COOPERATIVE OF
AMERICAN PHYSICIANS

THE PHYSICIAN'S ACTION GUIDE TO SMARTER BILLING

How to Get Paid Faster and More Fairly

Private practices are now among the largest unsecured creditors in the country.[1]

More than 11 percent of all patient debt is written off as bad debt.[2]

Your practice can do better, and this guide can show you how.

---

[1]*Best Practices to Improve Patient Payments*. 2017. ADP/Advancedmd.com

[2]https://www.mgma.com/Connexion/2010/Perspective-on-patient-payments-MGMA-Connexion-April-2010.pdf

Table of Contents

Introduction

Nobody goes to medical school because they're passionate about insurance paperwork or the intricacies of medical billing.

Doctors become doctors because they want to help people.

And since the health of your patients depends on the health of your practice, it's vital to get billing right.

A clear, formalized, *smart* billing process in place means you can do the right things for your patients *and* your practice at the same time. The result?

- Less stress for everybody: patients, staff, insurers – and yes, physicians too
- More time to focus on what your patients care about most
- More revenue and more money to invest when the time is right
- More loyalty and more referrals from providing a better patient experience

We encourage you to share this guide with all staff members who play a role in the billing process (and as you'll see in the coming pages, that's virtually everyone!). While some of the information included in this guide may sound obvious, we all know that even the most basic processes and procedures can sometimes be overlooked.

Setting up or improving your billing process will require some work and commitment from you and your staff, but this guide will show how it can be a surprisingly straightforward exercise.

Now is the perfect time to start!

Managing the Front Office

Pre-Registration

New Patients

For some patients, getting to the doctor is difficult. For many, it's stressful. Getting organized before a patient arrives not only provides a better patient experience – it is the first step in making your billing process work smoothly.

When a new patient calls to schedule an appointment with the physician, collect all the information you'll need for billing. It's much easier to do it at the start than to try to figure out later what's missing. Typically, the information you'll need includes:

- Name
- Address
- Birth date
- Reason for visit
- The name of the patient's insurance provider and its phone number
- The name of the primary policy holder and patient's relationship to primary policy holder, if not self
- The patient's policy number and ID number
- The patient's plan type (HMO, PPO, Medicare, etc.)

If there's any other information that insurers or auditors might need, be sure to ask for that information as well.

The more complete you can make the patient's medical files before their first visit, the easier patient check-in (and eventual billing) will be. Some practices use postal mail and email prior to the visit, dedicated patient tablets at check-in, or online tools such as PatientPop or ZocDoc, which let patients set up and manage appointments without talking on the phone. Whatever method you choose to collect patient information, make sure you're fully HIPAA compliant.

All front office staff should have a solid understanding of which insurance plans the practice currently accepts, as well as policies for how out-of-network patients—and patients without any health insurance at all—are managed.

Existing Patients

For existing patients:

- Confirm the patient's insurance information has not changed.
- Verify the patient's eligibility with the insurance carrier.
- Check that your contract with the patient's payer is still in force; if the contract has expired or will expire soon, inform the patient.

Smarter Office Visits

At Check-In

When the patient arrives, front desk staff should:

1. Greet the patient by name, and confirm that all billing and insurance information is up-to-date.
2. Make a copy of the patient's insurance card if there is not already a current copy on file.
3. Settle any unpaid balance from a prior visit. Ask, "How would you like to take care of your balance today?" and offer the payment options you accept, such as check, Visa, Mastercard, etc.
4. Collect any insurance policy copayment. (If the physician is ready to see the patient immediately, this can wait until patient check-out.)
5. Politely remind the patient of any scheduled services that will not be covered by insurance.

Never ask a patient, "Would you like to pay your unpaid balance?" as it suggests that paying is optional. Do role-playing exercises with staff to help them get comfortable with asking for payment in a way that is professional and matter-of-fact.

During the Appointment

Anyone who provides a billable service to the patient, including medical assistants or clinical staff, must document that service for billing. This includes those staff who give injections, administer vaccines, perform diagnostic studies like EKG and Pulmonary Function Testing (PFT), or X-rays, etc.

