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Practice Management Institute

On the topic:
Collecting Every Dollar Due
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Collecting Every Dollar Due

Brought to you by Maxine Inman Collins, MBA, CPA, CMC, CMIS, CMOM

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U.S. HEALTHCARE
COSTS AND QUALITY – HOW ARE WE DOING?

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U.S. Spending on Healthcare

- The United States spends far more on health care than other developed nations.
- According to the latest OECD health statistics, the United States spends 16.4% of GDP on healthcare –
  - Nearly 2 x the amount the OECD average of 8.9 percent
- The U.S. fares even worse in per capita health spending:
  - Spending $8,713 per capita; or more than 2.5 times the OECD average.

Source: (https://www.ced.org/blog/entry/top-healthcare-stories-for-2016-pay-for-performance; "Top Healthcare Stories for 2016: Pay-for-Performance")
Reports from the Commonwealth Fund

- “Since 2004, the Commonwealth Fund has released five reports on how the US healthcare system compares internationally. The report evaluates five dimensions of performance: quality, access, efficiency, equity and health outcomes.

- Each year, the US has ranked last relative to 10 other developed nations (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, and the United Kingdom).”


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CLOSER TO HOME

MEDICAL PRACTICES NOW HAVE INCREASED BURDENS TO COLLECT

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The Facts

• Self-pay (uninsured) individuals in the U.S. has decreased “from 16% in 2009 to 9% in 2016”.
  – However, more newly insured patients have “high-deductible plans”
    • Per the Centers for Disease Control and Prevention:
      – In 2010, 25% of plans were high deductible plans
      – Today, this has increased to 36% of plans being high deductible plans
    • Who bears the burden for these changes?
      – Statistics show that patients are “unlikely to pay medical bills that are more than 5 percent of their household income”.
        • What is today’s average household income? Nearly $53,000.
        • 5% of $53,000 = $2,600. Therefore, it is unlikely that patients will pay more than $2,600.
      – The Kaiser Foundation reports the “average deductible was around $2,099” for 2015
        • This represented a “70% increase” from 2010!
        • This is only the average. Some patients pay a $5,000 - $10,000 deductible.


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Statistics

• “Physician practices collect only 60% of patient co-payments; these co-pays account for about one-fifth of a doctor’s office’s revenue, according to an older report by Medical Group Management Association.”

  – Putting the pencil to these facts. Let’s assume:
    • Average patient co-pay = $30
    • Average patients seen per day = 15
    • Average % of those with a co-pay = 75%
    • Average days worked per month = 22
    • Average patients seen per month (15 x 22) = 330 average patients
    • Average co-pay per patient per month (330 x 75% = 248 x $30) = $7,425.
    • Average amount of uncollected co-pays ($7,425 x 40%) = $2,970.00 per month uncollected per month
    • Average lost collection of co-pays per year ($2,970 x 12) = $ 35,640.00 !!!
  – These are fairly low practice averages being used for uncollected co-pays.
  – Imagine adding the average of uncollected deductibles and co-insurance!


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What Can You Do?

- **Collection efforts** - begin at the front desk
- **Create a Practice Policy & Procedures** and make sure staff and providers are on board with it
- **Collect payment at time of service!**
- **Utilize technology** – starting with effective, efficient use of practice management software tools
- Consider easy pay solutions
- **Train! Train! Train! How to collect & knowledge of Collection laws.**
- **Provide** answers (scripts) on how to respond to patient complaints and excuses
- Think outside the box!

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What Can You Do?

- **Patient portals provide interaction with office**
- Let patients know – utilize website, appointment reminder calls, keep them informed at every opportunity of what the practice expects –
  - “No copay, No visit” policy
  - Track collection rates by office and/or staff member
  - Improve the “Ask”
- **Online payment options**
- Automated reminders; capture email addresses of patients
- Kiosks

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A Little More on Kiosks

• From eWeek, Baseline Magazine, Redmond Channel, Alison Diana, editor, contributor at Internet Evolution, and editor-in-chief of 21st Century IT reports:

“When Sharp Healthcare installed 27 kiosks across 11 clinics, the San Diego-based provider primarily aimed to improve patient engagement and satisfaction while meeting federal mandates, said Michelle Calleran, manager of information systems, in an interview. Patients can use the kiosks to update their contract information, check in for appointments, and settle their bills.”

• The clinic now experiences up to $15,000 per month now in payments on patient balances through the kiosk.

