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On the topic:
Managing Collections in Your Medical Practice
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Managing Collections in Your Medical Practice

Presented by
Lisa Maciejewski-West
CMC, CMIS, CMOM, MCS-P

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Disclaimer

- This presentation contains examples of forms used to assist doctors in managing and streamlining their practice. These documents are not exclusive and may not be all of the documentation you need for office administration. These forms are for illustration purposes only and are not intended or designed to be a substitute for legal or clinical advice.

- Be sure to check with your State Board of Medical Examiners and any other regulatory entity prior to using these forms or implementing the financial procedures discussed in this presentation.
What did things cost?

<table>
<thead>
<tr>
<th></th>
<th>1982</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postage stamp</td>
<td>$.20</td>
<td>$.50</td>
</tr>
<tr>
<td>Gas/gallon</td>
<td>$1.59</td>
<td>$3.05</td>
</tr>
<tr>
<td>Movie Ticket</td>
<td>$3.00</td>
<td>$10.00</td>
</tr>
<tr>
<td>Bread</td>
<td>$.55</td>
<td>$2.75</td>
</tr>
<tr>
<td>Milk/gallon</td>
<td>$1.30</td>
<td>$3.75</td>
</tr>
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</table>

• 59% increase
• 37% increase
• 70% increase
• 80% increase
• 66% increase

Collections - Then and Now

• 1982 (Insurance Patient - routine OV)
  – Patient goes to the doctor, doctor bills ins company $50
    • If patient has unmet deductible, they just pay cash fee
    • If deductible was met at the hospital or other facility, patient
      pays coinsurance (usually 10-20%), insurance pays the rest 80-90%
      – $50 X 80% = $40, from insurance
      – Patient pays $10 at 20% coins, $5 if it's 10% coins
  
  – BOTTOM LINE: Doctors aren't as concerned about getting
    100% of the fee. If they get 80-90% from insurance, the
    10-20% from the patient is just gravy. If the patient is
    uninsured or underinsured, they pay cash and don't even
    bill insurance.
Collections - Then and Now

• NOW (35 years later)
  – Patient goes to the doctor, if they have insurance, doctor bills ins company $100
    • If Doctor “in-network,” they have to take reduction in billed fee to about $70
    • Patient has average copay of $35 - $40 or deductible/coins.
  – BOTTOM LINE: Doctor CAN’T “just take insurance.” In 1982, they could get $40 from an insurance company on a $50 bill. Now they get $35-40 (after reductions and copay), or about $65-70 if patient has a deductible. Plus, the cost of living is significantly higher now than 1982. And additionally, the doctor has higher administrative costs than in 1982. EVERYTHING THAT CAN BE COLLECTED MUST BE COLLECTED.

Medical Revenue

• Medical Spending represents 17% of the GDP
• By 2025 Medical Spending is projected to represent 20% of the GDP
• Medical Revenue comes from three main sources
  – Federal/State Funds (Medicare, Medicaid, etc.)
  – Private Payer Reimbursement (BCBS, UHC, Cigna)
  – Patients (Self Pay, Insurance Cost Share amounts)

How Bad Are the Losses?

- 24,114 BUSINESSES filed BANKRUPTCY in 2016
- 22 Hospitals
- 3858 Medical Clinics (16% of all Bankruptcy Filings)
- 770,846 PERSONAL Bankruptcies in 2016
- Medical Bills are Leading Cause of Personal Bankruptcy (avg. debt $5000)


Look what happens to $1.00 when you don't collect it TODAY!

<table>
<thead>
<tr>
<th>$1.00</th>
<th>$0.90</th>
<th>$0.80</th>
<th>$0.70</th>
<th>$0.60</th>
<th>$0.50</th>
<th>$0.40</th>
<th>$0.30</th>
<th>$0.20</th>
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<td></td>
<td>$0.93</td>
<td>$0.85</td>
<td>$0.73</td>
<td>$0.62</td>
<td>$0.57</td>
<td>$0.42</td>
<td>$0.26</td>
<td></td>
</tr>
</tbody>
</table>

HOW QUICKLY DOES YOUR MONEY DEVALUE?

