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Meet the Presenter…

Regina Mixon Bates,
IRO, CPC, CPC-I, CMC,
CMOM, CMIS, TPA

On the topic:

A/R Management and Collections
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Practice Management Institute®
8242 Vicar | San Antonio, Texas 78218-1566
tel: 1-800-259-5562 | fax: (210) 691-8972
info@pmimd.com
A/R Management and Collections

Overview

• Using Emotional Intelligence in RCM
• Developing Financial Policies
• Obtaining accurate patient information
• Verification of Benefits
• Implementing policies on payment options and collections
• Setting collections benchmarks and/or goals
• Educating patients on payment policies
• Facilitating and effectively requesting timely payment
• Payment plans and financial arrangements
• Extending professional courtesies
• The legal aspects of collections
• Handling difficult collections situations
Emotional Intelligence and the Revenue Cycle

- Emotional intelligence (EI) can enhance your revenue cycle collections strategies with all members of your staff
  - It will create a culture of self-awareness that allows each staff member to engage in his or her role in the collections process
  - EI is based off of already gained knowledge and instincts
  - Using EI helps you to maintain an even decision-making system in a sometimes chaotic culture

What is Emotional Intelligence & How does it work with RCM?

- Emotional Competence
  - The communication between your emotional and rational “brains” is the physical source of EI
    - Social Awareness
      - What I see in others
    - Relationship Management
      - What I do for others
Primary Emotions – Controlling the Initial Reaction

Our brains are wired to make us emotional creatures.

- Sadness
- Disgust
- Anger
- Surprise
- Fear
- Happiness

Taking the Business of Medicine to the Next Level

Emotions/Actions and Immediate Steps

- What’s the goal?
  - Enrich revenue and lessen conflict
- Improve overall time of service performance and patient collections
- Start with your front desk/billing and time of service
- Collection at check-in
- A perfect example of controlling emotional reaction:
  - *Never place the patient in a place of shame*
- CCOF or Care Credit could be the answer for the patient

Taking the Business of Medicine to the Next Level
Obtaining Correct Information

• The best time to resolve a payment issue is prior to the patient receiving services
• Bad information is worse than no information
• Billing and follow up must be accurate and accomplished in a timely manner

Verification of Benefits

Liability for false representations made during verification of benefits may be the responsibility of the insurer according to many state courts.

We believe that your obligation is to provide accurate information throughout the benefit verification process. Knowingly misstating facts and policy benefits may be a violation of state courts rulings as well as a breach of the Unfair Claims Settlement Practices Acts.
Verification of Benefits

• Keep a copy or screen shot of online verifications in the patient record
• Depending on your phone system record the call and notify payers of your policy regarding Verification and Preauthorization of Benefits
  – Script: ‘For your protection and ours we record all calls for prompt payment’
• Archive your calls for easy retrieval. You can use the same process for managing patient conversations.

Timely Filing: State & Federal Law

• Each state has specific rules regarding timely payment of claims (30-45 days). Claims must be paid or denied within a reasonable amount of time and comply with the states unfair claims settlement practices.
• Medicare: Current law mandates 30 days but there is a minimum of 14 days to pay clean claims that have been submitted electronically
• Medicaid
  – The ARRA has 2 prompt pay provisions which are applicable to claims received from practitioners on or after February 18, 2009:
    • 90 percent of clean claims received by the State must be paid within 30 days of receipt.
    • 99 percent of clean claims received by the State must be paid within 90 days of receipt.
Financial Policies

• The medical practice financial policy is the most critical component for managing revenue, cash flow and collections. Your policy sets the table for how your staff will interact with patients about insurance, past due balances, and co-payments.
  – Is your financial policy in writing? A financial policy that is not written down doesn’t exist.
  – Is your policy up to date? Do you offer several payment options or on-line payment portals?
  – Does your staff understand how to communicate with patients and what the protocols are for implementing policy; when to make exceptions or ‘hold the line’? This is where EI plays a big role.