(Source: http://www.medigain.com/blog/strategies-to-help-your-staff-increase-patient-collections)

Kiosks, continued

• “While the kiosks, developed by Vecna, are meeting Sharp Healthcare's primary goals by expanding enrollment in the provider's patient portal and improving patient relations, Sharp Healthcare also noticed a growing trend in patients paying overdue invoices. "This was a real surprise," Calleran noted.

(Source: http://www.medigain.com/blog/strategies-to-help-your-staff-increase-patient-collections)
Example: Image of Vecna

Source: (http://www.medigain.com/blog/strategies-to-help-your-staff-increase-patient-collections)

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INSURANCE & COLLECTIONS

FUNDAMENTALS FOR SUCCESS

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When the Patient Arrives

1. Providing a proper environment for the patient
2. Obtaining the proper information from the patient
3. Educating the patient
4. Getting liability statements and applicable waivers signed
5. Discussing financial arrangements and/or payment
6. Physician involvement

1. Providing a Proper Environment for the Patient

- The environment has much to do with the patient's trust and cooperation in gathering information.
- Human relationships are important. Part of the relationship is making the patient feel "comfortable" with the communication.
- A private room is the proper environment to discuss financial information.
2. Obtaining Patient Information

• The key to collections is to get all of the additional necessary information up front.
• Gathering information falls into the following categories:
  – New patient forms
  – Established patient data
  – General data for all patients

3. Educating the Patient

• When a patient comes into your office, they may have misconceptions at the start of the visit.
  – They may think insurances covers everything
• Education should be done in several ways:
  – Phone
  – Welcome letter
  – Patient brochure
  – Website
  – Signage
  – Patient Information Sheet
  – Review of information
  – Superbill/Routing Slip
  – Waivers
4. Liability Statements

• When the patient pays the fees, it is necessary for the patient to sign liability forms.
• Medicare has strong regulations regarding patient's awareness of their liability.
• It is important to educate the patient on what money they will have to pay to you.

5. Discounts and Courtesies

• It was once very common to give professional discounts/courtesies.
• But now, a discount or courtesy billed to an insurance carrier can actually hurt the provider’s profile and/or be considered fraud and abuse under CMS guidelines.
• If you do discount on courtesies - write off internally, and don't send adjusted fees to carriers.
6. Provider Involvement

• The provider is not the primary person who should discuss fees with the patient.
• Providers need to appoint the RIGHT PERSON to collect, talk about fees and be the key person dealing with patient collections.
• There is one exception regarding provider involvement, which is when a patient has a past due balance and the staff has tried to collect without success.

Accountability and Control of Collections

• Theft can happen. Therefore, when we collect, we need to set up "systems" to protect our assets.
• You should have:
  – Cash/Check Accountability
  – Payment at the Time of Service
Asking for the Money

• Be sure you and the patient are in the proper one-on-one environment (not in front of other patients).
• Have the RIGHT PERSON ask for money.
• Give the charges due and say something like, "Your bill today, Mrs. __________, is $150.00. Will that be cash, check or credit card?"
• Then KEEP SILENT.
• Respond to their reply according to your policies.
• Be sure your attitude reflects that it is RIGHT and NORMAL to expect payment for services.

Prepare for Excuses

• Common Excuses
  – "I don’t have my checkbook with me"
  – "I don’t have a copay"
  – "I forgot to bring my insurance card"
• Do not confuse a patient’s inability to pay with a patient’s inconvenience of paying.
• Patients will resist at first, but soon it will become a habit to Pay At Time Of Service.
Discussion Points

• When a new patient calls for an appointment, the person making the appointment will inform the patient that the visit is to be paid for at the time of the appointment.
• The receptionist will total all charges and ask for the amount due.
• Every time a patient calls, bring up the account and quickly review for past due amounts, failed appointments, or other significant information.

Tips for Collection

• Have a consistent policy for ALL patients.
• Pick the RIGHT PERSON to do the job of collections.
• Don't harass, threaten, badger or intimidate a patient into paying.
• Keep surprises to a minimum - especially fees.
• Don't spend a lot of time on smaller amounts. Hit the large ones first.
Tips for Collection

- The elective surgeries should be paid in full prior to the operation.
- Lead the patient into paying - don't ask "if they want to."
- Let physicians practice medicine - let staff handle the business.
- Send statement monthly without fail.
- Don't threaten anything that you will not follow through on.
- Know your state "harassment" laws.

