

Get Paid Now!

Maximize Third Party Reimbursements
& Increase Patient Collections



The intention of this presentation is to give you tools to increase practice revenue, reduce paperwork and simplify your billing and collecting process.

We encourage you to use the information that follows and apply the tools and techniques to fit your practice. If you need any help with implementation, or have any questions, please do not hesitate to contact us!

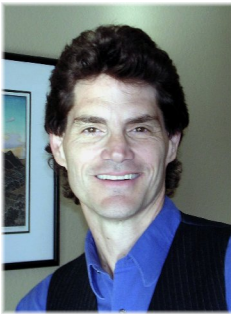
Bridge Practice Management Group

PO Box 130513 Carlsbad, CA 92013

www.jerrybridge.com

760-918-6701

Jerry Bridge
Motivational Speaker for Healthcare
6778 Via Casa Del Sol, Carlsbad, CA, 92009
Office 760.918.6701 ~ email: jerrybridge@att.net



Jerry Bridge, founder and president of Bridge Practice Management Group, is a trainer, coach and motivational speaker. Over the past fifteen years Jerry has trained over 75,000 healthcare providers, practice managers and administrative staff on a variety of practice management issues including; customer service and communication, stress management and productivity, and billing & collections.

Additionally, Jerry integrates over 25 years of training and development with Landmark Education Corporation; a leader and innovator in the field of transformational education. He has worked with both individuals and organizations to bring forth dramatic, powerful and lasting results personally and professionally.

Jerry lives in San Diego, California. He is a dad, drummer and occasional stand up comic. His passion is to lead inspiring, motivating programs that make a positive lasting impact and have a great time in the process.

Offers from Bridge Practice Management

"21st Century Productivity: Time & Stress Management Program

Tools & Practices for managing everything when there's more to do than time to do it!

- Dramatically increase your productivity and produce the results that are most important to you,
- Learn a new way to think about, organize and manage your work
- Reduce stress and worry
- Create a new level of focus and effectiveness in your work and in your life

"Mission, Service & Well Being"

Tools & Best Practices for fulfilling your company's mission, providing remarkable service and managing the well being & vitality of your employees.

- Productivity: Handling everything there is to do in the digital age
- Service: Providing consistent, remarkable service
- Well Being: Practices for managing employee vitality & well being

"Extraordinary Customer Service for Healthcare"

Transforming Conflict into Co-operation; effectively dealing with demanding patients, communication breakdowns, stress and other service problems unique to healthcare

- Breaking through the limits of **ordinary** communication
- Extraordinary communication: a reliable tool for handling breakdowns & conflict
- Practical applications and practice in the real world

"Get Paid Now!"

*Super effective techniques for collecting from Insurance Companies & Patients
Specifically designed for billing and collections specialists*

- Collect from insurance companies promptly and fairly
- Collect from Patients easily & effectively

Get Paid Now!

Maximize Third Party Reimbursement & Increase Patient Collections

1. Protocols for Maximizing Third Party Reimbursements

- Resources & Contact Information
- California State/Federal Law
- 5 Steps to powerfully expedite claim payment
- Appeals Letters: Appeal, Appeal, Appeal!
- Insurance Scripts that get results



“Breakable bones, a tendency to bleed when cut, vulnerability to germs and viruses. These are all preexisting conditions.”

2. Protocols for Increasing Patient Collections

- Implementing your 'financial policy'
- Integrate paperless billing through 'easy pay'
- Customer Service issues: the good, the bad, & the poop
- Effective Collection Calls; know what to say & how to say it
- Effective Collections letters; positive past due, co-pay, & more
- Legal issues, HIPAA, cocktails

Resources:

U. S. Department of Labor

<http://www.dol.gov/dol/pwba/public>

The U.S. Department of Labor is responsible for regulating employer self-insured plans under the Employees Retirement Security Act (ERISA). The Department of Labor Website has regulations, informational pamphlets, and other materials concerning recently enacted Federal health care laws. These materials include information on the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity Act of 1996 (MHPA) and the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). The U.S. Department of Labor, Pension & Welfare Benefits Administration can be reached at (202) 219-8776.

National Association of Insurance Commissioners

<http://www.naic.org>

The National Association of Insurance Commissioners (NAIC) Web site has information on the insurance regulators from the 50 states, the District of Columbia and the four U.S. territories.

Appeals Solutions, Denial Management

Tammy Tipton, President www.appealsolutions.com 888-399-4925

Health Care Financing Administration

<http://www.hcfa.gov>

HCFA's Website has regulations, questions and answers, and other materials concerning recently enacted Federal health care laws.

California Billing & Collection Resources

California Department of Insurance
Consumer Services Division
300 S. Spring St.
Los Angeles, CA 90013
Phone 800-927-help
<http://www.insurance.ca.gov>

California Medicaid
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814
916-654-0391
www.dhs.ca.gov/mcs/medi-calhome/default.htm/

Department of Managed Care
HMO Help Center/Provider Desk
980 Ninth Street, Suite 500
Sacramento, CA 95814
(877) 525-1295
(916) 229-0465
www.dmhc.ca.gov

Attorney General's Office
California Department of Justice
Attn: Public Inquiry Unit
P.O. Box 944255
Sacramento, CA 94244-2550
1-800-952-5225 (Toll-free in CA)
<http://caag.state.ca.us/contact/index.htm>

California Paymehbnt Laws:

- Indemnity: 30 days
- HMO/PPO: 45 days
- Workers Compensation: 15 working days
- Self Insured's: 30 days to respond

“The squeaky wheel gets the grease!”