You can't bill what you don't document, so this is an area where no practice can afford to slip. In today's medical environment, every penny counts. "Minor" charges that go unrecorded will add up and eventually force hard choices.

If services were provided that may be denied for reason of medical necessity, have the patient sign an Advanced Beneficiary Notice or similar disclosure. This will allow you to bill the patient if their insurance denies the claim.

Keep in mind that unlike many commercial plans, Medicare will only accept an Advanced Beneficiary Notice.

At Checkout

When the patient's visit with the clinician (doctor, NP, PA, etc.) ends:

1. The clinician should thank the patient by name, and direct him or her to patient checkout. Every practice should have clearly marked signs that direct patients to the checkout area. If your practice doesn't have these yet, have them made and installed.
2. Staff at the checkout desk should check to see if the patient's copayment and unpaid balance were paid during check-in. If it was not paid, collect it now.
3. If payment wasn't received at check-in or there are additional treatment charges, give the patient a statement showing the current balance due. If the patient is unable to pay their balance onsite, provide him or her with a self-addressed envelope to mail in the payment as soon as the patient arrives home.
4. Thank the patient by name and schedule the next appointment, if needed, before he or she leaves.

Managing the Billing Office

Insurance Billing and Collection

Medical billing and coding is one of the most complicated and time-consuming aspects of practice management, and an area that can have significant financial ramifications if not done properly.

Whether you are doing manual billing or have implemented medical billing/practice management software, close attention to detail is critical to ensure prompt and fair payment from insurers and patients alike.

Preparing the Claim

1. Code all diagnoses and medical procedures performed during the patient's visit using ICD-10 and CPT/HCPCS. Remember to accurately use the appropriate modifiers, when required.
2. Do a 100% compliance audit before transmitting the claim to the insurance company. When your documentation precisely matches what is being billed, claims are far less likely to be denied.

The more you can reduce these errors in advance, the fewer denied claims you will have to manage.

Transmitting the Claim

Claims, whether paper or electronic, are either handled directly (by high-volume insurers like Medicare, Medicaid/Medi-Cal, and/or Anthem Blue Cross), or sent to a clearinghouse. A clearinghouse acts as a liaison between healthcare providers and insurers. The clearinghouse receives claims from the healthcare provider, formats it for the insurance requirements, and submits it to the insurer.

Once the insurer receives the claim, it is adjudicated to determine whether the insurer will pay the entire bill or a portion of the bill, require additional information, or deny the entire claim. The amount insurance pays will be based on the patient's policy and the payer's contract with your practice.

Payment is delivered with an Explanation of Benefits (EOB), Remittance Advance Notice (RAN), or invoice. The patient typically gets a copy of the same notice. Ensure that each payment is in accordance with the contract between the practice and the payer. If the insurer opted not to pay for certain procedures, these unpaid charges should be explained in full on the report.

Every medical practice must interact with a variety of payers every day. So it's smart to build relationships with insurers that are every bit as professional and buttoned-up as the relationships you have with your patients. Good relationships are vital to maintaining trust and mutual respect, both of which will help you smoothly resolve disputes when they arise.

Receiving Payment and Reconciliation

Don't assume the checks you receive from payers are correct and automatically cash them. Often, they aren't.

1. Once payment is received, confirm that all procedures listed on the insurance claim you sent appear on the statement received from the insurer, and match your contracted amounts with that payer.
2. Confirm that the codes included in the payer report are identical to the claim that was submitted.
3. Most payers do not reimburse 100% of the patient's services–it is possible that more than one insurance provider/payer covers the patient. If so, send a claim for the remaining bill to the second payer (and third payer, and so on).

It's important to know your contracts. There may be differences among payers such as: what is paid individually, which services are "bundled", which are paid for with specific diagnoses only, which services have specific time limitations for payment, etc.

