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On the topic:
Patient Collections - Strategies for Success

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Patient Collections - Strategies for Success

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Overview

• High-Deductible Health Plan Statistics
• Why We Manage Patient Collections
• Registration/Pre-registration Eligibility Verification
• Sample Financial Policy
• Front Desk
• Medical Necessity
• Patient Collections
• Patient Collection Reporting (Key Indicators)
High-Deductible Health Plan Statistics

• The Affordable Care Act has lowered the uninsured rate in the U.S. from 15.7 percent in 2009 to 9.1 percent, according to a report from the CDC.

• Health systems used to collect a majority of healthcare reimbursements from government or commercial payers.

• From 2011 to 2014, the number of consumer payments to healthcare providers increased 193 percent, according to a study from InstaMed.

• In a recent survey, 62 percent of adults are concerned with being able to pay for medical treatment due to illness or injury, with 48 percent stating they are not confident that they could afford care if they became seriously ill.

• Most (91 percent) are concerned about how healthcare costs will affect them in the future, with 57 percent strongly agreeing and 34 percent agreeing.
• Benefit plans with high cost-sharing do much more than just shift costs from employers and health plans.
• Designed to help lower overall medical expenses by making patients more selective and cost-conscious, high deductibles could result in patients avoiding necessary preventative care or treatment in fear of more costly care down the line.

• Patients with high-deductible policies are struggling with significantly greater out-of-pocket costs.
• The Kaiser Family Foundation reports the average annual out-of-pocket costs per patient rose almost 230 percent between 2006 and 2015.
• The same study found employee deductibles on average increased 67 percent from 2010 to 2015.
• Rising insurance deductibles have outpaced the average increase in employees’ wages during the past five years.

• Workers’ wages increased 1.9 percent between April 2014 and April 2015. Whereas American’s out-of-pocket medical expenses jumped 9 percent from 2014-2015.

• Twenty-four percent of employees enrolled in employer-sponsored high-deductible plans in 2015, up from 4 percent of employees in 2006.

• About 52% of employees offered a minimum of one high-deductible health insurance plan to employees in 2015, according to a report by Benefitfocus.
• Given the choice of a high-deductible option, about 41% of employees chose HDHP, according to Benefitfocus.

• Over the last two years, enrollment in PPOs has fallen 10 percentage points while enrollment in HDHP/SOs has increased 8 percentage points.
• As deductibles continue to creep upwards at a faster rate than workers’ wages, and as the number of patients enrolled in high-deductible plans increases, a greater number of insured patients have reported difficulty paying medical bills.

• According to Kaiser Family Foundation, 43% of insured patients said they delayed or skipped physician-recommended tests or treatment because of highs associated costs.

• For patients whose deductibles equaled 5% or more of their annual income, 40% said they chose not to see a physician, get a medical test or visit a specialist, according to a Commonwealth Fund survey.

• When patients delay necessary or preventive medical care, they may end up in hospitals' emergency rooms for treatment.

• About 80% of emergency physicians said they are treating insured patients who have sacrificed, or delayed medical care due to unaffordable out-of-pocket costs, co-insurance or high-deductibles, according to a poll by the American College of Emergency Physicians.
• A KFF survey of employees found employee deductibles increased 67 percent from 2010 to 2015.

• In the individual ACA marketplaces, almost 90% of enrollees are in a plan with a deductible beyond the qualifying threshold for an HDHP, reports Health Affairs.
• As healthcare spending continues to climb, some expect the prevalence of high-deductible plans to increase. According to Health Affairs, healthcare spending is predicted to outpace GDP growth through 2024.

• Healthcare spending is predicted to grow at a rate of 5.8 percent per year from 2014 to 2024, and is expected to amount to 19.6 percent to the GDP by 2024.
Why We Manage Patient Collections

• 24% of employees were in an employee-sponsored high-deductible health plan in 2015, a 600 percent increase over just ten years prior.
• The average out-of-pocket cost for patients has increased by 230 percent over this same period.
• More than 90 percent of persons enrolled in an Exchange Plan through the Affordable Care Act are in high-deductible health plans.