United Healthcare Ordered to Pay Civil Fines

March 10, 2006 - Insurance Director, **Christina Urias**, announced the results of market conduct examinations of United HealthCare of Arizona, Inc. and **United HealthCare Insurance Company**, ordering United HealthCare of Arizona to pay a civil penalty of \$243,250 and United HealthCare Insurance Company to pay a civil penalty of \$121,250, for violations of Arizona's insurance laws. **The combined fine of \$364,750 is the largest the Insurance Department has ever assessed for such unlawful practices** and both companies have agreed to take corrective action to prevent future violations.

In particular, the Department found that both companies had **violated state laws** governing: (a) member appeals of denied services and claims; (b) **timely payments to providers**; (c) **provider grievances**; and, (d) record keeping and documentation requirements.

California Revised Statues

§ 1371. Time for reimbursement of claims; contested claims

A health care service plan, including a specialized health care service plan, shall reimburse claims or any portion of any claim, whether **in state or out of state**, as soon as practical, but **no later than 30 working days** after receipt of the claim by the health care service plan, or if the health care service plan is a **health maintenance organization, 45 working days** after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of **15 percent** per annum beginning with the first calendar day after the 30- or 45-working-day period. **A health care service plan shall automatically include in its payment of the claim all interest** that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten dollar (\$10) fee.

5 Steps to Expedite Claim Payment

(Normally, insurers are governed by the state in which you provide service. For information on out of state companies go to: www.naic.org)

1. Get the **patient** involved... They have the power to get paid!

To: The Insurance Commissioner or Regulatory Board	date
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 CC. Provider	

2. Use **'Stamper's or Stickers'** – THEY WORK!

For any claim that leaves your office by paper or report you can stamp (in bright colors);

'Attention! Unless this claim is paid or denied in ___days, I will file a written formal complaint to the insurance commissioner.'

For any claim that's filed electronically you can type on the HCFA (line 19), or on the ADA form (notes box);

'Attention, this claim is being audited for legal action...' or,
'Attention, we know where you live, so don't mess with us!'

3. **RECORD your CALLS** when getting Verification and preauthorization of benefits!

What are the 2 things insurers always tell you when you call to verify benefits and get pre-authorizations?

1. _____
2. _____

'For your protection and ours we record all calls for prompt payment'

Go digital! Archive your calls for easy retrieval. You can use the same process for managing patient conversations.

4. Use your **AGING REPORTS!** Check aging reports and trial balances. Go after your worst payers.



Payer	30	60	90	120
Aetna				
Met. Life				
United HC				

5. Appealing Your Claims Effectively

1. Get the patient involved. They should authorize complaint letters ahead of time if possible. The consumer has the power!
2. Address your letters to the Claims Manager or Claims Supervisor.
3. Make sure you send a copy to the regulatory agency, i.e., the insurance commissioner, department of labor, or Attorney General in your state.
4. Maintain and be ready to send a second appeals letter restating your position with factual information and documentation.
5. Check to see if the claims being denied fall into a certain category. You might be able to fix the claim up front and before submission.
6. Maintain fax numbers and collect e-mail address for the payers' that you routinely bill. Record your calls!
7. Keep a log of which appeals letters have the greatest impact.

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## **California Prompt Payment Appeal**

Dear Director of Claims,

We request immediate payment of the above referenced claim. According to our records this claim was filed on [~Insurance Policy #1 File Date~]; however, payment has not been received. We believe failure to release payment may be a violation of California law.

Please be advised *that California Revised Code § 1371 states:*

Every insurer issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses, as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

If an uncontested claim is not reimbursed by delivery to the claimants' address of record within 30 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-working-day period.

For purposes of this section, a claim, or portion thereof, is reasonably contested where the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

Based on this mandate, we ask that this claim be paid to this office immediately. We appreciate your prompt attention to this matter.

Sincerely, Claims Analyst

### **§ 1371.8. Rescission or modification of authorizations**

A health care service plan that authorizes a specific type of treatment by a provider **shall not rescind or modify this authorization** after the provider renders the health care service in good faith and pursuant to the authorization. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan.

## **Authorization Appeal**

Dear Director of Claims,

Your company denied the above referenced claim due to lack of coverage.

This letter is to inform you that our office was granted prior approval for this treatment. Your representative stated that coverage was available for this treatment.

Please be advised, California's Health and Safety Code prohibits certain health service plans from retroactively denying authorized care. Section 1371.8 states the following:

A health care service plan that authorizes a specific type of treatment by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization. This section shall not be construed to expand or alter the benefits available to the enrollee or subscriber under a plan.

It appears your company may be in violation of California law. Therefore, we request immediate payment of the above referenced claim. Your prompt response is appreciated.

## **Workers Compensation-Prompt Payment Appeal**

Dear Director of Claims,

We request immediate payment of the above referenced claim. According to our records this claim was filed on [~Insurance Policy #1 File Date~]; however, payment has not been received. We believe failure to release payment may be a violation of the **Cal. Ins. Code § 4603.4**.