Source: The Commercial Law League of America
After one year, the uncollected dollar you worked for is only worth 26 cents!
Mastering Collections

• Maximize insurance reimbursements
  – Coding and Documentation
  – Demographics
  – Verifications
  – Referrals
  – Billing
  – Follow Up
  – Appeals

Improve Collections: Coding

• Practices lose money through improper coding
  – Codes not checked before going to billing
  – Billers assume Coders got it right, don’t vet claims
  – Claim rejected; financial loss to fix and rebill
  – Claim denied; financial loss to appeal
  – Claim Paid improperly; financial loss to appeal
  – Policy for transferring Bad Debt
Improve Collections: Documentation

• Documentation provides carrier with a “receipt” for payment
• Documentation protects HCP against financial loss due to malpractice claims
• Documentation protects revenue already obtained from being taken back (recouped)
• How much money have you lost or stand to lose on audit due to poor, or no documentation?

Improve Collections: Demographics

• Practices lose money through incorrect demographics
  – GARBAGE IN…. GARBAGE OUT; Patient and insurance demographics not entered correctly
  • Patient NAME must match name on Insurance card
  • Obtain valid phone number in case you need to reach the patient
  • Accurate entry of Policy/Subscriber ID
  • Current Insurance information obtained
Improve Collections: Verifications

• Failure to properly verify benefits leads to significant financial loss!
• ASK for copy of insurance card at EVERY VISIT
  – Many individual policies are month to month
  – Keep a card scanner at front desk
• VERIFY Coverage at EVERY VISIT
  – Failure to pay premium may cause policy lapse
  – Benefits may have changed (co-pay, deductible, etc.)
• VERIFY for PREAUTHORIZATION requirements
• VERIFY procedures

Improve Collections: Referrals

• HMO Plans require referral to specialist
• Certain types of Health Care Require Referrals
  – Physical/Occupational/Speech Therapy
  – Behavioral Health
  – Skilled Nursing
  – Home Health
• Failure to correctly obtain and update referrals leads to significant revenue loss
Improve Collections: Billing

• Don’t let claims go without review …scour your claims first!
  – Print/view a pre-billing report. Look for coding and claims errors.
  – Common errors
    • Missing patient information
    • Incorrect CPT/HCPCS Codes/modifiers
    • Missing CPT codes
    • Incorrect ICD-10 codes, not coded to highest specificity
    • Incorrect ICD-10 code sequencing

Improve Collections: Billing

• Track Claims through the Revenue Cycle
  – Match Claims Billed to Claims Sent
  – Check for Clearinghouse reject
  – Check for Payer rejects
• Handle Secondary Billing regularly (1 week)
• Post payments promptly
• Follow up on improperly processed/adjudicated claims ASAP (72 hours)
**Improve Collections: Follow Up**

- Follow up on improperly paid claims within three business days of receipt
- Print Outstanding claims report weekly, look for claims over 2 weeks (Commercial Payers), 3 weeks (Medicare), 4 weeks (Medicaid)
- Print Account Aging Report Monthly, look for claims aging out 45-90 days
- Document all activity
- Create a follow up/task schedule (tickler file)

**Improve Collections: Rebills and Appeals**

- How to appeal a claim or rebill a corrected claim
  - Dependent on Carrier, check their rules
  - Don't appeal/rebill claims the same way for every carrier
    - Some are sent as a corrected bill (notate on claim form)
    - Some are mailed with documentation
    - Some are faxed
    - Some are completed online through Provider Portal
Mastering Collections

- Maximize patient collections
  - Financial Policy
  - Over the Counter Collections
  - No Statement Policy
  - Payment Arrangements
  - Automatic Payments
  - Online Payments
  - Beneficiary Notices
  - Hospital Patients

