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Little Things That Make You More Money

by **Robert E. Goff**

Secrets to a long happy marriage

A old woman was sipping on a glass of wine, while sitting on the patio with her husband, and she says, "I love you so much, I don't know how I could ever live without you"... Her husband asks, "Is that you, or the wine talking?"... She replies, "It's me... talking to the wine."

Official Disclaimers

The information presented is for general information only and are not meant to substitute for legal advice. Always seek the advice of an attorney on legal matters.

The presenter makes any recommendation as to an individual physician's participation or non-participation with any specific health plans, insurance company or payer. Each physician is urged to give due and proper consideration to their own individual practice needs and act independently regardless of the actions or non-action of other physicians.

Legal Guidance

Little things That Can Maximize Your Income Is About Maximizing Receiving What You Have Earned

5-15% lost	• Uncollected patient responsibilities • Virtual Credit Cards
5-10% Lost	• Under coding caused by the chilling effect of coding challenges
5-15% Lost	• 50% of rejections not resubmitted
3-7% Lost	• 50% of denials not appealed (70% of appealed successful)
6% Lost	• Payments less than fee schedule not identified or challenged
Finding Money You Did Not Know Was Missing	• Escheatment

Why Now More Than Ever Does Revenue Leakage Matter

The “Average” Physician Carries an “overhead of 60% Many carry more

A $1 lost in revenue must be replaced by billed and collected services of $1.60

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Top 10 rules of claim payment

1) Just because it has a code, does not mean it's covered
2) Just because it's covered, does not mean you can bill for it
3) Just because you can bill for it, does not mean you will be paid for it
4) Just because you have been paid for it, does not mean you get to keep the money
5) Just because one health plan paid you, does not mean you will get paid by another
6) Just because you have been paid for it once, does not mean you will be paid for it again
7) Just because you got paid for it in one state, does not mean you will get paid in this one
8) You will never know all the rules
9) Not knowing the rules can cost you big
10) The rules are subject to change without notice

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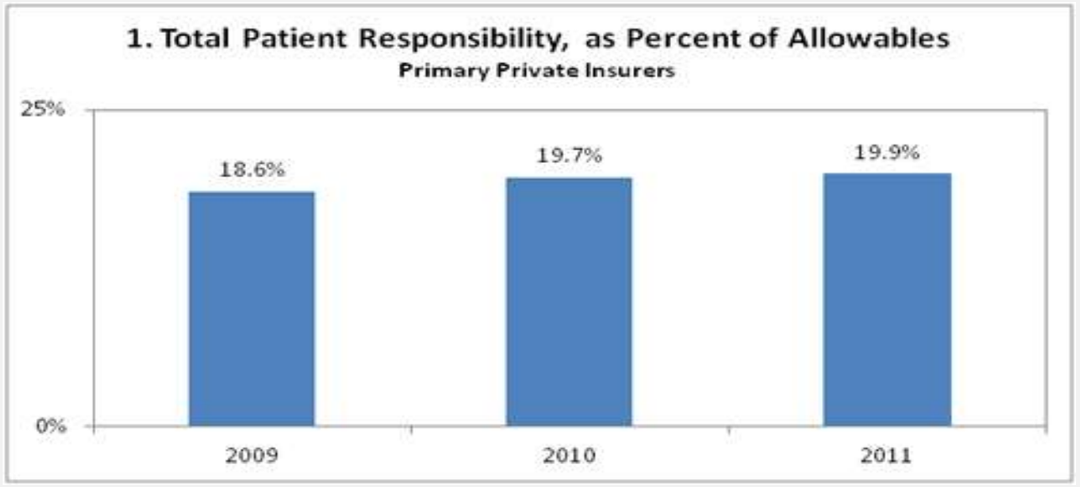
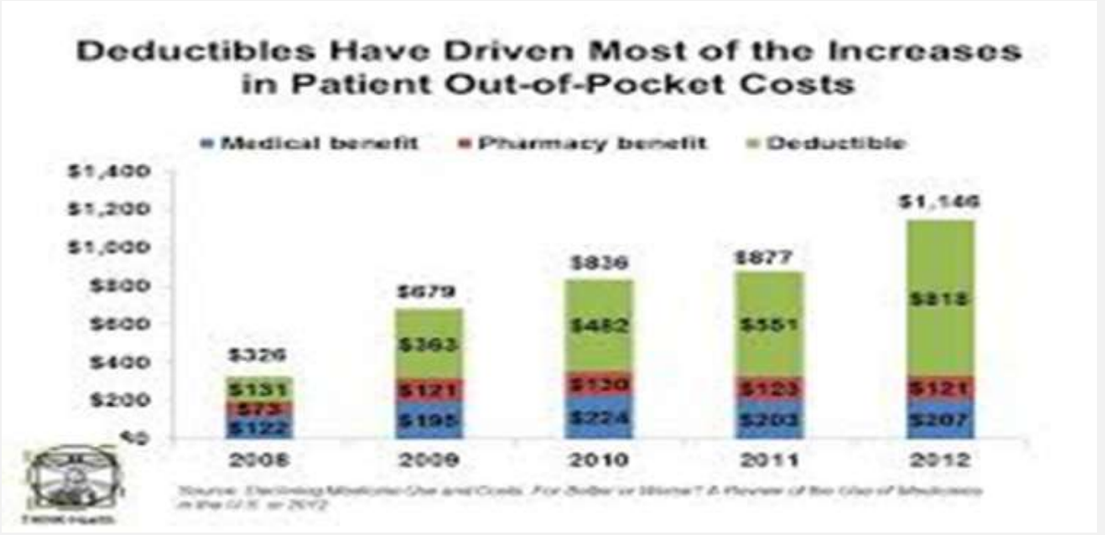
By 2015 30% Of Medical Costs Are Expected To Become The Responsibility Of The Patient

