts receivable management very important.
It’s common to dislike asking patients for payment at the time of service, but that is the best and easiest time to collect, if the staff is trained to determine what is owed by the patient and how to go about asking for payment.

- Your staff can be trained on how to handle this delicate task with self-assurance.

The most successful practices are ones who have physicians that are also involved and effective managers.
Direct Contact with Patients Regarding Collections

Generally, physicians should not get directly involved in collections contacts with their patients, but they should monitor the system to make sure it’s operating properly.

How to monitor the system’s effectiveness:

1) How much money is collected relative to how much is billed (considering amounts actually collectable after contractual write-offs), and
2) How well your staff is able to maintain desirable relations with the patients when dealing with this aspect of medical practice.

Physicians need to be involved in setting and oversight of the following:

1) Drafting of a collection policy and determining how it will be presented to patients.
2) Determining how aggressive in-house collection efforts should be.
3) A general policy on payment arrangements.
4) Use of a collection agency, which one, and how aggressive they should be.
5) When legal action will be pursued.
6) What patient account balances will be considered too small to pursue collection efforts and at what point in the collection process should they be written off.
When does the Revenue Cycle Begin?

It begins when…

… the patient calls for an appointment!

When does the Revenue Cycle Begin?

Patients need to know…

1) If payment is expected at time-of-service.
2) They are responsible for your bill notwithstanding slow-paying insurance companies, even though you may help them with insurance filing.
3) They may be responsible for the entire bill if they are part of a plan with which your practice does not participate.

*** These should be listed and clearly defined in your new patient brochure, as well as posted on your website with your other billing policies. ***
Rhonda’s Healthcare Clinic participates with the following insurance carriers:

- BCBS
- Cigna
- Aetna
- Medicare
- Medicaid
- Kaiser
- PHCS

We modify this list periodically, so we suggest that you call our office to verify that we participate with your plan. Insurance coverage will be verified prior to your visit. It is the patient’s responsibility to bring copay, coinsurance, deductibles, and payment for non-covered services at the time of your visit. Please be sure to bring your current insurance card and ID with you to each visit. For your convenience we accept cash, check, and major credit cards. If we do not participate with your insurance plan, you are responsible for payment at that visit. We will be happy to discuss payment arrangements with you.

Thank you for your cooperation.

The Importance of Verifying Insurance Coverage & Benefits

- Collect the patient’s portion at the time of service to avoid bad debt (PATOS).
- This requires knowledge of the plans allowable, coinsurance, and any unmet deductibles.
- Let the patient know they will receive a bill.
### The Importance of Verifying Insurance Coverage & Benefits

- Do not rely on the HR department at the employer to inform the patient of their plan benefit.
- New patients should be **required** to complete a new patient form well in advance of their first visit.
- Be sure to determine who the responsible party is. (Ex: Pediatrics)

### The Importance of Verifying Insurance Coverage & Benefits

- Note that even if the patient’s health plan does not change, copayment and deductible requirements may change.
- Insurance cards are not always reliable!!!
- Clearing house vendors and practice management systems usually offer insurance eligibility verification service.
The Importance of Verifying Insurance Coverage & Benefits

• There may be an additional software fee for this service. Physicians and managers do not like the idea of paying an additional fee, but truthfully the fee is small and the reward can be great with insurance eligibility.
  – *Just go ahead and do it!*

The Importance of Verifying Insurance Coverage & Benefits

• Some systems allow for “batch” eligibility inquiry based off the appointment scheduler. This is a great feature.

• Suggestively, you can set this feature at least two days ahead of the visit, and this will give you time to contact the patient if the insurance cannot be verified.
The Importance of Verifying Insurance Coverage & Benefits

• Failing to verify accurately & completely can lead to improper collections from the patient at the time of service.
• When this happens, the practice can incur additional collection costs.
• Try to avoid a patient balance write-off.

Medical Necessity Denials

• Train your front desk to be “coverage aware.”
• Educate staff and insist that they employ Advanced Beneficiary Notices (ABNs).
• Medicare and ABNs can be found at http://www.medicare.gov/claims-and-appeals/medicare-rights/abn/advance-notice-of-noncoverage.html
Medical Necessity Denials

• Medicare can change the form at anytime. So, be sure that you are using the correct version or you may forfeit your rights to collect from the patient.