Registration/Pre-registration
Eligibility Verification

• Gather accurate patient information before and during registration.
• Collect patient demographics and insurance information during the scheduling initial phone call with patient.
• Obtain authorization for any procedure that requires it.
• Describe the practice’s payment expectations to patients at the time they make appointments.
• Provide Financial Policy to patient.
• Communicate appointment reminders phone calls, text, electronic.
Scripts for Requesting Payment or Informing about Payment Responsibilities

Prior to Day of Service

- When a new patient with insurance makes an appointment:
  - “Payment is due at the time of service, unless you bring your current insurance card, in which case only the co-payment and deductible amount will be due.”
- When a new patient without insurance makes an appointment:
  - “Payment in full is due at the time of service”
- When a patient with a previous balance makes an appointment:
  - “Both your payment (or co-pay) for this visit and your prior balance of $75 will be due at the time of service.”
- Informing patient of expected financial responsibility ahead of time:
  - “Mr. Brown, I contacted you insurance company and according to your insurance the procedure the doctor has ordered for you is a benefit under your plan…..(pause)….I also want to let you know that according to your insurance you have a co-pay of 30% after deductible. I calculated what you would have to pay. You will be responsible for approximately $120. We do require payment on the day of the appointment. We accept MasterCard, Visa, Checks and Cash. …Do you have any questions?”

Sample Financial Policy

The providers and staff at the _______ Group feel that we can better serve your healthcare needs if you are familiar with the following policies and procedures of the group:

OFFICE HOURS: The _______ Group is open Monday through Friday from 8:00 a.m. to 5:00 p.m. Providers are available on an emergency basis at any time.

APPOINTMENTS: Appointments may be made by calling (555) 555-5454 during our office hours. Appointments may be requested with the provider of your choice. Every effort will be made to provide the earliest possible attention for the convenience of the patient. Due to the unscheduled nature of emergencies imposed upon the providers, occasional delays do occur. We hope that you will understand that these delays are unavoidable. If you are unable to keep your appointment, please cancel as far in advance as possible. Some other patient who can be booked into the open time will be grateful for your thoughtfulness. If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee.
PAYMENT FOR SERVICES: Patients are requested to pay at the time the service is rendered. In our contract with insurance carriers, we are required to collect a co-pay for your visit with the provider, therefore, we will be collecting your co-pay prior to your visit. We will accept cash, check, or credit card. Returned checks will incur a $30.00 service charge. In order to participate in protecting your medical identity, we do ask for a copy of a health insurance card, Driver’s License (ID card) upon check-in.

Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, payment in full is expected at the time of your visit.

However, if this is not possible, a copy of your account charges will be provided the day of your visit. Payment of your account is expected within 10 days of receipt of charges. In the event that timely payment cannot be made, special and specific arrangements may be made by calling our Patient Accounts Department at (555) 555-2455. We will be most understanding and willing to accommodate unusual circumstances.

You are directly responsible for any unpaid balance on your account with us. You will receive a statement each month, even if insurance payment is pending. The medical information necessary for insurance claim forms is provided as a courtesy to you.

The _______ Group cannot accept responsibility for collecting your claim or negotiating a settlement on a disputed claim since we are not a party to your insurance contract.
Any special arrangements between patient and provider for payment of your account must be presented directly to the patient Accounts Department.

After 90 days, if no payments have been received and no extended payment arrangements have been made, necessary collection proceedings will begin.

It is important that you notify us of any changes of address promptly since undeliverable statements are turned over to collection agencies immediately.

In accidents, legal cases, etc. in which an insurance company or other party is presumed liable for your expenses incurred as a result of your accident or illness, the _______ Group looks to the party receiving the services for payment and cannot be expected to wait for the conclusion of long-term court cases or the settlement of disputed insurance claims before being paid. The party receiving such services is normally expected to take care of his/her account in line with the above credit guidelines.

INSURANCE CLAIMS: If you have indemnity insurance, which will pay for services rendered at the ______ Group, it is our policy to provide to you, without charge, a statement with all the information needed by your insurance company. You should forward this statement together with your insurance claim form, filling out the patient part only, directly to your insurance company. It must be understood, however, that financial responsibility for the account rests with the patient. Insurance claims on services performed must be requested by the patient. You will be responsible for any deductible at time of service.

*Caution: If your insurance covers services rendered in the ______ Group, it is your responsibility to request an itemized statement from our insurance department covering these services. If you have filed an insurance claim and no payment or rejection notice has been received within 60 days from the date of filing, we encourage you to:

A. contact your insurance company as to the reason for delay.

B. make regular payments on your account to keep it in good standing. Any overpayment will be refunded in the event that the insurance pays directly to the ______ Group.
DIVORCED PARENTS OF PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

FORM FEES: There will be a $10.00 fee charged to complete forms. The following list includes, but is not limited to: disability, FMLA, loan, cancer policy, supplemental insurance policy & daycare forms. Payments must be made prior to the completion of the forms. The office will have 10 business days in which to complete forms before making them available for patient to pick up.

EMERGENCIES: Call our phone number, (555) 555-5454, at any time. A provider is available on call to meet emergency needs. New patients making their first visit to the group are requested to arrive 15 minutes before their scheduled appointment for the purpose of registration.