**Please be advised, this mandate states the following regarding prompt payment of workers compensation claims:**

(a) The administrative director shall adopt rules and regulations to do all of the following: (1) Ensure that all health care providers and facilities submit medical bills for payment on standardized forms. (2) Require acceptance by employers of electronic claims for payment of medical services. (3) Ensure confidentiality of medical information submitted on electronic claims for payment of medical services. (b) To the extent feasible, standards adopted pursuant to subdivision (a) shall be consistent with existing standards under the federal Health Insurance Portability and Accountability Act of 1996.

(c) The rules and regulations requiring employers to accept electronic claims for payment of medical services shall be adopted on or before January 1, 2005, and shall require all employers to accept electronic claims for payment of medical services on or before July 1, 2006.

(d) Payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within **15 working days** after electronic receipt of an itemized electronic billing for services at or below the maximum fees provided in the official medical fee schedule adopted pursuant to Section 5307.1. If the billing is contested, denied, or incomplete, payment shall be made in accordance with Section 4603.2.

Based on this information, we ask that this claim be paid in full to this office immediately. We appreciate your prompt attention to this matter.

Sincerely,

Claims Analyst

## Timely Filing Appeal

Dear Director of Claims,

This letter is to request immediate payment of the above referenced claim.

**According to your representative, this claim was not processed due to failure to meet the applicable timely claim filing requirement.**

**According to a number of California court decisions, an insurer may not refuse to process a claim due solely to lack of timely filing unless the insurer can prove that it was substantially prejudiced by the late filing.** Further, the burden of proving prejudice is on the insurer. Please see *Northwestern Title Sec. Co. v. Flack*, 6 Cal. App. 3d 134, 85 Cal. Rptr. 693 and *Clemmer v. Hartford Ins. Co.*, 587 P.2d 1098, 151 Cal. Rptr. 285. The Flack case states that an insurer may be prejudiced by its inability to contemporaneously investigate the claim, interview witnesses or make an early settlement of the claim.

It is our position that your company was not prejudiced by late filing. Therefore, we appreciate your prompt processing of this claim. If payment is not released, we would appreciate your written response in regards to the cases cited above.

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Important Letters To File

- Verification of benefits
- Medical necessity
- Benefit reduction
- Refund request
- Letter for stalls
- Timely filing
- ERISA

*I am sending out timely filing letters left and right. Most recently, I got a very large claim paid that was denied for timely filing by **Railroad Medicare**. The claim was from 8/31/01 and I mailed the claim with the letter the day we got back from the seminar, which was 12/9/03. We received payment on that claim on 12/15/03!*

Michelle Gipson, Insurance Manager
Purchase Orthopedic Associates
Paducah, Kentucky

§ 1371.37. Unfair payment pattern; prohibitions

(a) A health care service plan is prohibited from engaging in an **unfair payment pattern**, as defined in this section.

(b) Consistent with subdivision (a) of Section 1371.39, the director may investigate a health care service plan to determine whether it has engaged in an unfair payment pattern.

(c) An "unfair payment pattern," as used in this section, means any of the following:

(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.

(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.

(3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section **1371**, 1371.1, or 1371.35.

(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

(d)(1) Upon a final determination by the director that a health care service plan has engaged in an unfair payment pattern, the director may:

(A) Impose monetary penalties as permitted under this chapter.

(B) Require the health care service plan for a period of three years from the date of the director's determination, or for a shorter period prescribed by the director, to pay complete and accurate claims from the provider within a shorter period of time than that required by Section 1371.

Underpayment/Incorrect Payment Appeal

Dear Director of Claims,

Please be advised, the claim referenced above was not paid in accordance with the applicable contract with our office. Upon review, it appears that one or more charges were underpaid by your company.

California insurers and managed care provider carriers are prohibited from engaging in **unfair payment patterns**. An unfair payment pattern is defined by West's Ann. Cal. Ins. Code § 1371.37 to mean any of the following:

(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that result in **payment delays**.

(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of **reducing the amount of payment** or denying complete and accurate claims.

(3) Failing on a repeated basis to **pay the uncontested portions of a claim within the timeframes** specified in Section 1371, 1371.1, or 1371.35.

(4) Failing on a repeated basis to automatically **include the interest** due on claims pursuant to Section 1371.

Unfair payment patterns can be reported to state regulators pursuant to Regulation 1371.39 which states:

(a) Providers may report to the department's Office of Plan and Provider Relations, either through the toll-free provider line (877-525-1295) or e-mail address (plans-providers@dmhc.ca.gov), instances in which the provider believes a plan is engaging in an unfair payment pattern.

Based on this information, we request immediate reprocessing of this claim to avoid being reported to the Office of Plan and Provider Relations. If an adjustment is not made, we request your written response with a specific reference to the portion of the fee schedule or other information to support the initial payment.

Sincerely,
Claims Analyst

Refund Request

Dear Director of Claims,

We recently received your request for a refund in regards to payment made on the claim referenced above.

Please be advised, California courts have generally ruled that an insurer cannot recover amounts paid absent a fraudulent inducement. In *City of Hope Nat. Medical Center v Superior Court*, 8 Cal App 4th 633, 10 Cal Rptr 2d 465, a health care insurer was denied restitution of money that it mistakenly paid to a hospital even though the insurer made its payment under the mistaken belief that the insured's treatment was covered.

It does not appear that your company had incorrect facts at the time payment was rendered. Therefore, we maintain that no refund is allowed.