Improve Collections: Written Financial Policy

- Addresses fiscal expectations for Self Pay, Commercial Insurance, Medicare, etc.
- Written clearly and concisely
- Available in __________ language
- Given to patient at first visit
- Given to patient once a year
- Staff reviews and patient signs
Financial Policy

**Please read through this financial policy. A representative of this clinic will review it with you. If you have any questions, don’t hesitate to ask.**

**Patients with Insurance:** We will bill your insurance for services rendered in the office. The $250 deductible on your benefit is a courtesy to you. However, insurance companies will never allow that a quote of coverage is a guarantee of benefits. We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance or unmet deductible, you will be responsible for payment of your utilized out of pocket costs at time of service. Please note that some patients’ policies are written such that you may have to pay a deductible for certain services, and/or a copay for certain services. Insurability is a contract between the patient and their carrier, it is important that you take responsibility for understanding your benefits. Our office has implemented a “no statement policy” in order to keep our billing costs down and not have to pass them on to our patients. If your policy prohibits collection of deductible/coinsurance prior to claim processing, we will require a credit card to be kept on file. Payment for services not covered due to unmet deductible, coinsurance amount or policy exclusions will be automatically processed after receipt of Explanation of Benefits (EOB) from your insurance carrier.

**Medicare Part B:** You will be required to meet your annual Part B deductible, and pay 20% of the allowed fee for Medicare Approved Services rendered in this office. You will have to pay 100% of all services not covered by your Medicare plan. Medicare Advantage plans may have the full deductible and the 20% coinsurance, but only for services covered by Medicare. Medicare patients will be required to sign an Advance Beneficiary Notice which will override your copay obligations as a Medicare patient. Our office has implemented “no statement policy” in order to keep our costs down and not have to pass them on to our patients. We may not be able to collect your deductible/coinsurance prior to claim processing, so we will require a credit card to be kept on file. Payment for services not covered due to unmet deductible, coinsurance amount or policy exclusions will be automatically processed after receipt of Explanation of Benefits (EOB) from your insurance carrier.

**Medicare Advantage:** Medicare Advantage plans generally follow the same guidelines as Medicare Part B, except you might have to pay instead of a deductible and coinsurance. Medicare Advantage, also known as Medicare Supplement Policies, may also cover your hospital and prescription costs. Patients with Medicare Advantage plans do not have supplemental coverage, with the exception of patients who are dual eligible for Medicare and Medicaid.

**HMO Plans:** You will be responsible for obtaining a referral from your Primary Care Physician prior to your visit at this clinic. If you do not have a referral you will be denied, and will be responsible for paying for the entire visit at the time of service.

**Improve Collections: Over The Counter Collections**

- **Front desk collections can represent up to 40% of the total revenue of an average medical practice.**
  - Check for updates to insurance EVERY VISIT
  - Check eligibility; is the patient’s policy in force?
  - Collect Co pay on check in
  - Collect or attempt to collect something on past due amounts
  - Collect deductible/coinsurance cost share on check out
Improve Collections: No Statement Policy/Auto Pay

- No Statement Policy Saves time, money and improves Collections immediately
- Patients pay at TOS, or upon receipt of EOB
- Auto Debit System Implemented
  - Notify patients
  - Collect Auto Pay information
  - Secure the data
  - Set up auto debit schedules for weekly or monthly payments on past due accounts

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DEAR VALUED PATIENTS,

IN ORDER TO MAINTAIN COMPLIANCE OF FEDERAL AND STATE REGULATIONS REGARDING HEALTH CARE COSTS AND FEES, AND TO KEEP YOUR HEALTH CARE COSTS AFFORDABLE WITHOUT COMPROMISING THE CARE YOU NEED, OUR OFFICE WILL BE ADOPTING THE FOLLOWING COLLECTIONS POLICIES, EFFECTIVE JANUARY 1, 2015:

PATIENTS WITH INSURANCE: IF WE ARE CONTRACTED WITH YOUR PLAN, AND HAVE A VERIFIED/CHECKED POLICY ON FILE, WE WILL BILL YOUR INSURANCE. ALL ESTIMATED FEES NOT PAID BY YOUR INSURANCE PLAN, INCLUDING CO-PAYS, CO-INSURANCE AND/OR DEDUCTIBLE AMOUNTS, NON-COVERED SERVICES, MAXED BENEFITS, ETC., *MUST BE PAID AT THE TIME OF YOUR VISIT*. IF WE CANNOT VERIFY YOUR BENEFITS PRIOR TO YOUR VISIT, YOU WILL BE TREATED AS A CASH PATIENT, UNTIL BENEFITS CAN BE CHECKED AND COVERAGE VERIFIED. VERIFICATION OF BENEFITS DOES NOT GUARANTEE PAYMENT BY YOUR INSURANCE COMPANY. IF YOUR INSURANCE PAYMENT IS MADE AND IS DIFFERENT THAN THE AMOUNT OF THE ESTIMATED BENEFITS, THE REMAINING BALANCE WILL BE YOUR RESPONSIBILITY.

PATIENTS WITHOUT INSURANCE WHO PAY CASH AT TIME OF SERVICE WILL RECEIVE A 15% ADMINISTRATIVE DISCOUNT ON THEIR SERVICES.

ALL PATIENTS MUST HAVE A CREDIT CARD ON FILE. IN THE EVENT THAT SERVICES ARE NOT PAID TODAY, OR DENIED BY YOUR INSURANCE COMPANY, WE HAVE SHORT-TERM IN-HOUSE FINANCING OPTIONS AVAILABLE TO THOSE PATIENTS WHO NEED TO PAY THEIR BILL OUT OVER A LONGER PERIOD OF TIME. IF YOU WOULD LIKE MORE INFORMATION ABOUT THE FINANCING OPTION, PLEASE DISCUSS WITH THE FRONT DESK.

RESPECTFULLY,

[Name]

*Patients whose insurance plans prohibit up front collections will have their portion automatically debited from their credit/bank card upon receipt of insurance remittance.
Use form similar to this to set up agreement for Auto Debit of Deductible and Coinsurance Amounts

Be sure to set up a minimum threshold for notification.

FINANCIAL AGREEMENT FOR PAYMENT OF DEDUCTIBLE AND COINSURANCE COST SHARE AMOUNTS

Date: _______________________________

Patient Name: _______________________________________________

Home Phone _____________________ Cell _________________________

E-Mail Address ________________________________________________

The Fee Schedule and Financial Policy of <NAME OF CLINIC> has been explained to me, and all questions regarding my treatment plan and the Fee Schedule have been answered to my complete satisfaction. I understand that my insurance plan will pay some of my medical bills, but not all. My provider will defer payment of my deductible and/or coinsurance amounts, as well as services that may be denied for non-coverage, until my insurance carrier has processed and adjudicated my claim. Upon final adjudication, I agree and authorize <NAME OF CLINIC> to automatically process any amounts not covered by my insurance plan, and have approved and secured this automatic payment with a ____ Credit/Debit Card on File OR ____ ACH Debit (voided check).

I understand that, upon final adjudication of my claim, should the amount owed by me exceed $________, <NAME OF CLINIC> will set up a payment arrangement with me to pay off the bill in installments. Should I fail to respond within 10 business days of initial contact, <NAME OF CLINIC> will assume that I agree with the above, and process the payment in full.

In the event I default in my agreement with <NAME OF CLINIC>, any remaining amounts owed will be immediately due, and subject to further collection action, including the possibility of my account being turned over to an outside collection agency and being listed as a delinquent account on national credit reports.

I / We, the undersigned, state that I / We fully understand and agree to the provisions set forth above.