If there's a payment discrepancy, you may need to file an appeal. Before you do:

1. Check to be certain that the discrepancy isn't simply a difference. There are sometimes differences among payers in what is paid individually, which services are "bundled", which services are paid for with specific diagnoses only, which services have specific time limitations for payment, and more. Knowing the details of your contracts is key.
2. Remember, the appeal rules and process for each payer can be different.

Make it easy for the payer to understand and expedite payment of your appeal. Clearly state the reason for the appeal, submit the right supporting documentation, and follow the process the payer has outlined. Clear, well-documented appeals will get processed first; appeals that are hard to understand risk being denied—which means you'll have to start all over again.

Trust is a two-way street: every practice should have a compliance plan. Payment discrepancies that are in favor of your practice need to be reported and adjusted every bit as quickly as those that are not in your favor.

> *We know a billing manager at a successful practice who noticed something odd with her billing software. After she updated her computer's operating system, the modifiers that should have been in place for her pathology reports mysteriously disappeared and Medicare was overbilled. The moment she noticed the error, she arranged to pay Medicare every penny that had been overbilled and provided an explanation for the error.*
>
> *Correcting errors and dealing fairly is a legal requirement, but it's more than that. When payers know you are as rigorous about protecting their interests as you are about protecting your own, it builds a trustworthy and positive working relationship.*

Billing Patients

Any balance due that the insurance company will not pay is the responsibility of the patient. Here too, clear, well-documented billing statements will get paid first; unclear statements will result in patient confusion, slow or no payment, and needless re-work for your staff.

Creating Billing Statements Patients Will Pay

1. **Provide a simple account summary.** This should include what the patient has paid and what insurance has paid, with a clearly marked "Balance Due" on the first page.
2. **Design for clarity**. Research shows that bills printed on white paper, using large, easy-to-read black type get paid faster. Use bold type to emphasize items like balance due and payment date.
3. **Be ready to help**. Include clear instructions for how patients can get in touch with the practice if they have billing questions.

Make payment easy. Let patients pay online, in the office, by credit card, or by mail. The more payment options you offer, the better!

Overdue Bills

No matter how easy you make it for patients to pay, there will always be some who do not pay their bills on time. Many billing systems have templated dunning statements that can be printed on patient statements. These statements should be progressively more urgent as the overdue balance ages. For example:

"This amount is now due—please remit promptly."

"Your account is now overdue—please call our office to arrange for immediate payment."

"Your account is in danger of being referred to our collection company—please make immediate arrangements to avoid further action."

It's often effective to include a deadline, such as 10 days.

Consider setting up a "credit card on file" policy to automatically charge overdue amounts to the patient's credit card. If you do this, be sure to find a Payment Card Industry (PCI) and/or HIPAA compliant vendor. You'll also want to ensure that you have a valid authorization on file and that your patients clearly understand that automatic payment is optional.

Collection Agencies

On average, practices send 3.3 statements before receiving payment, and more than 11 percent of all patient debt is written off as bad debt[1].

So when is the right time to refer patient accounts to a collection agency? As a rule of thumb, it is when the practice's cost to collect the debt and the net recovery are less than what would be received from a collection service after deducting applicable fees. At most practices, this is when a payment has aged 120 days or more.

If you must refer your patient's unpaid bills to a collection agency, be sure to notify the patient politely, professionally, but without apology. Recognize that sending a patient to collections is simply the next step in the process.

---

[1]*https://www.mgma.com/Connexion/2010/Perspective-on-patient-payments-MGMA-Connexion-April-2010.pdf*

However, it is not a step that should be done without care or oversight. Instead, **practice staff should provide a list of patients that they believe should be referred to collections, and the physician should make the final decision.** This will help guard against mistakenly referring a professional courtesy patient to collections, or a patient that is potentially litigious.

Selecting the Right Collection Agency

Working with an outside collection agency is part of how you deliver a good patient experience. Choose an agency with a proven track record with other practices in your area, and one that reflects the attitudes and philosophies of your practice.