Preparing Financial Policies

• Policies related to patients and those needed for Third Party Payer:
  – Verifications
  – Assignment of Benefits
  – Coordination of Benefits
  – Insurance plans informational sheets
  – Financial Policies
Financial Policies

• Introducing to new patients
• Convert Existing Patients
  – Review all existing patient files for missing or outdated information
  – Enclose updated forms to be completed and returned
  – The forms should be available online and in your patient portal include:
    • The Patient Information Form, The Insurance Benefits Verification Form, The Easy-Pay Form with Credit, Debit or Check information. Optional: Care Credit, on-line payment authorization options.

Financial Policies
Payment Options and Collections

• Your policies should have several account payments options
  – PATOS
  – Payment plans (remember truth in lending laws)
  – Loans
  – CCOF: credit/debit card on file
  – Care Credit (www.carecredit.com)
In House A/R Policies

• We would never drive a car that did not have indicators, the same idea is important for the practice.
• A good collection system has controls and indicators to manage the operation of the practice.

In House A/R Policies

• Reports
  – Daily Charges
  – Daily Cash Receipts
  – Credit Balance Reports
  – Monthly aging of A/R
    • By date of service and billed date
    • Compare carriers
In House A/R Policies

• **Cash Receipts Log**
  – Monitor daily comparisons (for trends)
  – Balance/Compare with sign in sheet
  – Compare monthly totals from previous month and previous year.

• **Look at Insurance Carrier payment trends**
  – Know how long it takes for them to process the Electronic Transmission
  – Compare your fee schedule of the top 25 codes with your top 10 payers, this may indicate a need for payment negotiations
In House A/R Policies

• Know your Manage Care Contracts
  – Coverage
  – Benefits
  – Deductibles, co-pays, PATOS
  – Annual Maximums
  – Frequency clauses
  – Timely Filing Issues

Collection Goals & Aging Reports

• The standard – no more than 18% of total A/R over 90 days.
• Check aging reports. Make a plan to audit, follow up and file written formal complaints with your worst payers.
  – Look at all aging buckets by carrier
Be Prepared to File Appeals

• Depending on the number of claims you submit each week you should expect to spend time filing appeals letters on a regular basis.
• Address your letters to the Claims Manager or Claims Supervisor.
• Make sure you send a copy to the regulatory agency, i.e., the insurance commissioner, department of labor, or Attorney General in your state.
• Maintain and be ready to send a second appeals letter restating your position with factual information and documentation.
• Maintain fax numbers and collect e-mail address for the payers’ that you routinely bill.

Be Prepared to File Appeals

• Letter for Stalls
• Medical Necessity
• Benefit Reductions
• Timely Filing
• Refund Request
• Verification of Benefits
Other Avenues: 
Get the patient involved

To: The Insurance Commissioner or Regulatory Board
From: The patient

Dear Insurance Commissioner,
On [date] a claim was submitted on my behalf by [name of provider] to [name of insurer]. As of [date], my claim has not been responded to. According to [statutory code] this claim must either be paid or denied in [number of] days.

My provider has informed me, that all necessary claim information was filed in an appropriate and timely manner. In addition, my provider has supplied me with all other documentation I might need to pursue a formal complaint against [name of insurer].

My doctor and I have operated in good faith with [name of insurer]. This letter shall serve as a written formal complaint with your office.

Thank you for your time and attention.
Sincerely,
(Name of patient)

CC. Claims Manager

Patient Education

• It is predicted that providers will face up to a 25% decline in revenue over the next five to ten years due to reductions in reimbursement in an ever changing healthcare marketplace.

• Taking a proactive approach to collecting payments ‘up front’ is necessary in order mitigate both bad debt and decreases in cash flow.
Patient Education

- Patient Education on your policies should be consistent across the board
  - Telephone
  - Patient Portal
  - Registration
  - Welcome emails, letters and/or brochure
  - Website

Patient Education: Telephone Scripting

New or established patients; minimum payments due at time of service:

- “The minimum you can expect to pay on the first visit is $____. How will you take care of that?”
  or
- “Can you please confirm your co-payment? How do you think you will take care of that when you come in, cash, check or charge?”