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*"I wanted to impress how well one of your letters has worked in collecting from insurance companies. Now when my doctors get an EOB stating a procedure was **not medically necessary**, they respond with a letter to the Claims Department Supervisor requesting the name and credentials of the person(s) who reviewed the claim for processing, along with all criteria they used to come up with their final decision.*

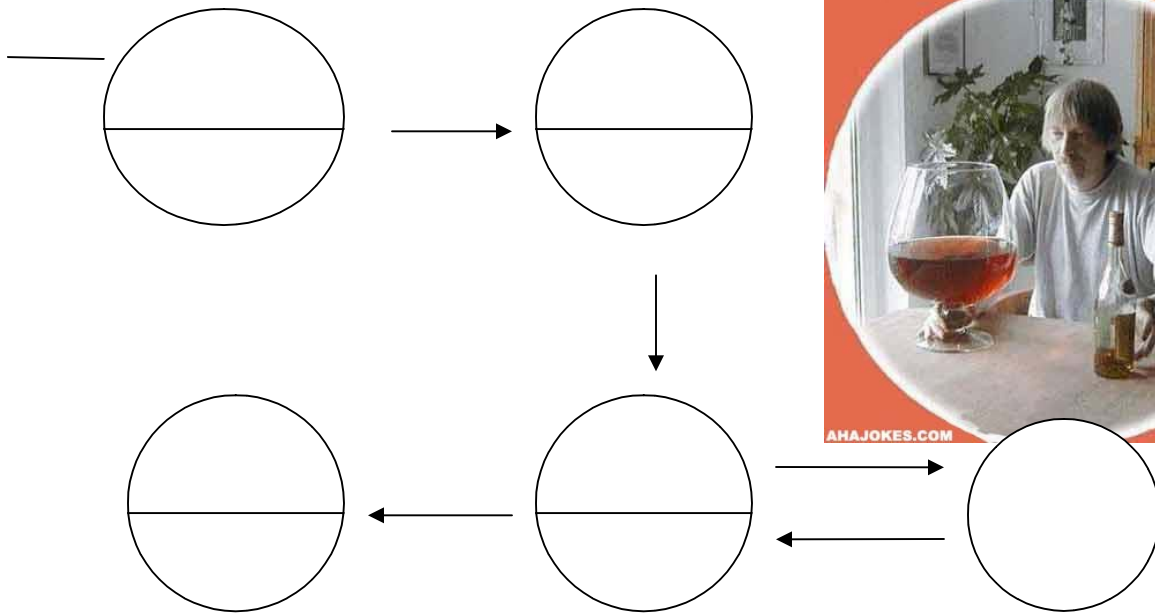
***Not once have we had the letters responded to with the requested information, however, within three (3) weeks we receive the corrected EOB and payment. We have not been denied payment a second time. We have used this letter multiple times this past year with complete success each time!!!"***

Joyce Griffin, Insurance Department,  
East Valley Rheumatology & Osteoporosis, P.c.

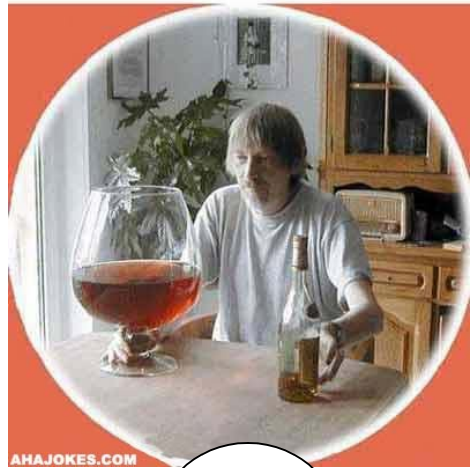
## Self Insured Companies and Union Plans

- Most large employers and Unions are Self-Insured.
- These plans are regulated by the Department of Labor under ERISA Law (Employee Retirement Income Securities Act of 1974)
- **Required to respond within 30 days or claim may become a 'Bad Faith Claim.'**
- Get a copy of the 'Summary Plan Description' from the employee.
- Look at the insurance card to determine whether the company is self-funded. Look for ERISA or 'underwritten by' or the name of the employer.

The money flow



My Doctor said "Only 1 glass of alcohol a day". I can live with that.



The two people in this model that can get your bill paid are:

1. \_\_\_\_\_ 2. \_\_\_\_\_

**Recommendation:** perform a payer mix analysis.

|                           |  |  |  |
|---------------------------|--|--|--|
| Third party administrator |  |  |  |
| Employer/union            |  |  |  |
| Human Resources/Benefits  |  |  |  |
| Thank you card sent       |  |  |  |

## Self Insured ERISA Appeal

Attn: Director of Claims  
[~Insurance Policy #1 Carrier~]  
[~Insurance Policy #1 Address~]

Re: Patient: [~Patient Name~]  
Policy: [~Insurance Policy #1 Number~]  
Insured: [~Responsible Party Name~]  
Treatment Dates: [~Admission Date~] - [~Discharge Date~]  
Amount: [~Total Charges~]

Dear Director of Claims,

We request immediate payment of the above referenced claim. According to our records this claim was filed on [~Insurance Policy #1 File Date~]; however, payment has not been received. **We believe failure to release payment may be a violation of Title 29 of the United States Code of Federal Regulations.**

This portion of Pension and Welfare benefits law prohibits self-funded group employer-sponsored health plans from unnecessarily delaying claims processing. Section 2560.503-1 (f) (2) (iii), "Other Claims," states under Paragraph B:

(B) Post-service claims. In the case of a post-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

**Based on this mandate, we ask that this claim be paid to this office immediately.** We appreciate your prompt attention to this matter.