Some questions to ask when interviewing agencies to ensure they maintain a high standard of ethics and professionalism:

- → *How do company representatives reach out to patients?*
- → *What practices does your agency forbid when seeking collections?*
- → *Can you show us the script your staff use when they call a patient?*
- → *Can you show us an example of an early collection letter?*
- → *How will you report on collections activity to our practice? Can you show us a sample month-end report?*

If a patient calls your practice after being turned over to collections, train your staff to politely refer the patient back to the collection agency. Agencies must reciprocate this trust and responsibility by providing confirmation of all collections activity, and issuing timely month-end reports to the practice.

If your practice is large enough to merit it, consider using more than one collection agency. Comparing their results is a good way to gauge how effective each agency is at collections.

Training, Documentation, and Coding

Training

Most practices only hire certified medical coders, who report to a practice manager who is also certified so he or she can audit the medical coder's work.

To retain their certification, coders do a minimum number of hours of training each year. Still, well-run practices are aware that the minimum training requirement is not enough, and encourage continuous learning. In fact, many practices ask their staff to maintain a log of all the things they're doing to stay up to date—for example, spending a half hour reading the latest Medicare email update, familiarizing themselves with the latest compliance requirements, etc.

When insurers send postcards and other notifications to advise of changes to their policies, make sure those are placed in a single compliance book for future reference.

Improving Staff Performance

Lead by example, and model the behavior you want your staff to emulate.

Listen carefully, be engaged, and be open to constructive feedback.

Hire carefully, and invest in training.

Ensure you are hiring the right people, for the right positions, with the right job descriptions.

Insist on courtesy, respect, and privacy for every patient.

Documentation: Be Careful With EHRs

When using Electronic Health Records (EHRs), be careful of issues with cloning and over-documentation.

Cloning (aka 'cut and paste', 'copy and paste', or 'carried forward') – This refers to any documentation that is worded exactly like previous entries. Payers will be suspicious of cloning if records show that:

- Different patients had the exact same problem/symptoms, and required the exact same treatment; or
- The same patient had the exact same problem/situation on multiple visits.

Over-documentation – This is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher-level services. This practice can often happen innocently. Some EHR software auto-populate fields when using built-in templates, while other systems generate extensive documentation based on clicking a single checkbox. Unedited, it may inaccurately suggest that the practitioner performed more comprehensive services than were actually rendered.

Authorship and documentation in an EHR must be authentic and specific to a particular patient visit. Cloned and over-documented communications are likely to be rejected by most payers, including Medicare.

Common Coding Errors to Avoid

Every practice should try to avoid these common coding problems:

Not Coding to the Highest Level – Every diagnosis and procedure should be coded to the highest level of specificity. This means abstracting the most information out of the medical reports from the provider. This requires knowledge of the medical terminology for both procedures and diagnoses. Coding to a general level (aka 'undercoding') can lead to a rejected or denied claim.

Poor Documentation/Missing Documentation – Providers must thoroughly describe each procedure and/or other service they provide. Providers should not leave any important details of a procedure or service out of the report or documentation of a patient's visit. *Be sure to document all signs and symptoms and associated diagnosis in the medical record.*

Illegible/Incomprehensible Reports – All reports must also make sense and thoroughly describe exactly what was done for the patient on the date of service in question. Make sure notes are legible and clear to others reading them.

Failing to Use Current/Updated Code Sets – The three principal medical code sets (ICD, CPT, and HCPCS) are updated annually and should be purchased by your practice. This expense should be accepted as part of the cost of doing business to help ensure claims will not be rejected for invalid code usage. The cost of rejected claims far outweighs the cost of purchasing code updates. Staff members should review the coding changes annually, and review all templates and commonly used codes periodically to ensure everything is up to date.

Undercoding or Overcoding – Undercoding is the purposeful reporting of less expensive medical services than were performed, while overcoding is the reporting of more expensive procedures or services than were performed. Both undercoding and overcoding are considered fraud and can lead to audits and investigation. Physician leaders must be wary of overzealous coding, as the consequences can be severe.

Unbundling – Unbundling means separately coding procedures that would normally be included under one umbrella code. Unbundling is closely related to overcoding, in that it involves false reporting designed to earn the provider a higher payout from a payer.