60% of commercial plans nationally carry a high deductible ($1,000 - $3000)

The most popular products of the HIX are expected to carry large deductibles





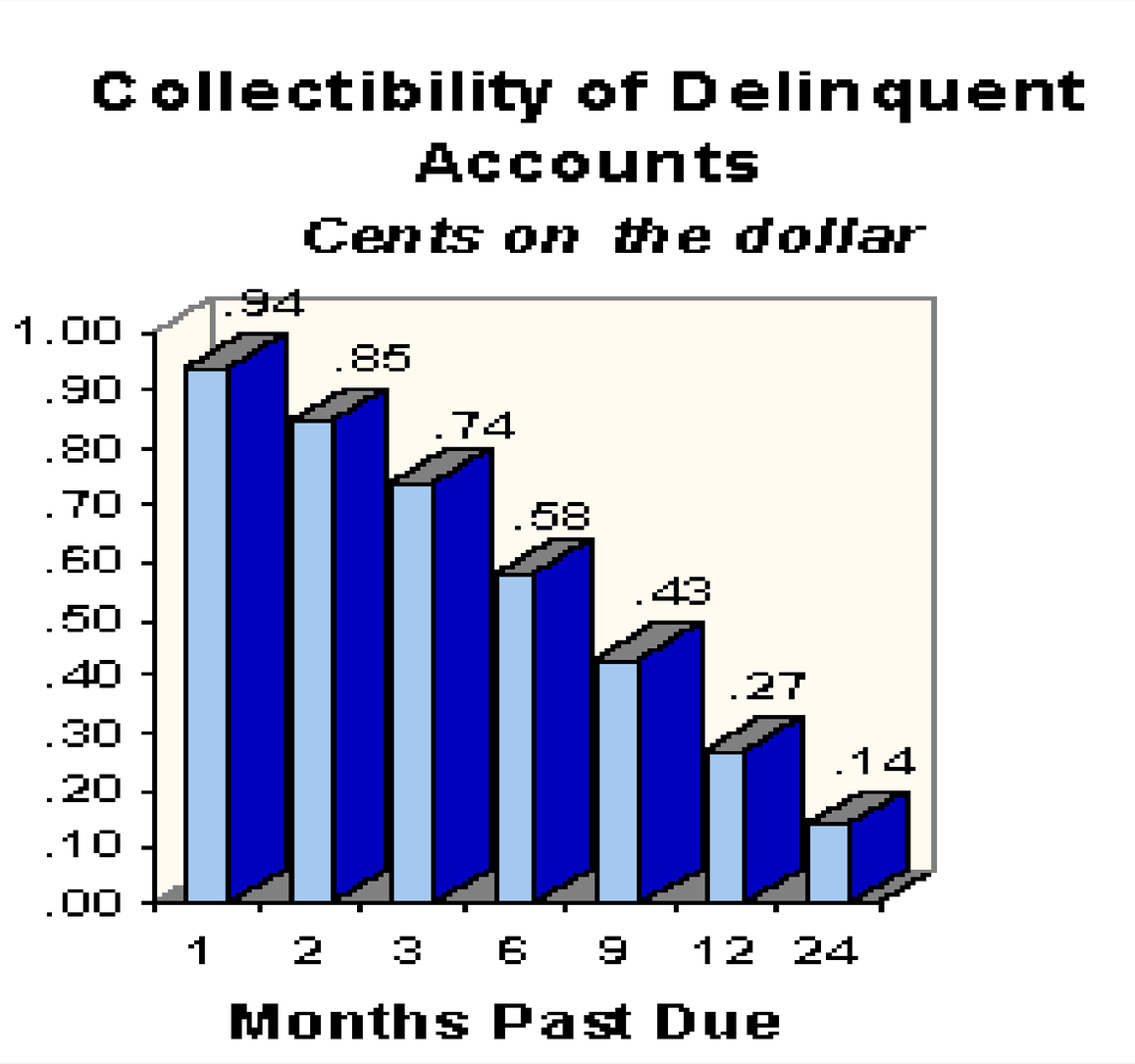
Increasing Patient Responsibility Cost You