Sincerely,

Claims Analyst

## Usual, Customary, and Reasonable Charges

- Most people think doctors overcharge because the insurers have been saying so.
- The term 'Usual & Customary' was derived from Medicare, now practically all payers use those terms to control payments.
- Don't waste time trying to find out how the insurer came up with their fees.
- Use the UCR letter when the insurer says you're charging too much and you're NOT CONTRACTED.
- Send a copy to the patient. Most people won't mind paying the bill; they just want to know you're not gauging them.

Dear Claims manager,

This office has been made aware that your company has determined that our charges exceed the usual, customary, and regular rates for our geographic area. As we have conducted both an internal and external review of rate charges for similar services in our area, we have found absolutely no evidence to substantiate your statement(s) about our charges.

**In point of fact, we have found that in some cases our fees for service are below what is considered the customary rate for our community. Unless you can provide us with both the Value Study Data, Conversion Factors and the specific methodology that you have used to calculate those charges, we strongly request that you update your explanation of benefits to reflect what is right and accurate; that the patient has reached or exceeded the maximum payments that your company will allow.**

Since we have no contractual agreement to accept such rates as payment in full, and because, by law, we are required to collect insurances balances and co-payments we will be advising our patients accordingly.

Sincerely,

Dr. Jones  
cc. patient

Try using this letter when you are contracted with the insurer or T.P.A. and you want increase your payments. Attempt to negotiate a more equitable fee schedule.

To: Medical Director/ Claims /Benefits Manager

date

Dear Medical Director,

Providing high quality medical care to the patients referred by you is a great privilege that we honor and appreciate. The relationship between your company and ourselves as healthcare providers is also one we value and hold in high regard.

**However, after conducting an internal review of our charges and your payments we find we may no longer be able to continue to provide services under the existing rate schedule. Please consider increasing your payments (new schedule enclosed) or allow us to increase the patient co-payments. Either action would help offset the financial burden so that we may continue to accept new patients.**

Many of our patients (your policy holders or employees) enjoy the trust and convenience of coming to our practice. We sincerely hope to maintain that important relationship and continue with your company for many years to come.

Sincerely,

## Scripts for dealing with stalled insurance payments

|                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>When speaking with insurance companies get the name of the person with whom you are speaking, as well as the name of the supervisor or floor manager.</b></p> <p><b>If they will not give the name of the supervisor</b></p> <p><b>Record Conversations</b></p> <p><b>“We’ve never received your claim”</b></p> | <p>Could you please give me the name of the person you’re accountable and responsible to; in case you’re unavailable when I do my insurance follow up...which I always do.</p> <p>Your office really helped me on a prior claim; I’d love to tell your boss what a great job you are doing! To whom should I address the the thank you card?</p> <p>You’re not saying your company has a history and a policy of being uncooperative regarding the prompt payment laws of our state, are you?</p> <p>For our protection and yours, we <u>may</u> record and document all calls for prompt payment according to the laws of our state.</p> <p>We know for a fact that you did receive this claim because I’m holding a receipt from the United States Postal Service (I can document an electronic transmission or a faxed copy)...” “It’s nothing personal, but my boss tells me that my job is to audit, track, and trace each and every claim form that leaves our office...”</p> <p>By the way, I’m the chief executive responsible for all insurance reimbursements in the northwestern region (that’s your office!)</p> <p>Shall I hold the phone while you research and process this claim, or shall I have to name you and your supervisor personally, in my written, formal complaint, signed by your premium paying subscriber, to the insurance commissioner and the attorney general in this state? What would like me to do?</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

## Financial Policy: A solid foundation for patient responsibility & payment

Thank you for choosing [~Name of Facility~] as your healthcare provider. We are committed to your treatment being a successful. Our Insurance Department and Patient Finance Counselor(s) will work very hard to make sure your paperwork is filed accurately and promptly.

In order to provide you with the highest quality service while keeping our billing costs low, we offer [require] paperless billing through Easy-PAY. We simply maintain your credit, debit, or check card number on file to satisfy all co-pays, deductibles, and balances not covered by your insurance. Our Patient Finance Counselor(s) will be more than happy to give you more information about Easy-PAY.

WE ACCEPT ALL MAJOR CREDIT CARDS, DEBIT CARDS, CHECK CARDS AND CASH. WE OFFER THE CARE CREDIT CARD AS OUR EXTENDED PAYMENT OPTION. Our Patient Finance Counselor(s) can give you details on how to apply.

### **Insurance & Insurance Collection:**

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. Our billing staff has undergone extensive training to maximize your insurance reimbursement, while reducing the time by which they pay. Please **initial** next to your category of insurance listed below, as this will help us to speed up payment and eliminate any confusion in the future. Thank you.

### **Non-Contracted / Indemnity Insurance Plans:**

\_\_\_\_\_ 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. However, we require that you pre-authorize the "letter for insurance stalls" in order to expedite your insurance payment. If you are a new patient, we may require that you enroll in Easy-PAY to guarantee your account. 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.

\_\_\_\_\_ Transfer my balance.      \_\_\_\_\_ Call first, I might want to send a check.