Unbundling and the Correct Coding Initiative (CCI)

The Correct Coding Initiative (CCI) was developed by The Centers for Medicare & Medicaid Services (CMS) to promote correct coding of healthcare services by providers for Medicare beneficiaries, and to prevent Medicare payments for improperly coded services. CCI consists of automated edits provided to Medicare contractors to evaluate claim submissions when a provider bills more than one service for the same Medicare beneficiary on the same date of service (unbundling). CCI identifies pairs of services that, under Medicare coding/payment policy, a physician ordinarily should not bill for the same patient on the same day.

Edits are updated quarterly and can be found on the CMS website:
www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Many commercial health plans have adopted CMS policies and the CCI as their preferred editing program, while other plans have developed their own bundling policies and use other editing programs for claim submission. Staff should be aware of what editing programs each of their health plan partners use when adjudicating claims.

HIPAA and Medical Billing

The billing process must be compliant with requirements set by the Health Insurance Portability and Accountability Act (HIPAA). The passage of HIPAA established a set of regulations and guidelines for the electronic transmission of healthcare data, and set up guidelines for the code sets used in medical billing and coding, such as ICD and CPT.

The goal of Administrative Simplification was to establish a regular and uniform method of communication for any entity involved in healthcare, such as insurance payers, providers, clearinghouses, and government agencies. All bodies covered by HIPAA (this includes most providers and payers, including Medicare and Medicaid/Medi-Cal) must adhere to these standards of transactions.

Title II of HIPAA also established the mandatory use of National Provider Identifier (NPI) numbers. These numbers are thus far 10 characters long and are never reused. Each healthcare provider has a Type 1 NPI number, and organizations have a Type 2 NPI number. Any one organization may have as many NPI numbers as needed, while individual healthcare providers each have only one Type 1 number. Type 1 NPI numbers are used to identify the "rendering/performing or ordering" provider, while Type 2 NPI numbers are used to identify the "pay to" provider.

In addition to establishing the above regulations and rules, Title II of HIPPA also outlines a number of offenses related to healthcare, and prescribes civil and criminal punishments for these fraudulent offenses.

If a practice wishes to establish policies for courtesy adjustments, such as financial hardship or professional courtesy, these adjustments should be realistically established and spelled out in a written policy that is available for all staff members and patients to see. The policy should be administered universally throughout the practice by all providers and monitored closely by practice administration.

The following are tips to help ensure your billing is HIPAA compliant to protect your practice and expedite payment:

- Establish the practice fee schedule fairly and realistically.
- Keep practice courtesy adjustments to a minimum.
- Ensure all staff members clearly understand the difference between Type 1 and Type 2 NPI numbers and know how to use them correctly for requesting referrals, ordering studies, and generating health insurance claims.
- Avoid medical coding errors.
- Ensure that staff understand the importance of diligent, detail-oriented coding and that all work is double-checked before being sent to payers.
- Communication between provider and biller should happen frequently and immediately when questions arise.
- Make sure that all ICD-10, CPT, and other HCPCS codes are up to date in your practice management system and coding manuals to allow the appropriate reporting of all services and diagnosis on claims.

A Final Thought

Increasing deductibles, copayments, and co-insurance have significantly increased the patient's direct financial responsibility for physician services. As a result, both patient liability and bad debt are on the rise in healthcare.

Now, more than ever, it is important for the physician leader to lead by example. Your staff members take their cues from you: what you ask questions about and show interest in is what they will prioritize.

Meet at least once a quarter with both front- and back-office, and billing staff. Ask what billing challenges they have faced, and what steps they are taking to resolve them. Ask for suggestions about how to improve the process, from first contact with the patient to final billing. Ask what training is needed, and make sure your employees get it. And finally, don't forget to share this guide with your staff, as the information provided will be of value to all.

The health of your patients and the financial future of your staff rely on the financial health of your practice. Building and maintaining healthy billing habits will help ensure a long, happy life for your practice.