80% of self-pay accounts are never paid in full

50% of patient financial responsibilities become bad debts

31% of physicians say they lose revenue due to uncollected patient responsibilities

The ability to collect the full amount of patient financial responsibility drops to less than 20 percent after the patient has left the physician's office.



Require Contingent Credit Card Authorizations

Require Credit Cards as a guarantee

Well, not a perfect guarantee, but the increased likelihood of being compensated

But as near perfect as you can get, other than requiring a cash deposit

Contingent Credit Cards Also Protect Against

Inaccurate eligibility verification
Inaccurate benefits verification

Promised payments under HSA that never materialize

Copays higher than represented

Deductibles higher, or not fully satis[illegible]ices

Plans always use weasel words

If you look at any eligibility confirmations, you will find that eligibility and benefit confirmations are not guarantees of coverage or benefits

If the payer won't guarantee, why should you be at risk?

Take Credit Cards For Patient Responsibilities – Not Plan Responsibilities

Virtual Credit cards

Payments from plans

Unless your participation agreement provides for payment my VCC – you can decline (Refuse)

Aetna Signature Administrators

Virtual Credit cards

Payment from patients

Even if you take credit cards, no you want to take VCC from patients?

InstaMed® - United

Do EFT – Electronic Funds transfer

Aetna – EFT or VCC

Problems with Accuracy of Health Plan Member Data

17% of Americans change address per year

25% of returned mail concerns accounts recievable

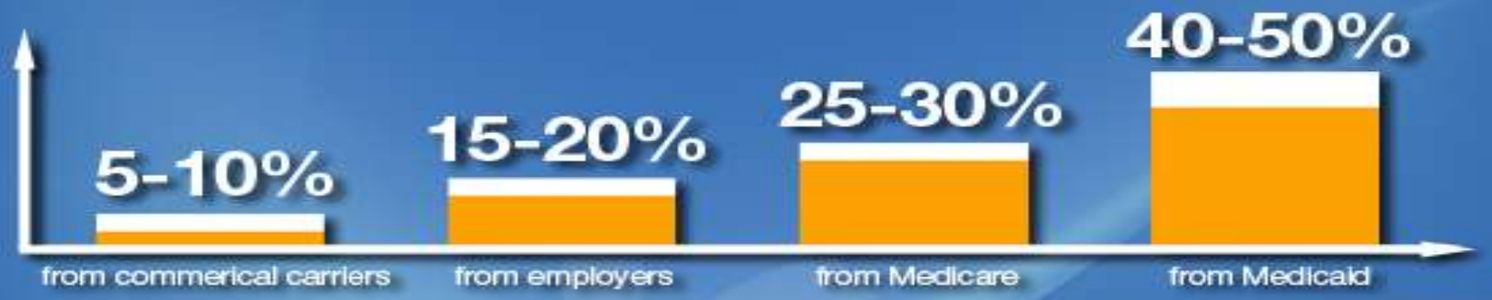
33% of movers fail to notify the Post Office

69.9% of mail is delivered as addressed

3 million name changes/year due to marriage, divorce, different names

40 million address changes per year

Incorrect individual contact information is reported at a rate of:



Source: "Better Health Care Delivery: The Importance of Data Accuracy" LexisNexis-AHIP Webinar August 2014

mcol

Don’t Overpay for Merchant Services

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Hold Payers To NYS Prompt Pay