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 recommend QUICK-PAY. After your insurance has cleared, you may leave the balance on your card, or you can send a check. Please indicate your preference.

\_\_\_\_\_ Transfer my balance.      \_\_\_\_\_ Call first, I might want to send a check.

---

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

Cardholder Signature: \_\_\_\_\_ Account#: \_\_\_\_\_ Exp: \_\_\_\_\_

**Self-Insured/Union Plans:**

This office has been thoroughly trained on how to get reimbursed by your employer; however, in the event there is a problem, you must provide us with the name of your human resources director and/or benefits manager. We may also require your authorization to file complaint letters to the Department of Labor and your administrator if necessary.

**Medicare:**

\_\_\_\_\_ As a participating provider, we may bill your Medicare carrier. You are responsible for your 20% co-payment and we must collect it each and every visit. If you prefer, we can bill your co-pays to your QUICK-PAY account on a weekly, biweekly, or monthly basis.

**Secondary Insurers:**

\_\_\_\_\_ Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

**Usual & Customary Rates:**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

**Divorce Decrees:**

\_\_\_\_\_ This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

**Minor Patients:**

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service has been verified.

**Interest & Rebilling Fees:**

We are not a billing company. We reserve the right to charge interest in the amount of \_\_\_\_\_% as provided by state law. Or, at our option, we may charge a rebilling fee of \$\_\_\_\_\_ per bill.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree with this Financial Policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

Date: \_\_\_\_\_

**Patient Easy Pay Consent Form**

I authorize \_\_\_\_\_  
(Name of health care provider)

to maintain my credit, debit or check card on file for the balance of charges not paid (by insurance) within 90 days.

Not to exceed \$ \_\_\_\_\_

Annually

Monthly

Weekly

Per Visit

Date(s) of Service \_\_\_\_/\_\_\_\_/ to \_\_\_\_/\_\_\_\_



I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the health care provider.

\_\_\_\_\_  
Cardholder Signature Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Cardholder name

\_\_\_\_\_  
Cardholder address

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Card Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Exp Date \_\_\_\_ - \_\_\_\_ V Code \_\_\_\_

I just wanted to share with you how effective your idea of asking patients to set up a payment plan using their credit card for a payment plan has been. I attended your workshop a few years ago and again a few months ago. I learned many things from your workshops, but my favorite is the credit card payments plan/easy pay. I have utilized this in a couple of different ways.

Many of our patients that are good about paying their bills but cannot afford to pay it in one payment appreciate that we will save them the trouble of writing a check once a month. I love using the credit card payment plan for those patients that are certain that their insurance should pay more and "are working with their insurance to get additional payment to our office". I tell them "that is fine but why don't I take their credit card information and I will only charge it once a month until their insurance resolves their claim". I also use it on my final attempt to collect balances on patients that are ready for the collection agency.

Joan Cotham, Patient Accounts Manager, Dr. Jeffery Klein MD

**TYPICAL BILLING COSTS VS. IMPLEMENTATION OF  
'EASY PAY' PAPERLESS MEDICAL BILLING  
RETURN ON INVESTMENT**

**Based on average fee for service revenues from \$399,000 to \$584,000 per physician**  
**Current costs range from \$14,000 to \$25,000 per physician**

Billing Costs per Physician as a percentage of net revenue

|                                          |                             |                             |
|------------------------------------------|-----------------------------|-----------------------------|
|                                          | 25 <sup>th</sup> percentile | 75 <sup>th</sup> percentile |
| Billing Costs                            | \$23,500                    | \$35,500                    |
| Billing costs as per cent of net revenue | 5.9% to 8.9%                | 4% to 6.1%                  |
| Billing related costs                    | \$10,000                    | See below                   |

**HARD & SOFT COSTS FOR MEDICAL BILLING EXPENSES**

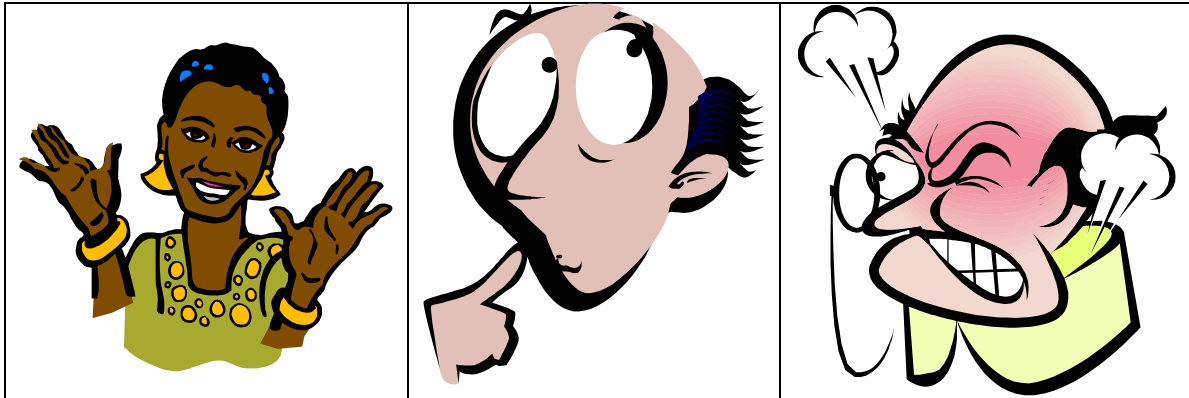
| SPACE COSTS<br>(ONE FULL TIME<br>EMPLOYEE PER<br>PHYSICIAN) | POSTAGE<br>PAPER                          | COMPUTER<br>COSTS<br>(DEPRECIATION,<br>MAINTENANCE &<br>SERVICE) | PHONE COSTS | TOTAL           |
|-------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------|-------------|-----------------|
| \$1,500                                                     | \$4,000 (8,000<br>MAILINGS AT<br>.50 EACH | \$3,000                                                          | \$1,500     | <b>\$13,000</b> |