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Tips for Maintaining Enthusiasm during the Collections Process

- A = ACTION
- B = BELIEF
- C = CONVICTION
- D = DEDICATION
- E = ENJOYMENT

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Collection Agency

- Send patient to collections when all other steps in house have been exhausted.
- Many large facilities send patients to collections too soon. It would be more cost effective to keep in-house.
- Find Collection Agency that specializes in Health Care collections, and understands HIPAA compliance rules.

Identifying Insurance Coverage

- Front office procedures are needed to distinguish between fee-for-service (FFS) and Managed Care patients as soon as they make an appointment or enter the office.
- Both front office personnel and the medical personnel in the physician’s office must understand how each plan works and what services are generally covered or not covered.
Insurance Information Gathering and Claims Filing

• HMO - Primary care physician provides referral/authorization. Practice files claim forms.
• PPO - IN NETWORK - Patient chooses physician from contracted provider list.
• PPO - OUT OF NETWORK - Patient chooses any physician.

Verification of Insurance Benefits

• Corrected and current insurance
• Insurance claims address and phone number
• Electronic payor ID
• Patient name and date of birth in carrier’s system
• Subscriber
• Relationship of the patient to the subscriber
• Benefits
• Exclusions
**Verification of Insurance Benefits**

- Co-pays
- Deductibles
- Co-insurance
- Out-of-pocket maximums
- Coordination of benefits
- Verify if insurance is primary, secondary, or tertiary.
- Contact person and phone number
- Pre-certification and referral requirements

**Verification of Insurance Benefits**

- Preparation of Insurance Processing:
  - The key to insurance processing is to get all of the necessary information up front to avoid reimbursement delay.
  - New patient forms need to be filled out completely, accurately, and before the patient’s appointment in order to verify information and benefits.
Verification of Insurance Benefits

- Corrected and current insurance
- Insurance claims address and phone number
- Electronic payer ID
- Patient name and date of birth in carrier’s system
- Subscriber
- Relationship of the patient to the subscriber
- Benefits
- Exclusions

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Verification of Insurance Benefits

- Check eligibility on every patient before every visit to ascertain:
  - Co-pays
  - Deductibles
  - Co-insurance
  - Out-of-pocket maximums
  - Coordination of benefits
  - Verify if insurance is primary, secondary or tertiary.
  - Contact person and phone number
  - Pre-certification and referral requirements

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Coordination of Benefits

• If a patient is covered by more than one insurance plan, you must determine which is the primary and secondary.
• You will submit payment to the primary and once they have rendered payment you will submit to the secondary carrier.
• If you send to the wrong carrier, it will only delay your reimbursement.

After the Patient Leaves

• First, bill the patient, the third-party payer, or both.
• Keep track of all payments and all charges.
• Step 1  Statement #1  Superbill - patient takes home
• Step 2  Statement #2  Mail within 30 days
• Step 3  Statement #3  Mail within 60 days
Concepts for Statements*

- Send them a “Check”!
- Remove the aging buckets (e.g., 0-30 days, 31-60 days, 61-90 days) from the bottom of your patient statements.
  - Aging buckets are an invitation to patients to wait another 30 days to pay you.
- Patient statements should go out at least weekly
  - Your initial statement should simply state, “DUE NOW.”
  - Your second statement should state, “PAST DUE.”
  - The next step should be either a phone call or a final-notice letter giving the patient 15 days to pay before his balance is sent to collections
- Send to Collections


Out-of-pocket Costs*

- “Out-of-pocket” Costs continue to increase, while patients’ budget continues to decrease;
- Other financial burdens are also increasing
- According to the 2016 TransUnion Healthcare Report:
  - “For every $100 in healthcare costs in the first quarter of 2016, consumers had $1,720 in revolving credit to potentially make those payments.”
  - “51 percent of patients owe more than $1,000 in bills to their healthcare providers.”
- According to a Consumer Financial Protection Bureau report issued in 2014, Consumer credit reports: A Study of Medical and Non-Medical Collections:
  - “4.3 million consumers have overdue medical bills on their credit reports.”