• If an insurance plan frequently denies services for medical necessity and yet will not let you collect from the patient, then the plan may not be a good financial fit for your practice.

Dealing with Patients from Day 1

• Stick to the PATOS rule.

• If you choose not to collect payment at that time, try to encourage some type of commitment regarding payment.

  –Example: “Mrs. Smith your bill today for medical care is $95. $55 is for an extended office visit, and $40 is for your x-ray. Would you like to pay by cash, check, or credit card?”
Dealing with Patients from Day 1

• Inexperienced staff may have trouble learning how to determine what the patient may owe.
• Calling patients and demanding payment is very difficult.
• File insurance claims as soon as possible, especially if the patient will owe a balance.

Dealing with Patients from Day 1

• Suggestions for statements:
  – Send first statement 1-30 days after service.
  – When the patient owes or is likely to owe a balance, send them a statement at the regular billing cycle.
  – Sometimes patients have to decide who they will pay in the month.
  – Even if insurance has not paid, you may add a clause that says insurance is pending.
  – Statistics from the AMA show that patients will pay about 50-65% based on their first statement that includes a patient due amount and itemized bill being presented at the time of service.
Dealing with Patients from Day 1

• Suggestions for statements continued:
  – Some consulting physicians enclose a letter explaining their role in the patient’s care.
  – If you are a consultant be sure to note to the patient that they will receive a separate bill from other people/facilities involved in their care.
  – Be sure to include a phone number for the patient to call if they have any questions.
  – Sending statements early prompts the patient to pay faster.
  – 45-60 days after service send a second statement if insurance has not paid.

• Suggestions for statements continued:
  – 15-20 days after the 2nd statement, if the payment has not been received by this time it is preferable to contact the patient by telephone.
  – If there is a hardship, ask them to call at the beginning of the next month and give them a specific date for them to call you.
  – If they don’t follow through, then you may want to send another statement and be “firm.”
Dealing with Patients from Day 1

• Add a line to your patient information questionnaire asking for 2 credit references, such as major credit cards or banks… unless they will be paying in full.
• This technique can tip you off to patients that could be a potential collection problem.
• If someone without credit cards and without a checking account gets behind 90 days, odds are they will not pay.

Dealing with Patients from Day 1

• It is essential to accept credit cards today. This offers a convenient way to pay.
• Patients without a credit card is probably a greater credit risk.
• Be sure to train staff and protect credit card information.
• Patients who understand the costs of services will likely pay more promptly.
## Dealing with Patients from Day 1

- Use color scheme paper for correspondence.
- Have your collections staff work on scripts for various patients responses when it comes to asking for money.
- Never ask: “Is everything the same?” OR “Has anything changed?”

## Restrictive Endorsements on Checks

- Sometimes patients will place some type of notice on the back of their check payment.
- Be very careful if the patient writes something similar to the following on the back of the check: “Cashing or depositing this check constitutes payment in full on my account.”
- Some state laws may allow for the cancelation of a patient’s debt if you cash a check that has a restrictive endorsement.
Co-pays.Org

• There is a program called the Co-Pay Relief Program that offers a dedicated secured website for medical providers to enroll electronically for the CPR program on behalf of their patients.

• It may free up some money that the patient can use to pay the practice.

Teamwork

• Plan effective staff meetings that communicate goals so that everyone can be on the same page.

• Cross-training is a paramount to effective “collection efforts.”

• If your practice is running smoothly then your staff has more time to spend meeting patient needs, improving collections, and finding ways to reduce costs.
Teamwork

• Assign reasonable collection goals and use your meetings to monitor goals.
• One way to set a reasonable and effective patient collection goals is to calculate the number of visits/encounters conducted by each physician during a week, month, and year. Then determine the average amount of patient pay responsibility and multiply those together.