Patient asks “why do you need this information now?”

- “For legal reasons, we are required to collect co-payments each and every visit. We want to make sure you are prepared. This will avoid rescheduling if you forget!”
  or
- “Our system doesn’t even allow me to block time into the schedule until I enter how much and by what method you will be paying...”
Patient Education: Sample Language

**Regarding Your Insurance, Balances & Payments** (This can be used in your conversations and posted on the patient portal or website):

*We accept all major credit cards, checks and cash. We are also pleased to offer several online, secure, easy pay options to help manage copayments, deductibles, or balances that may not covered by your insurance.*

*Our Patient Finance Counselors are dedicated to making sure your insurance claims is filed accurately and promptly. Your partnership in this process is certainly appreciated, this will help us to expedite your claim payment and minimize your out of pocket expenses. Thank you.*

Patient Education: Sample Language

**Indemnity (non-contracted) Insurance Plan:**

*We may bill your insurance as a courtesy. Our office, as a convenience and a service to you, will absorb all costs incurred for billing. In the event that your insurance does not reimburse us within 45 days, we will simply transfer the balance of your account to your credit, debit, or check card. Please indicate your preference.*

**Plans in which are a participating providers:**

*HMO Plans; all co-pays must be satisfied each and every visit. There can be no exceptions due to contracting and uniform compliance rules. You are responsible for getting proper referral information in advance of your appointment.*

*PPO Plans; we have agreed to accept the discounted rate from your plan, however all co-insurance is your responsibility. We will estimate balances to the best of our ability. Since the balances are estimates only, we may require one of our ‘easy pay’ options to guarantee any balance due after service. Once your insurance has cleared, you may leave the balance on your card, or you can send a check.*
CCOF/Easy Pay Scripting

“We offer easy-pay. It’s a program by which we simply maintain your credit or debit card on file to capture any co-pays, deductibles or balances not covered by insurance. We offer this as a convenience to all our patients. Which card works best for you?”

“Our Easy Pay payment options are very similar to many of the other on-line services you are probably already using. They are secure and simple, saving you time and the hassle of receiving paper bills in the mail and writing checks!”

“As of [date] we will no longer be able to bill for co-pays, deductibles, and out pocket expenses. We have done that in the past but times have really changed, haven’t they! What I can do is set up one of our easy options for you.”

“As of [date] we will no longer be mailing paper bills. Our practice is upgrading to a secure, on line payment portal. We are doing this to improve efficiencies in billing, reduce administrative costs and increase focus on your healthcare!”

EASY PAY FORM

I authorize [“Name of Doctor”] to maintain my credit account on file and I assign my insurance benefits to the [“Name of practice”].

Account Information:
Credit Card: ________________________________
Care Credit: ________________________________
Check Acct: ________________________________
Other: ________________________________

___ Transfer my balance to my preauthorized account on file
___ Please contact me before processing my card on file; I may want to use another option.

I have read the Financial Policy. I understand and agree with this Financial Policy.
Signature of responsible party X ________________________________
Signature of co-responsible party X ________________________________
Date __/__/__
Waiver of Copayment

AMA Opinion 6.12 - Forgiveness or Waiver of Copayments

It is vitally important for healthcare providers to collect or make an attempt to collect copayments, deductibles, and coinsurance.

Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers.

Sample Co-Pay Letter

Dear Patient:
We are required to collect co-payments each and every visit. It may be considered fraud for us to collect from some patients and not from others. Please be advised that should you choose not to pay your copayments for any reason we may notify your insurance insurer, and in turn, they may drop you as a subscriber. We refer to AMA Opinion 6.12 - Forgiveness or Waiver of Insurance Copayments which states; “Routine forgiveness or waiver of copayments may constitute fraud under state and federal law.”

Our intention is to support you by providing the highest quality of care and assist you you’re your insurance plan. We would never want to jeopardize your insurance by not collecting your co-payment.