COMPLAINTS: It is our sincerest desire that you will have no occasion to register a concern, but if that occasion should arise, please call any of the providers or the clinic administrator at (555) 555-5454. Your constructive criticism is encouraged at all times to assist us in improving service to our patients.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

____________________________________               ____________________
Signature of Patient (or Guarantor, if applicable)                Date

Please print name of patient
Front Desk

- When patient checks in, front desk should always verify demographics.
- Mandate that time-of-service collection is a core function of front-office staff.
- Easier to collect from patients prior to service being rendered.
- This reduces the number of patient accounts that end up in bad debt or collections status.

On Day of Service at Registration or Check-out

- Apply discount if applicable but always, always let the patient know what the total charges were, what the discount is, and what their portion is....Start off by saying:
  - “The total charge is $___ but after I apply your discount of $___ your portion is $____.
  - “Mrs. Jones, the charges for today’s visit is $120. After I apply your discount of $80 your payment is $40. Would you like to pay with cash, write a check or with a credit card?”
- Persuade to pay any past due balances in addition to today’s fees
  - “Mr. Smith, the charge for today was $10 due to your copay responsibility according to your insurance. You also have a previous balance of $320, so the amount due to today is $330. Will you be paying by cash, check or credit card?”
• If patient cannot pay in full, obtain date they will return to pay for today’s visit in full. Check your policy on how much time can give. It is important to develop urgency…explain that the health center needs to be paid so it can continue to provide care.
  – “Ms. Jones, if you are not able to pay today when will you come back within the next week to take care of this payment? Your payment is very important to help us keep our services going….”
  – “Ms. Jones, what day of next week should I schedule a call from our billers to obtain your payment over the phone? Your payment is very important to help us keep our services going….”

Medical Necessity

• According to Medicare.gov, “medically necessary” is defined as “health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

• For a service to be considered medically necessary, it must be reasonable and necessary to diagnosis or treat a patient’s medical condition.

• When submitting claims for payment, the diagnosis codes reported with the service tells the payer “why” a service was performed. The diagnosis reported helps support the medical necessity of the procedure.
For example, a patient presents to the office with chest pain and the physician orders an electrocardiogram (ECG).

- A 12-lead ECG performed in the office and interpreted by a physician is reported with CPT® code 93000.
- The reason the physician orders the ECG is because the patient is complaining of chest pain. The diagnosis code for unspecified chest pain is R07.9.

Advance Beneficiary Notice

- The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied.

- Guidelines for mandatory and voluntary use of the ABN are published in the Medicare Claims Processing Manual, Chapter 30, Section 50.
A. Notifier: 
B. Patient Name: 
C. Identification Number: 

**Advance Beneficiary Notice of Noncoverage (ABN)**

**NOTE:** If Medicare doesn't pay for D. below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. below.

<table>
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<tr>
<th>D.</th>
<th>E. Reason Medicare May Not Pay</th>
<th>F. Estimated Cost</th>
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**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS:** Check only one box. We cannot choose a box for you.

- **OPTION 1.** I want the D. listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

- **OPTION 2.** I want the D. listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

- **OPTION 3.** I don't want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

**H. Additional Information:**

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

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<th>I. Signature:</th>
<th>J. Date:</th>
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**CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.**
Patient Collections

• Give the patient a bill upon rendering service if it is agreed the patient will pay for services after leaving the office and if their insurance company doesn't cover the full amount of the bill.

• After insurance has paid their portion and an explanation of benefits (EOB) has been received, immediately send the first mailed statement.

• If no payment is received within 30 days, a letter and second mailed statement should be sent with a handwritten note on the statement.

• If no payment is received within 15 days, the first phone call should be made and documented in the patient’s file.

Note: the most successful times for reaching patients are 8:00 a.m. to 10:00 a.m., 5:00 p.m. to 9:00 p.m. and on Saturdays.

• If no payment is received within 30 days after sending the last statement, a letter and third mailed statement needs to be sent to the patient requesting payment.

• If no payment is received within 15 days after sending the letter requesting payment, a second phone call should be made.

• Finally, if no payment is received within 30 days after sending the last letter, send a letter and final, fourth mailed statement noting that payment is due within ten days or the matter will be forwarded to a collections agency.

• Stay professional yet firm when attempting to collect on patient bills. If it makes you or your staff uncomfortable to call patients about unpaid bills, you can hire a professional collector.
Optimize Patient Payments with Technology

• The longer patients owe their physicians money, the less chance a practice has to collect the balance. Medical offices can improve cash flow by enabling patients to pay for services online.