Patient Collection Sequence/Debt Resolution

- Work with the patient.
- Collection calls
- Collection letters
- Dismiss patient from the practice
- Collection agency (external)
- Attorney
- Small Claims Court
- File lien
- Write-off

Know Your State’s Laws

EXAMPLE: State of Michigan – Attorney General
- Michigan consumers are falling behind on paying bills for all types of reasons, including job losses, increased mortgage payments, or medical emergencies. Because dealing with debts and debt collectors can be frightening and overwhelming, this consumer alert provides background on the do's and don'ts of debt collection, and tips on how to spot and avoid debt collection scams.
- Debt Collectors – Is that Legal?
- There are varying state and federal laws that govern how debt collectors operate in the State of Michigan. Here is a general roadmap of how debt collectors should legally operate:
  - Debt Collection and Federal Law: The Federal Fair Debt Collection Practices Act (FDCPA) generally governs how debt collectors may legally operate nationally, as well as in Michigan. The law applies to individuals or businesses that regularly collect debts, including some attorneys, and companies that buy debts and try to collect on them.
  - The FDCPA covers the collection of personal, family, or household debts, but it does not relate to debts incurred through ownership or operation of a business.
  - Debt Collectors and their Contact with Consumers: A debt collector may not call you before 8 am or after 9 pm, unless you permit them to do so. And they may not call you at work if they have been notified orally or in writing that you may not receive calls at work. Debt collectors who call consumers at work are the source of many consumer and employer inquiries, so it is important to reiterate – in order to stop receiving calls from debt collectors at work, you or your employer should inform the debt collector by phone, followed up with notification by certified mail, return-receipt requested, that such calls are prohibited. Keep the return receipt for your records, and if they contact you at work after you provided this notification, report the debt collector immediately!

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On February 16, 2016, the Centers for Medicare & Medicaid Services (CMS) and America’s Health Insurance Plans (AHIP) released their first set of clinical quality measures as part of their Core Quality Measures Collaborative – an initiative that aims to reach consensus among public health plans, commercial insurers, physician groups and other stakeholders on major quality measurements.

The collaborative supports the recent shift toward value-based care, which stems from America’s predicament of high costs and subpar quality in health care.

*Source: [https://www.ced.org/blog/entry/top-healthcare-stories-for-2016-pay-for-performance](https://www.ced.org/blog/entry/top-healthcare-stories-for-2016-pay-for-performance); by COURTNEY BAIRD, March 08, 2016*
Health Care Transformation Task Force*

- Coalition of private insurers and provider organizations, recently announced:
  - Goal to move 75 percent of their contracts into alternative payment models by 2020.
  - Includes Aetna and Blue Cross and other private carriers with:
    - Aims to implement most effective payment models for hospitals, private insurance companies, and public payers;
    - To accelerate change in health care delivery.
    - Private insurers are making headway in implementing new payment models:
      - 11% of commercial payments were value-oriented in 2013.
    - The Centers for Medicare and Medicaid Services (CMS) have also pushed aggressively towards what has been called “value-based or quality-based reimbursement.”


Insurance Follow-Up

- Most states have a clean claim law that require carriers to pay providers submitting clean claims in 30 or 45 days, or be charged penalties and interest.
- If it seems like a carrier has violated the applicable law for your state, you may file a complaint with your state insurance commissioner.
EXAMPLE: TDI.TEXAS.GOV

• Prompt Pay FAQs
• Claims Filing and Deadlines | Contracts | Clearinghouses and Third Party Administrators | Form-Specific Questions | General Prompt Pay Questions | Other | Payment | Preauthorization and Verification | Privacy Issues

• Use your state’s Insurance Department’s website to acquire information to train your billing/collections staff.

FAQ FROM TDI PROMPT PAY LAW

• Question:
  – What remedy does a carrier have when it pays, and did not dispute, a claim within the required time frames, but later determines after 180 days that an overpayment has been made? Some examples of how this might occur include:
    • A fee schedule was loaded improperly in the health plan’s system; or
    • The federal government provides clarification on a Medicare payment methodology, such as Ambulatory Procedure Categories (APC), that is followed throughout the industry.

• Answer:
  – In order to recover an overpayment, a carrier must notify the provider within 180 days of the date the provider received the overpayment. The statute and rules provide no remedies or exceptions to this time frame except in the case of fraud or material misrepresentation.
Know What Is Being Reviewed in Your Area

Medical Review Part B has the following service specific edits in effect for Jurisdiction H:

<table>
<thead>
<tr>
<th>Edit Number</th>
<th>Service Type</th>
<th>Providers Specialties Impacted</th>
<th>Current Procedural Terminology (CPT)/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>379D</td>
<td>Evaluation and Management</td>
<td>11 - Internal Medicine, 29 - Pulmonary Disease, 93 - Emergency Medicine</td>
<td>99291 - Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Critical care visit note to support a reasonable and necessary critical care visit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Laboratory, radiology and procedure orders and results.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clearly identifiable documentation of critical care time spent with patient.</td>
</tr>
<tr>
<td>379D</td>
<td>Evaluation and Management</td>
<td>08 - Family Practice, 11 - Internal Medicine, 29 - Pulmonary Disease</td>
<td>99233 - subsequent hospital inpatient care, typically 35 minutes per day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Subsequent hospital progress note.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lab, radiology and procedure orders and results.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Physician orders/follow up.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Documentation of total time spent on counseling and coordination of care if billing based on time.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>E&amp;M service must contain documentation of 2 of 3 components. (detailed history, detailed exam and/or high complexity of medical decision making)</td>
</tr>
</tbody>
</table>
Appealing Medicare Decisions

• All appeal requests must be made in writing.

• For assigned claims, the physician or supplier may request a redetermination.

• For non-assigned claims, typically only the beneficiary or his/her representative can request a redetermination.

<table>
<thead>
<tr>
<th>Level</th>
<th>Days after previous step</th>
<th>Who makes the decision?</th>
<th>How long does it take to make a decision?</th>
<th>Required dollar amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Level Appeal Re-determination</td>
<td>120 days from receipt of the initial determination</td>
<td>Medicare Administrative Contractor (MAC)</td>
<td>Within 60 days of receipt of request</td>
<td>No required dollar amount</td>
</tr>
<tr>
<td>Second Level Appeal Reconsideration</td>
<td>180 days from date of receipt of the redetermination</td>
<td>Qualified Independent Contractor (QIC)</td>
<td>Within 60 days of receipt of request</td>
<td>No required dollar amount</td>
</tr>
<tr>
<td>Third Level Appeal Administrative Law Judge</td>
<td>60 days from date of receipt of the reconsideration</td>
<td>Administrative Law Judge (ALJ)</td>
<td>Varies</td>
<td>At least $150* remains in controversy</td>
</tr>
<tr>
<td>Fourth Level Appeal Appeals Council Review</td>
<td>60 days from date of receipt of the ALJ decision</td>
<td>Medicare Appeals Council</td>
<td>90 – 180 days from date of receipt of request</td>
<td>No required dollar amount</td>
</tr>
<tr>
<td>Fifth Level Appeal Judicial Review in U.S. District Court</td>
<td>60 days from date of receipt of the Appeals Council Review</td>
<td>Judicial Review in U.S. District Court</td>
<td>Varies</td>
<td>At least $1500*or more remains in controversy</td>
</tr>
</tbody>
</table>
First Level of Appeal: Redetermination

- A redetermination is an examination of a claim made by carrier personnel that are independent of those originally involved.
- The appellant has 120 days from the date of receipt of the initial claim determination to file an appeal with the local Medicare carrier.
- No monetary threshold is required to be met.

Second Level of Appeal: Reconsideration

- A Qualified Independent Contractor (QIC) will conduct the reconsideration.
- The appellant has 180 days from date receipt of redetermination to file an appeal.
- No monetary threshold is required to be met.
Requesting a Redetermination or Reconsideration in Writing

• With a written request, the appellant should attach any supporting documentation.
• A request for a redetermination can be filed on Form CMS-20027.
• A request for reconsideration can be filed on Form CMS-20033.

The request may also be in any other written format that includes:
  – Beneficiary name
  – Medicare Health Insurance Claim (HIC) number
  – Specific service and/or item(s) for which a redetermination or reconsideration is being requested
  – Specific date(s) of service
  – Name and signature of the party authorized or appointed representative of the party
Third Level of Appeal: Administrative Law Judge

- If at least $150* remains in controversy following the QIC’s decision, a request can be made within 60 days of receipt of the reconsideration for an Administrative Law Judge (ALJ) hearing.
- The ALJ will generally issue a decision within 90 days of receipt of the hearing request.

Fourth Level of Appeal: Appeals Council Review

- If a party to the ALJ hearing is dissatisfied with the ALJ’s decision, he or she may request a review by the Appeals Council.
- There are no requirements regarding the amount of money in controversy.
- The request for review must be submitted within 60 days of receipt of the ALJ’s decision, and must specify the issues and findings by the ALJ being contested.
Fifth Level of Appeal: Judicial Review in US District Court

- If $1,500* or more is still in controversy following the Council’s decision, judicial review before a US District Court judge can be considered.
- The appellant must request a US District Court hearing within 60 days of receipt of the decision.

Questions?

- Thank you for your attendance!
- Get your questions answered on PMI's Discussion Forum: http://www.pmiMD.com/pmiForums/rules.asp