Teamwork

• It is not reasonable to believe that your practice can collect every dollar of patient responsibility.
• No staff is perfect.
• Be reasonable.
• Offer payment plans if necessary, but make sure that your patients stick to it.
Tips for Selecting a Collection Agency

- Do not send accounts to a collection agency too early or too late.
- Use a collection agency for those accounts that need a more serious tone of a collector.
- You are NOT a collection agency.
- They must follow the laws of the state that are applicable to their agency.
- Accounts that are sent to a collection agency too late (older than 6 months) have a very low rate of being collected.

Tips for Selecting a Collection Agency

- Do not be “penny wise” and “dollar foolish.”
- The reality is that for patients that are not inclined to pay you, a collection agency is better trained and hopefully more experienced at dealing with this type of patient.
- Do not use an agency as an easy way out of your collection efforts.
- Make sure that the agency is sharing with you any interest that they may charge to patients.
Tips for Selecting a Collection Agency

- Ask for a list of other physicians that are using the agency and contact them to see how well they are performing.
- Ask to see the agency’s collection letters. This may be a step that you can do on your own.
- Check with the Better Business Bureau or the Chamber of Commerce to see if they have any complaints filed against them.
- Verify that they are a member of the National Collection Association.

Tips for Selecting a Collection Agency

- Are they bonded?
- Verify that their fees are based upon actual collections and not the amount of the bill assigned.
- Make sure they can provide you regular and detailed reports of accounts and collections efforts to date.
- Make sure you retain the right to withdraw an account at any time and approve any legal action that the agency may wish to take against the patient.
Tips for Selecting a Collection Agency

- Most agency fees are negotiable.
- Monitor their performance suggestively every three months.
- Some agencies get lazy, and only want to go after accounts with a high probability of collection. (These may be the accounts that you could have collected from to begin with.)

Elements of an Effective Patient Collection Work-flow System

- Not everyone can collect money so make sure you hire the right person who is willing to do so with enthusiasm.
- Make sure that the staff understands how sensitive the collection process is.
- If a patient is the victim of an accident, your staff must be aggressive in determining who can be reliable for payment... such as, workers comp.
Elements of an Effective Patient Collection Work-flow System

• Some attorneys are good at ducking bills.
• Make sure you have a process that prevents lost charges (missing revenue from the fee ticket).
• Do not wait to file claims until a patient is discharged from a long hospital stay.
• Establish a minimum amount… such as $15-$25 for which you will not pursue aggressive efforts.
• Do not be soft on slow paying patients because you’re afraid of losing them to another practice.

Elements of an Effective Patient Collection Work-flow System

• Become familiar with The Fair Debt Collection Practices Act.
• Watch out for HIPAA.
• Double-check that account balances are correct.
• Do not harass the patient.
• Stop collection efforts **immediately** if the patient has filed for bankruptcy or if there is an attorney involved.
Elements of an Effective Patient Collection Work-flow System

- Make your billing policies clear to everyone. This include patients and staff.
- Get accurate billing information.
- Make certain patients know what services were performed.
- Make it convenient for patients to pay at the time of service.
- Establish a *reasonable* payment plan.
- Constantly monitor your effectiveness of your collection system.
- Keep track of unpaid claims.

Eight Steps for Appeals

- Examine EOB
- Invoice the patient and/or the patient’s family
- Notify the patient’s employer
- Understand your state laws and the allowances for carriers to respond to claims
- Document all correspondence
- Develop a policy in regard to “administrative fee for additional information”
- Utilize external appeals process
- Lastly, file a complaint with the State Insurance Commissioner
Prompt Pay Law

• Become familiar with your state and use the prompt pay law as a defense.

  • [http://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/promptPayment_home.htm](http://www.fiscal.treasury.gov/fsservices/gov/pmt/promptPayment/promptPayment_home.htm)

• Reference in your appeal letter.

Appeal Letters

• Appeal letters should be tailored to the specific patient’s need(s) as documented in the medical record, and provide a clinical justification in support of the recommended treatment, item or service.

• Ask for credentials of the person that decided not to pay the doctor? Where did they go to medical school?
Skips

• What happens when a patient skips out on you?

• The best way to handle a skip is to prevent it.
• Check your files.
• Recheck the entire file again.
• Check moving companies or storage companies.
• www.skipease.com

QUESTIONS?

• Thank you for your attendance!

• Get your questions answered on PMI's Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp

• Contact information: Rgranja@pmimd.com