• This is an attractive proposition for a younger generation that pays most, if not all, of their bills online. Very affordable Internet enabled payment capabilities can be established directly on the provider’s website with credit card transactions or checking account withdrawals automatically routed to the practice’s bank account for current payments and payment plans. These online tools are available to providers regardless of whether or not they maintain a website.

• Providers should also use an online system to schedule recurring payments whenever possible. This enables practices to work with patients to establish a certain payment amount that is automatically charged to their credit card on a monthly basis until they reach a zero balance.
After Day of Service

• If calling to collect on an unpaid balance, say who you are and why you are calling:
  - “This is ___________ and I’m calling about your balance of $1000 which has been outstanding over 75 days.”
  - “Mr. Rivera, your account has been given to me for special attention, I’m here to help in any way I can.”

• When working with patient on a payment plan, establish exact amounts and time frame for payments to be made, establish how payments will be made, and confirm agreement.

• Follow up with phone calls immediately if payment not received on time:
  - “So let’s review, you will pay $50 every month for 6 months, to pay your $300 amount due. I’m very pleased we were able to work out a payment plan that will get your account up to date. I will expect your first payment of $50 on January 1st, and then every first of the month through June 1st.”

• On payment plans, follow up with a phone call immediately if payment not received on time:
  - “I’m calling about the check you said you would mail by January 1st. I see there have been no payments posted to your account and I wanted to be sure it wasn’t lost or posted to the wrong account. When did you mail the check?”
Scripts for Handling Patients’ Negative Responses to Payment Requests

Scripts/Role Play:

• Patient: I’ve never had to pay at the time of service before. Can’t you bill me later?”
  Responses:
  – “Many patients like taking care of their balances up front so they don’t have to worry about it later. That’s why we’re giving you the opportunity to pay now. Would you like to pay by cash, check or credit card?”
  – “Paying now helps The Health Center avoid further billing cost. We’re trying to do all we can do to control health care costs for our patients, and to make sure The Health Center is here if you need further care. Now, how would you like to take care of your balance today?”

• Patient: “I didn’t bring my checkbook.”
  Responses:
  – “Payment is due at the time of service. We accept cash or credit cards.”
  – “Payment is due at the time of service. Would you like to call home to get your credit card number, if you didn’t bring it?”

• Patient: “My ex-husband pays for all medical bills”
  Responses:
  – “No problem, I’ll give you receipts showing you’ve paid and you can send it to your ex so he can repay you.”
  – “If you put this on your credit card today, you can send the credit card bill to your ex to pay.”

• Patient: “I can’t pay in full” or “I don’t have the money.”
  Response:
  – “You may not know, but we have already applied the discount to your charges and payment is expected at time of service.”
  – “You can pay half today, and then come in and pay the remainder before statements go out on (date).”
• Patient: “The check is in the mail”
  
  Response:
  – “Thank you for mailing your check. What day did you mail it? Where? Amount?”

• Patient: “I don’t pay the bills. Talk to my wife…”
  
  Responses:
  – “Mr. Jackson, you are our patient. That is why I’m calling you regarding the account…”
  – “Mr. Jackson, you are our patient, however, let’s schedule a time I can speak with both of you…”

• Patient: “I can’t pay it all now…”
  
  Response:
  – “The balance has already been extended for over 3 months. Let’s establish a payment plan than can bring you current within a 6 month timeframe….”

• Patient: “I have insurance. They pay for everything.”

  Responses:
  – “According to your insurance, when you come in for a medical visit you have what’s called a co-payment which is due at the time of service. Your co-payment is $25. This is what you have to pay today. The insurance will then take care of the rest of your bill for today’s visit which the estimate shows may be around $160. I would be happy to help you call your insurance to clarify.”
  
  – “Here is a document that shows that the insurance company already took care of a portion of your bill ($120). The rest of your bill, $45 is what you must pay. Would you like to call your insurance company to clarify?”
Patient Collection Reporting
(Key Indicators)

- High-performing practices were also collecting receivables more quickly than their peers, having only seven to 10 percent of their total accounts receivable (A/R) in the 120+ days category.
- In contrast, the other groups had 19 to 35 percent of their total A/R in the 120+ day category, an indication that strong cash flow is crucial to the success of any practice.
- Concentrate on highest and oldest patient balances when running collections reports.
- 50 percent of better performers reported collecting 90 to 100 percent of co-payments at the time of service.

Tools, Tips, and Techniques

- Have policies in place that reflect your practice goals
- Train staff to communicate effectively with patients
- Educate patients on their financial responsibilities
- Choose key financial indicators to benchmark for practice success
Resources

- http://www.medigain.com/