Don’t lose to the payer’s lagging processing

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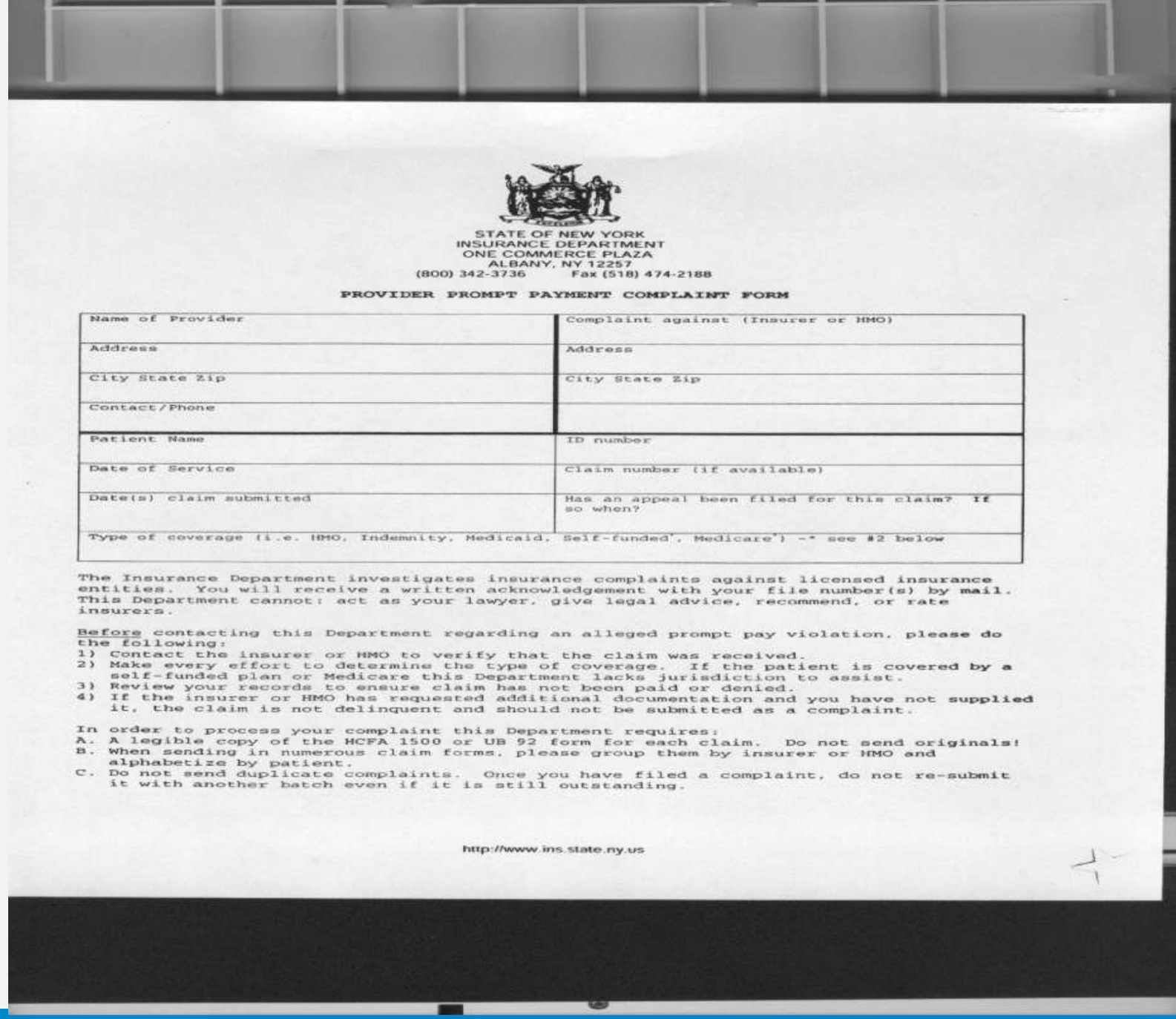
Use the Physician's Powerful and Not so Secret Weapon

Part 3224-a
The New York State Prompt Payment Regulations
These regulations must become YOUR rules in dealing with payers

- Claims must be paid in 45 days from the date received
  - As of January 1, 2010 – if you file claims electronically, you must be paid in 30 days
- The plan has 30 days from the date received to challenge you for more information or to question their obligation to pay
  - If they don't - 12% interest per year (but payment has to be greater than $2)
  - Potential fines and penalties by NYS DOI $200 a day to NYS if they don't respond in 10 days, and finds up to $50,000 for repeat offenders

Prompt Pay Complaints can now be filed on-line



STATE OF NEW YORK
INSURANCE DEPARTMENT
ONE COMMERCE PLAZA
ALBANY, NY 12257
(800) 342-3736 Fax (518) 474-2188

PROVIDER PROMPT PAYMENT COMPLAINT FORM

Name of Provider	Complaint against (Insurer or HMO)
Address	Address
City State Zip	City State Zip
Contact/Phone	
Patient Name	ID number
Date of Service	Claim number (if available)
Date(s) claim submitted	Has an appeal been filed for this claim? If so when?
Type of coverage (i.e. HMO, Indemnity, Medicaid, Self-funded', Medicare') -* see #2 below	

The Insurance Department investigates insurance complaints against licensed insurance entities. You will receive a written acknowledgement with your file number(s) by mail. This Department cannot: act as your lawyer, give legal advice, recommend, or rate insurers.