Patient/Authorized Representative Signature   ____________________

Date: ____________________

Signature of Witness/PRINTED NAME      ____________________

Date: ____________________

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FINANCIAL AGREEMENT: AGREEMENT TO PAY REMAINING PATIENT BALANCE

Date: ____________________

Patient Name: _______________________________________________

Patient Address: ______________________________________________

Home Phone _____________________ Cell _________________________

E-Mail Address ________________________________________________

I have been informed of a balance due on my account with <NAME OF CLINIC> in the amount of $________. I agree that this balance is my financial responsibility and that I am unable to pay this balance in full. I / We have agreed to pay the sum of $________ per month, until my bill is paid in full. I understand that <NAME OF CLINIC> is not a financial institution, and no interest will be charged for this service. I also understand that the only obligation required to obtain this financing is to make payment via an AUTOMATIC payment method, either, debit card, credit card, ACH (Automatic Clearing House) debit or voided check. I understand that any financial information I give to <NAME OF CLINIC> will only be used to pay my bill as authorized above, and all financial information will be kept in strict confidence and with utmost security for my personal financial information in mind.

In the event I default in my agreement with <NAME OF CLINIC>, any remaining amounts owed will be immediately due, and subject to further collection action, including the possibility of my account being turned over to an outside collection agency and being listed as a delinquent account on national credit reports.

I / We, the undersigned, state that I / We fully understand and agree to the provisions set forth above.

Patient/Authorized Representative Signature   ____________________

Date: ____________________

Signature of Witness/PRINTED NAME      ____________________

Date: ____________________

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Sample of Automatic Payment Authorization Form

Once info has been entered into secure database, shred immediately

Secure Storage of Financial Information

- CC/EFT Information must be securely stored in a PCI/DSS Compliant database
- Limited Access: Office Manager/Billing Manager
- Check your PM Software System to see if they have secure storage capability
- Compare Programs: i.e., Capterra (http://www.capterra.com/payment-processing-software/)
Improve Collections: Online Payments

• Many insurance carriers now have features that allow patients to pay their OOP costs online through a secure portal.
• Some Hospitals and larger Medical Groups allow patients to make online payments
• Many Patient Portals have options for online payments
• Research options that could work in your community and patient population
Improve Collections: Beneficiary Notices

- Insurance is Confusing to many Patients
  - Use Beneficiary Notices to explain their fiscal responsibility for non covered or medically unnecessary services
  - Some Carriers REQUIRE Beneficiary Notices
    - Medicare: ABN and Voluntary ABN
    - Other Carriers: Check their website to see if they have rules for notification and forms.
  - If no Beneficiary notification is required under your contract, be sure to have a signed Written Financial Policy

Improve Collections: Patient Collections for Encounters outside the Office

- Surgical Patients
- Hospital Patients
- SNF Patients
  - Particularly challenging, because you have not had a chance to meet patient or to go over financial policy
  - Some patients don’t understand that they will receive a separate bill from the doctor, think everything is included in the hospital bill.
Solutions

• Hospital/SNF Admits: First day that the Dr/HCP sees patient in hospital, get a list and have someone from your billing office do “rounds” that afternoon, or accompany Dr on afternoon rounds.
  – Go over Financial Policy, explain coverage and limitations for the procedure they may be having, or costs of Doctor’s visits when in the hospital or SNF
  – Explain how separate physician billing works
  – Bring tablet or laptop, demo how to pay bill online
  – Explain “no statement” policy. Let them know that after they receive their first bill they will be contacted to set up auto pay options.
  – Have patient/family member with MPA sign document acknowledging that they have been counseled (Written Financial Policy)

Solutions

• FLAG THE FIRST STATEMENT
  – When first statement is sent, follow up with phone call a week later to ask patient if they have any questions about their bill
  – Offer to set up auto pay over the phone
  – If they have an online payment option, let them know how to use it
  – Document conversation in patient account notes, and what patient agreed to
Collections DON’TS

• Waive copay, deductible, coinsurance
• Collect up front if your managed care agreement prohibits you from doing so
• Discount time of service payments more than 15% without a contract
• Make settlement offers on bill without an attempt to collect the full amount
• Set your cash fees lower than the Medicare allowable for your locality
• Discriminate on professional courtesy discounts

Questions?

• Thank you for your attendance!

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