As a convenience to all of our patients, we offer many easy payment options. Please ask (“Financial Counselor Name”) our Patient Finance Counselor about those options. Of course, you may prefer to use check or cash.

Please understand that if you come unprepared to make your co-payment, we must reschedule your appointment.

Thank you for cooperation,

Taking the Business of Medicine to the Next Level
Discounts and Courtesies

• If you forgive a co-pay it should be done only if insurance is not going to be billed or if the debt has become uncollectible.
• Discounts do not apply to your self pay patients as they do not fall under any third party payer rule.
• In general if you are going to give a self pay patient a discount do not go under the Medicare fee schedule.

The Collection Effort

• The best collection occurs while the patient is in the office
• A statement sent with the patient
• A statement sent after 30 days should follow (patient balance only)
• Insurance carrier follow up should begin at day 16!
The Collection Effort

• Subsequent phones calls no later than 45 days
• Send a letter that is signed by the Physician
• Any Insurance balances should also be transferred to the patient at this time
• At 60-90 days a collection agency should used

Revenue Cycle And EI strategies

• Self-Management
  – Think of this and now think of possible scenarios with one of your patients about the large sum of money that is overdue!
  – No emotion there right?!}

• Scenarios
  1. Identify with the patient as a victim...
  2. Identify with the patient who is angry...
El Strategies Before You Call

People are motivated by pleasure and pain

Be aware of what you are asking... This is where your emotional intelligence kicks in! Remember you cannot change demeanor. I am what I am! Time to revamp and redefine roles and goals?

Pre-Call Check list

• Have all documentation in hand and/or in front of you on your PC
  – Review the file
  – Know who you are calling
  – How much is owed
  – Know the contents of previous calls made
Pre-Call Check list

• Anticipate what you will say and set your objectives
• Have payment options available
• Get a firm commitment and send a confirmation email or letter
• Remember your EI - people are motivated by:
  – Pleasure: Keep the call upbeat
  – Pain: Do not raise your voice

Handling Difficult Collection Situations

If the patient says “no”, or says something like, “no one told me” or “can you just bill me?”

“I see that when you called to make your appointment you told Sally that you would be paying by check. We could not have put you into the schedule unless you told us how you would be paying. You may have forgotten. Did you forget?”

If yes, then say;

“That’s not a problem; you can pay check or if you like with credit or debit card…which one works best for you today?”

If you’ve now determined the patient has come unprepared to pay, you say;

“I really wish we could do it that way, but as we told you over the phone, we are legally required to collect your portion. We can’t collect from some customers and not others. Not only could we get in serious trouble, but also you could lose your insurance! If you don’t make your co-payment, we may be obligated to notify your insurer and they could drop you as a subscriber. We certainly don’t want that, do we?”
Collection Policies

- Keep a record of every call made
  - Document it in the patient billing record within your EMR

Medicare Regulations
- ABN Requirements CMS-R-131
- Collection Requirements: Bad debt and waiver due to economic hardship
- MSP
- Refunds

Collection Policies

- Collection Letters
- Using an Attorney
  - (Legal Shield for Business)
- Skip Tracing
  - Find and use a skip tracing service
  - Get 3 other persons names and contact information from patient during initial patient visit.
Legal Aspects of Collections
Federal Fair Credit Act

• Must acknowledge receipt from the patient with in 30 days if:
  – Notification is in writing
  – Name and account number is identified
  – The reason for pointing out the error and the amount in question.

Federal Fair Credit Act

• If the group practice has not made a correction or notified the patient as to why the balance is correct within 30 days, then the practice must do the following no later than 90 days:
  – Make any appropriate correction
  – Notify patient in writing of the correction
Federal Fair Credit Act

- Give an explanation of the change in the account
- If requested furnish the patient a copy of any document that verifies the balance due.

Additionally:

If the patient states the bill reflects services not given, the group practice must also provide the patient documentation to validate that services were indeed rendered.
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