Billing Checklist

Pre-Registration

- ☐ Do you have a solid understanding of which insurance plans the practice currently accepts, as well as policies for how out-of-network patients—and patients without any health insurance—are managed?
- ☐ Have you collected all pertinent information you'll need from a new patient for billing?
- ☐ Did you check with your current patient to make sure his or her insurance information has not changed?
- ☐ Did you confirm with the insurance company that the patient's contract is still in force?

Smarter Office Visits

At Check-In

- ☐ Did you greet the patient by name?
- ☐ Have you confirmed that all billing and insurance information is still up to date?
- ☐ Did you make a copy of the patient's current insurance card if there is not already one on file?
- ☐ Did you collect the patient's insurance copayment, if applicable?
- ☐ Have you relayed to the patient any services that will not be covered by insurance?
- ☐ Has the patient signed an Advanced Beneficiary Notice or similar disclosure for services that may be denied for reason of medical necessity?

During the Appointment

- ☐ Are clinical staff members documenting every billable service they provide to your patients?

At Checkout

- ☐ Does every staff member in the practice know how to direct patients to patient checkout?

- ☐ Are there clearly marked signs to direct patients to checkout?
- ☐ Did you check to see if the patient's copayment was paid during check-in, and collect it, if not?
- ☐ Have you given the patient a receipt showing their current balance, and have you asked that the balance be paid in full?

Insurance Billing and Collection

- ☐ Have you coded all diagnoses and medical procedures performed during the patient's visit?
- ☐ Have you conducted a 100% compliance audit before transmitting the claim to the insurance company?
- ☐ Have you checked that all procedures listed on the insurance claim you sent appear on the statement received from the insurance company, and match your contracted amounts with that payer?
- ☐ Have you confirmed that all codes included in the payer report are identical to the submitted claim?
- ☐ Have you sent claims to the second and third payer, etc., if the payer didn't reimburse for the entire bill?
- ☐ Do all billing staff know how to manage payment discrepancies?
- ☐ Is everyone up to date on the appeal rules and processes for all major payers?
- ☐ Are your appeals clear and well-documented?

Billing Patients

- ☐ Does your billing statement include a simple, clearly designed account summary, with a clearly marked balance-due on the first page?
- ☐ Have you provided clear instructions for how patients can get in touch with your practice with billing questions?
- ☐ Do you offer a number of payment options, including online, in person, by credit card, etc.?
- ☐ Have you engaged a collection agency to pursue payments that are seriously overdue?
- ☐ Have you done your due diligence to make sure your selected collection agency is the right fit for your practice to help ensure a positive patient experience?

About CAP

Physician-owned and physician-directed, the Cooperative of American Physicians, Inc. (CAP) provides superior medical professional liability coverage and a wide range of value-added services to more than 12,000 of California's finest physicians.

We are pleased to provide you with this guide as part of our efforts to support physicians like you with resources that address important front- and back-office issues. We hope you have found it useful.

To download other valuable free practice management resources, visit our website at **www.CAPphysicians.com/practice-management-guides**.

For more information about CAP, or to get a no-obligation quote on medical malpractice protection, please call **800-356-5672** or email **MD@CAPphysicians.com**.

When you join CAP, in addition to superior coverage, you automatically receive:

- 24/7 Risk Management Hotline
- Group Disability and Group Life Insurance
- Group Purchasing Program
- Human Resources Support
- Cyber Risk Liability Protection
- And much more!

Special Thanks

CAP would like to express its appreciation to June McKernan, COO of Patient Preferred Dermatology Medical Group, Inc. and Mary Jean Sage, CMA-AC of The Sage Associates for their valuable contributions and expert review of this important guide.

Published December 2018

COOPERATIVE OF
AMERICAN PHYSICIANS

333 S. HOPE ST., 8TH FLOOR, LOS ANGELES, CA 90071 | 800-252-7706 | www.CAPphysicians.com

SAN DIEGO | ORANGE | LOS ANGELES | PALO ALTO | SACRAMENTO