Before contacting this Department regarding an alleged prompt pay violation, please do the following:
1) Contact the insurer or HMO to verify that the claim was received.
2) Make every effort to determine the type of coverage. If the patient is covered by a self-funded plan or Medicare this Department lacks jurisdiction to assist.
3) Review your records to ensure claim has not been paid or denied.
4) If the insurer or HMO has requested additional documentation and you have not supplied it, the claim is not delinquent and should not be submitted as a complaint.

In order to process your complaint this Department requires:
A. A legible copy of the HCFA 1500 or UB 92 form for each claim. Do not send originals!
B. When sending in numerous claim forms, please group them by insurer or HMO and alphabetize by patient.
C. Do not send duplicate complaints. Once you have filed a complaint, do not re-submit it with another batch even if it is still outstanding.

http://www.ins.state.ny.us

New York State
Insurance Department

ISSUED: 10/18/2000 **FOR IMMEDIATE RELEASE**

DEPARTMENT LEVIES FINES AGAINST 21 HEALTH INSURERS AND HMOS
FOR VIOLATING PROMPT PAY LAW
Companies Paid Fines Totaling $575,000

Superintendent of Insurance Neil D. Levin today announced that the Department has once again levied fines against 21 health insurers and HMOs totaling $575,000 for violations of the state's Prompt Pay Law.

The fines paid in this, the fifth round of the prompt pay fines, exceed the total fines paid in all of the previous four rounds. This is in keeping with the warning given by Superintendent Levin to the industry earlier this year. In an earlier press release and Circular Letter number 6, both issued on January 27, 2000, Superintendent Levin advised that the Insurance Department would be intensifying its investigation of prompt pay violations and seeking tougher penalties for the insurers and HMOs that have repeatedly violated the statute.

"We are sending out the message loud and clear to insurers and HMOs in New York State and putting them on notice that failing to pay claims promptly will result in disciplinary action," said Levin. "Patients and health care providers deserve to be paid in a timely fashion and we will use all of our enforcement tools to ensure that insurers and HMOs fulfill this basic obligation to their customers."

The Prompt Pay Law, signed by Governor Pataki in September 1997, requires HMOs and insurers to pay undisputed claims within 45 days of receipt. Too often, consumers and health care providers experience unnecessary delays on their claims.

The current fines by company are:

HMO/Insurer	**Amount of Fine**
CIGNA Healthcare of NY, Inc	$ 15,000.00
Connecticut General Life Ins. Co.	$ 1,700.00
Empire BC BS of Grtr NY	$ 16,000.00
Excellus Health Plan, Inc.	$ 2,750.00
Group Health, Inc. (GHI)	$ 29,850.00
The Guardian Life Ins. Co. of America	$ 1,200.00
Healthcare Plan, Inc. (Univera)	$ 2,750.00
Healthfirst	$ 1,000.00
Healthnow New York, Inc.	$ 28,500.00
Healthsource of New York/New Jersey	$ 1,000.00
Health Insurance Plan of Grtr New York (HIP)	$ 37,000.00
Independent Health Association, Inc	$ 6,500.00
MDNY Healthcare, Inc.	$ 5,000.00
Metropolitan Life Insurance Co.	$ 18,000.00
NYLCare Health Plans of New York	$ 12,750.00
Oxford	$215,000.00
Physicians Health Services of New York, Inc.	$ 5,500.00
Prudential Healthcare Plan of New York, Inc.	$ 18,000.00
United Healthcare of New York, Inc.	$ 7,000.00
U.S. Healthcare, Inc.	$116,000.00
Vytra Health Services, Inc.	$ 34,500.00
Total	**$575,000.00**

Once Received a Claim is…

Paid
Challenged – more information requested
Lost in space – see prior slide
Rejected
Denied

Do you know what denials/rejections can be recovered using which approach?