**MEDICAL PRACTICES USING 'EASY PAY' OVER 6-12 MONTH PERIOD  
FOLLOWING IMPLEMENTATION DECREASE AVERAGE COSTS BY 35%**

| SPACE COSTS<br>(ONE FULL TIME<br>EMPLOYEE PER<br>PHYSICIAN) | POSTAGE<br>PAPER | COMPUTER<br>COSTS<br>(DEPRECIATION,<br>MAINTENANCE &<br>SERVICE) | PHONE COSTS | TOTAL          |
|-------------------------------------------------------------|------------------|------------------------------------------------------------------|-------------|----------------|
| \$975                                                       | \$2,600          | \$1,950                                                          | \$975       | <b>\$8,450</b> |

First year return on investment show a minimum savings of **\$4,550**; a 35% savings on typical billing costs. **Billing costs as percentage of revenue decrease on average from 6% to 2.5%**. In addition, practices that continue to implement paperless patient billing recover an average of 1 to 4 employee hours per work day. These practices are operating more consistently with a marketplace that understands and values online transactions as a way of conducting business. As a result, these practices become more profitable while building and increasing enterprise value.

## Existing Patients – Payment History Category



The Good

The Slow

The Poopy

### Recommendations;

- Discuss co-payments and balances when scheduling appointments.
- Focus attention on the **legal** aspects of making payments and uniform collection policy.
- Do not schedule with patients that have significant balances. Discuss with doctor or office manager in advance.
- Maintain a 'Brother-in-law' category.

### Post these scripts for increasing payments while enhancing service;

- “The minimum you can expect to pay on the first visit is \_\_\_\_\_.”  
How do you think you'll take care of that when you arrive?”
- “We are no longer billing for co-pays (or balances), please come prepared to pay.”
- “We can not collect from some and not from others; that may be considered illegal by the insurance company. I would just look horrible in an orange jumpsuit, and besides I've heard the food is even worse...”
- “I would not want to jeopardize your insurance by not collecting your co-pay...did you hear about Mrs. Jones, she lost her insurance, just terrible!”
- “Last time you were here you paid with visa. For your convenience we can bill to that account.”

## Patient Collections

Oh boy, how I love to talk to other people about their money...yeah!

First things first...Who are **you** about money?

On this 'scale' where are you?

a

b

c

d

e

|                                                                       |                                                                  |                                                                |                                                           |                                                                    |
|-----------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------|
| Wimpy...anything but collecting money! "I should have been a dancer." | The little train that could... "I think I can, I think I can..." | Calm, cool, & collected. How do I do it? I'm simply amazing... | Overanxious. A little too hyper...your pits are sweaty... | Pushy. Bleeding from the mouth...frankly, you're a little scary... |
|-----------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------|

(Be honest, the first step to recovery is admitting that you may have a problem.)

### Collection Matrix

| Bills   | Calls | Payment History | Dialogues                                                                                        | Outcomes                                                 |
|---------|-------|-----------------|--------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 30 days | 40    | Cat. 1 (good)   | "We can take care of the whole bill right now. I'll 'hold' while you get your card or checkbook. | Credit, debit, check card, check by phone                |
| 60      | 70    | Cat. 2 (slow)   | "How much more time will you need to take of your balance?"                                      | Payment Plan- Patient needs more time.                   |
| 90      | 100   | Cat. 3 (poopy)  | "...then you will not be paying your bill?"                                                      | Not paying; Verify personal information. SS#, Bank Info. |

Recommendations;

- Be yourself you're not a professional collector, stop pretending.
- Think of your job as a 'Patient Finance Counselor'.
- Think of collecting money as a game to play.
- Go for "How much and by when".

**Slow Payer with a (\$?) balance & 70 days aged:**

**Patient says...**

**Patient Finance Counselor**

|                                                  |                                                                                                                                                                                          |
|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Money is really tight right now.</p>          | <p>It sounds like you need more time to take care of your bill.</p>                                                                                                                      |
| <p>Maybe 3 months.</p>                           | <p>How much more time will you need to take care of your balance of ____.</p>                                                                                                            |
| <p>I have insurance; I don't owe anything.</p>   | <p>If I can give your 4 months would that help you out?</p>                                                                                                                              |
| <p>I don't have it, call me next month.</p>      | <p>Let me explain Easy Pay...</p>                                                                                                                                                        |
| <p>I don't have it, call me next month.</p>      | <p>I understand; but your insurance has cleared and there is a balance. Are you <b>willing</b> to take care of it?</p>                                                                   |
| <p>I don't have it, call me next month.</p>      | <p>What's happening? Is it that you simply <b>need more time</b>? I know you want to do the right thing. Are you willing to discuss it?</p>                                              |
| <p>I could send you \$5.</p>                     | <p>Ok. Let's see if we can work out an amount that would work for you and us? Are you <b>willing</b> to try?</p>                                                                         |
| <p>I have to talk to my spouse.</p>              | <p>No problem. Let me ask you; <b>how much more time do you think you'll need to take care of your entire bill?</b></p>                                                                  |
| <p>I'm not really sure how much time I need.</p> | <p>I know you may not know exactly, but when you look what do you see? 2months, 3 or more?</p>                                                                                           |
| <p>I've lost my job. We have no income.</p>      | <p>I'm so sorry. I hope you get on your feet soon. For my records, could you <b>please send me a note (financial statement) that says you are out of work and are unable to pay?</b></p> |