Resubmission
Appeal

I've got claims that have been rejected more than those guys on "The Bachelorette"

No 1 Reason for rejection

An error in the patient name
and/or address

Top 10 Reasons Rejections or Denials

1. Incorrect or missing patient demographics
2. Incorrect or missing ICD-9 diagnoses
3. Incorrect of missing CPT-4 modifiers
4. Incorrect or missing CPT-4 procedure code
5. Physician Identification missing
6. Incorrect or missing place of service code
7. Missing or incorrect number of units of service
8. Claim submitted to the wrong address
9. Duplicate claim
10. Additional information needed to process the claim

Denials

- Another opportunity to get paid
- 70-80% recoverable
- Never accept a denial without a challenge
- A lost appeal is learning opportunity
- Most denials are recoverable by simply correcting errors and resubmitting

Denials

- **Reason code (Claims Adjustment Reason Code)**: why a claim or service line was paid differently than it was billed
- **Remark code**: used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a CARC

List at www.wpc-edi.com/content/view/695/1

Denial Prevention

Current focus on denial management…

Can you prevent the denial?

Get it right the first time!

If you have to touch the claim, it delays cash flow and costs you money - $14.92!*

*The Physician Billing Process by Walker Keegan, Woodcock and Larch, 2008

Denial Management

- Appeal
  - Review the payer's own website for relevant policies
  - Develop standard statement from the physician
  - Attach supporting medical literature, policy statements from the specialty society, copies of the CPT book
  - Refer to Medicare coverage determinations… even from another state!
  - Request the appeal to be reviewed by an expert in the sub-specialty

Avoiding Denials

Lack of documentation of permission

- No referral
  - Set some policy
- No preauthorization
  - Get some knowledge

Lack of eligibility

- Ineligibility for coverage/Policy not in effect
  - Trust but verify
  - A role for credit cards
- An other insurer is primary
  - Understand the basics of COB
  - Procedures
  - New Technology

Appeal – Monitor - Get Help

Send appeal in within 30 days of the date of the denial

Send a NYS DOI Complaint at 50 days

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Knowing Coding Can Increase Your Income

No knowing it can get you into trouble

When it comes to coding & documentation

“Like frogs in boiling water,
physicians don’t feel the heat
until they are cooked”

The Chilling Effect Of Coding Challenges

5%-10% Lost

Audit by AAPC (AM Academy of Professional Coders) – 37% of records were under coded, extrapolated to loss of $64,000 per physician.

The average physician is under coding to the loss of $25,000 to $45,000 a year.

Severity of illness is under reported by a factor of 20%

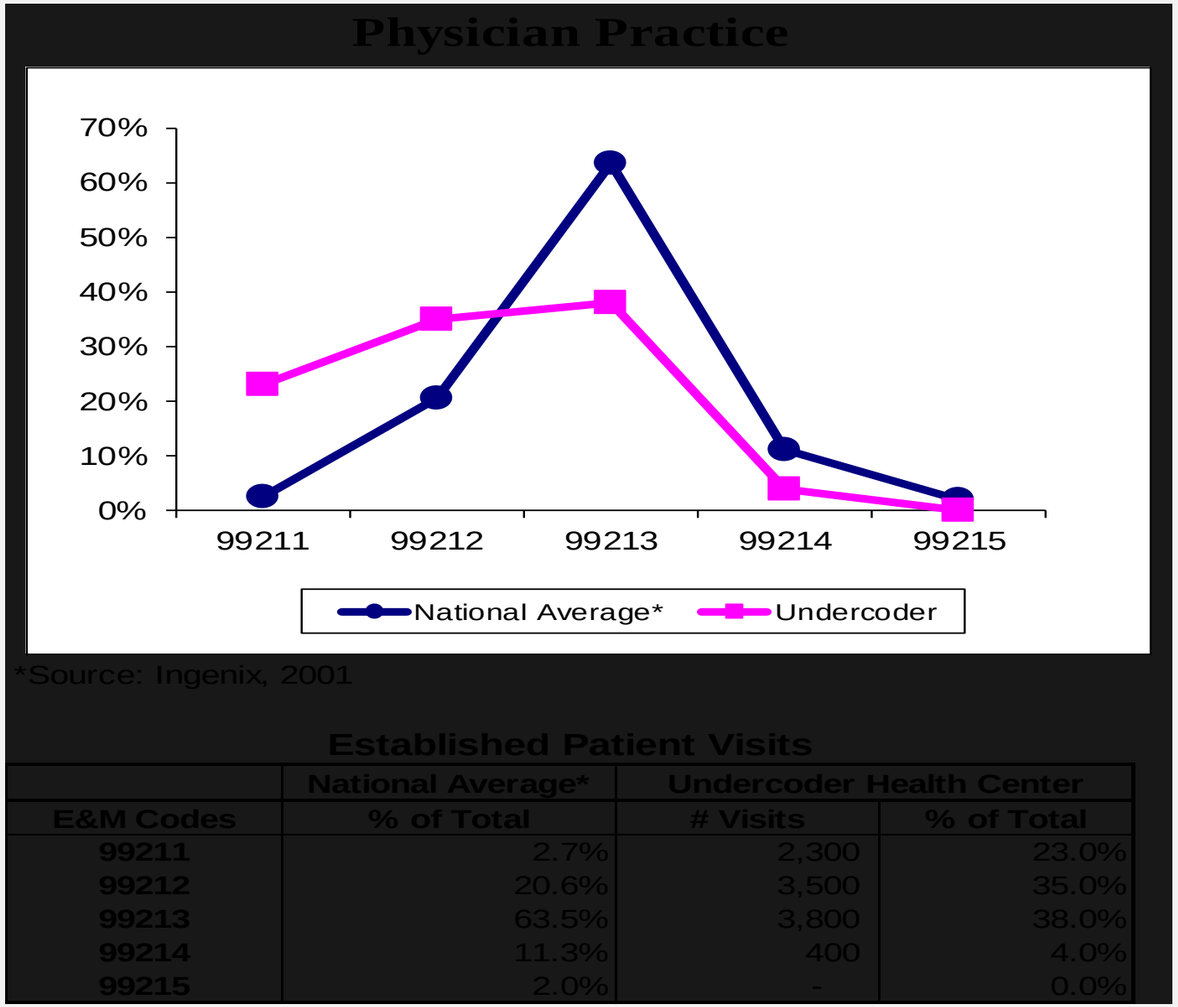
Learn how to document and code

Understand and fully use all applicable ICD codes

Code checker technology is an aide not a replacement for physician decision making

Compare your coding pattern with your specialty

How Can You Recognize Improper Coding?