## **Billing & Collection Legal Highlights; True or false?**

T/F

|    |                                                                                               |
|----|-----------------------------------------------------------------------------------------------|
| 1  | <i>A patient that is not satisfied with services is not required to pay the bill.</i>         |
| 2  | <i>A divorce decree can assign responsibility for the children's medical bills.</i>           |
| 3  | <i>You can not call a patient after 8pm.</i>                                                  |
| 4  | <i>You are required to treat chronically ill patients.</i>                                    |
| 5  | <i>You must accept "token" monthly payment amounts such as \$5.</i>                           |
| 6  | <i>You can not call patients at work</i>                                                      |
| 7  | <i>Post-dated checks are illegal.</i>                                                         |
| 8  | <i>You must notify patients before turning a past due account over to a collection agency</i> |
| 9  | <i>You can not charge interest on Medical Bills.</i>                                          |
| 10 | <i>The only person you can speak to regarding a medical bill is the patient.</i>              |
| 11 | <i>If a patient owes you money, you can withhold healthcare records from another doctor</i>   |
| 12 | <i>It is illegal for you to sue on a health care debt.</i>                                    |

## **Co-Pay/Cash Balance Scripts**

Phone Scripts-New Patients with non-contracted insurance plans;

**“The minimum you can expect to pay on the first visit is \_\_\_\_\_. How will you take care of that?”**

Patients new or established with minimum payments due at time of service;

**“What is your co-payment? How do you think you will take care of that when you come in, cash, check or charge?”**

If the patient asks why you need this information now, you say;

**“Legally, we are required to collect co-pays 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...it’s this dumb computer...”**

After you receive a firm amount, for example, \$25.00 by check, note the payment amount and the method of payment in the schedule and say:

**“Great! I’ll just make a note of that and we will see you on [~Date of Appointment~].”**

### **Office Scripts:**

“The co-payment today is \$\_\_\_\_\_. Are you still planning to write a check as you indicated when you called in?”

If Yes...

**“Just go ahead and make that out now and we can get you going as quickly as possible.”**

**“As you can see we are very busy today. By getting your payment information now I can process your paperwork faster...I’d hate to keep you waiting. If you’re like me when you’re ready to go- you’re ready to go!”**

If the patient says no, or they give an excuse like, “no one told me” or “can you just bill me”...

**“I see that when you called to make your appointment you told \_\_\_\_\_ 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 your checkbook?”**

If yes, the ask;

**“That’s not a problem; you can use cash or if you like credit or check card...which one works best for you today?”**

You've now determined the patient has come unprepared to pay. They will probably ask you to bill them or give you some other lame excuse. And now...your moment of truth...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 uniformly. 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 notify your insurer and they could drop you as a subscriber. We certainly don’t want that, do we?”**

- If a patient asks doctor for special payment arrangement, try this;

**"I'm sorry Mrs. Jones, my responsibility to you, my patient, is to dedicate all my efforts toward your good health. So, I made a deal with my office manager. I handle the medical decisions and she handles the financial arrangements. If I start talking to patients about payments, she gets to start doing surgeries...we wouldn't want that, would we?!"**

**"See our office manager before you leave; she's an expert when it comes to financial matters. She'll be more than happy to go over all the options with you. Thanks. (Now run along, bye, bye now)"**

~~~

“We have found your office procedures book to be our 'bible' and turn to it often for answers to questions as they arise. We also depend on this book for the **training of new employees, as well as for the helpful forms and sample documents which are provided.”**

Cheryl Bryant, Business Manager, New Visions Group, Inc., Austin Texas

Co-Pay Compliance Letter

Dear Patient:

We are required to collect co-payments each and every visit. It is considered fraud for us to collect from some patients and not from others. Please be advised that should you choose not to pay your co-payments for any reason we could notify your insurance insurer, and in turn, **they may drop you as a subscriber.**

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 now offer "Quick-Pay." We simply maintain your credit, debit, or check card on file to capture any co-pays, deductibles or charges not covered by you insurance plan.

Please ask [~Financial Counselor Name~] our Patient Finance Counselor about "Quick-Pay." Of course, you may prefer to use check or cash. However, if you come unprepared to make your co-payment, we must reschedule your appointment.

Thank you for your cooperation.

Insurance Check Remittance

Dear Patient,

We have received notification from your insurer that you are in possession of a check in the amount of [____]. In light of the fact that you have authorized this office to receive assignment from your insurer, we ask that you forward that payment to us immediately.

If we do not receive a response within 7 days, we will be forced to report that amount to the Internal Revenue Service. IRS code states that such payments are considered income and must be reported on federal returns.

We provided service in good faith and ask that you respond in kind.

[~Closing Text~]

Enclose verification of social security number and IRS form 1099

ADA/M Discount

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