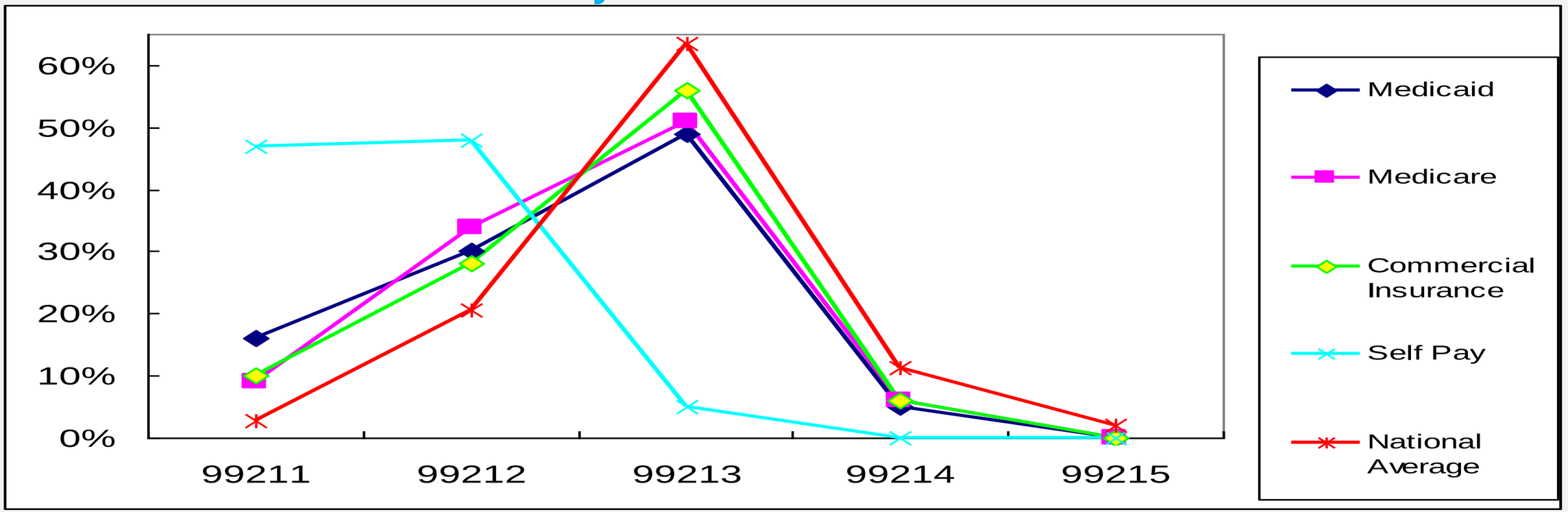
*Source: Ingenix, 2001

Established Patient Visits

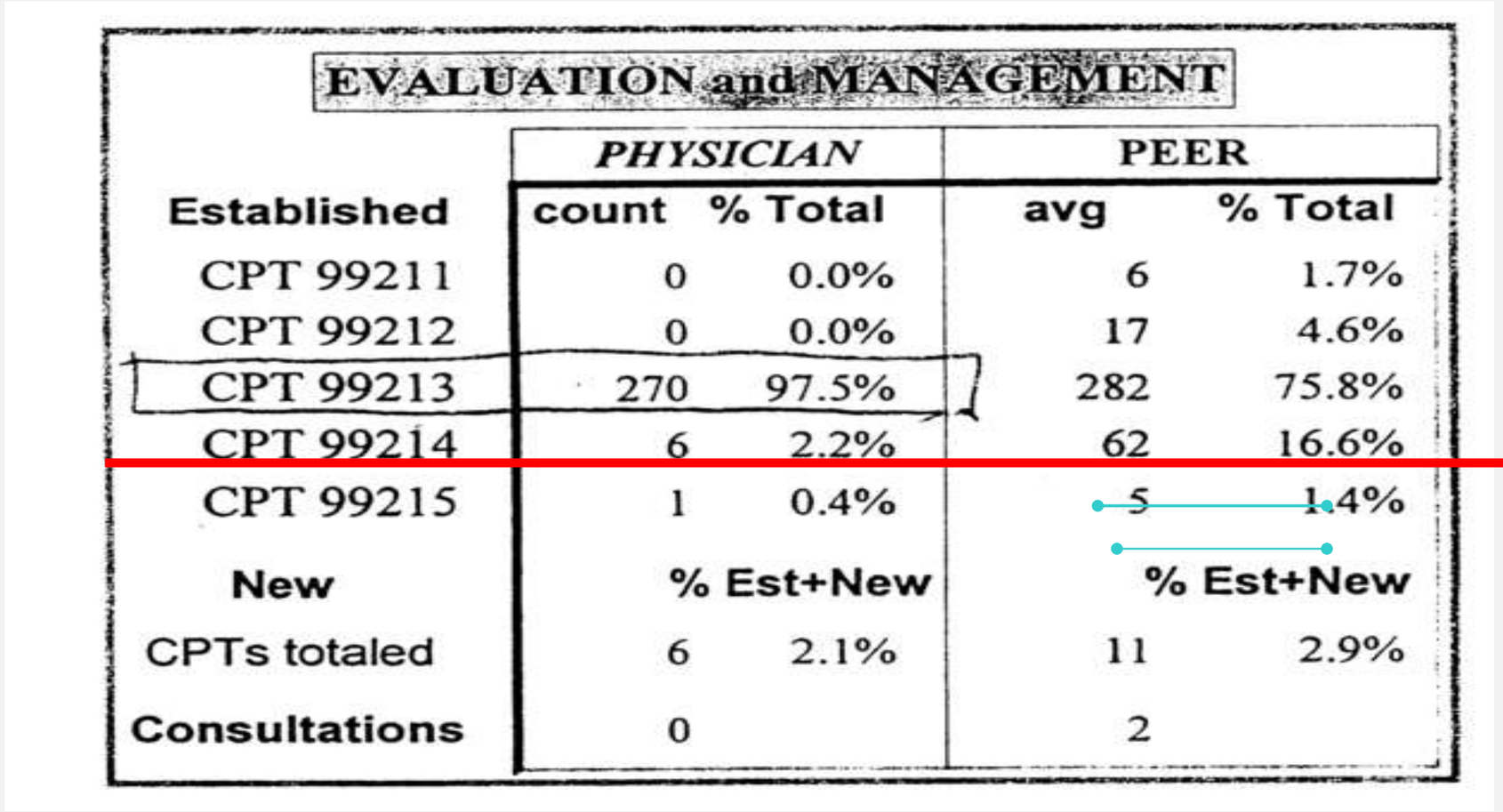
	National Average*	Undercoder Health Center	
E&M Codes	% of Total	# Visits	% of Total
99211	2.7%	2,300	23.0%
99212	20.6%	3,500	35.0%
99213	63.5%	3,800	38.0%
99214	11.3%	400	4.0%
99215	2.0%	-	0.0%

How Can You Recognize Improper Coding?

When we add payer-based coding information, the differences may become even clearer:



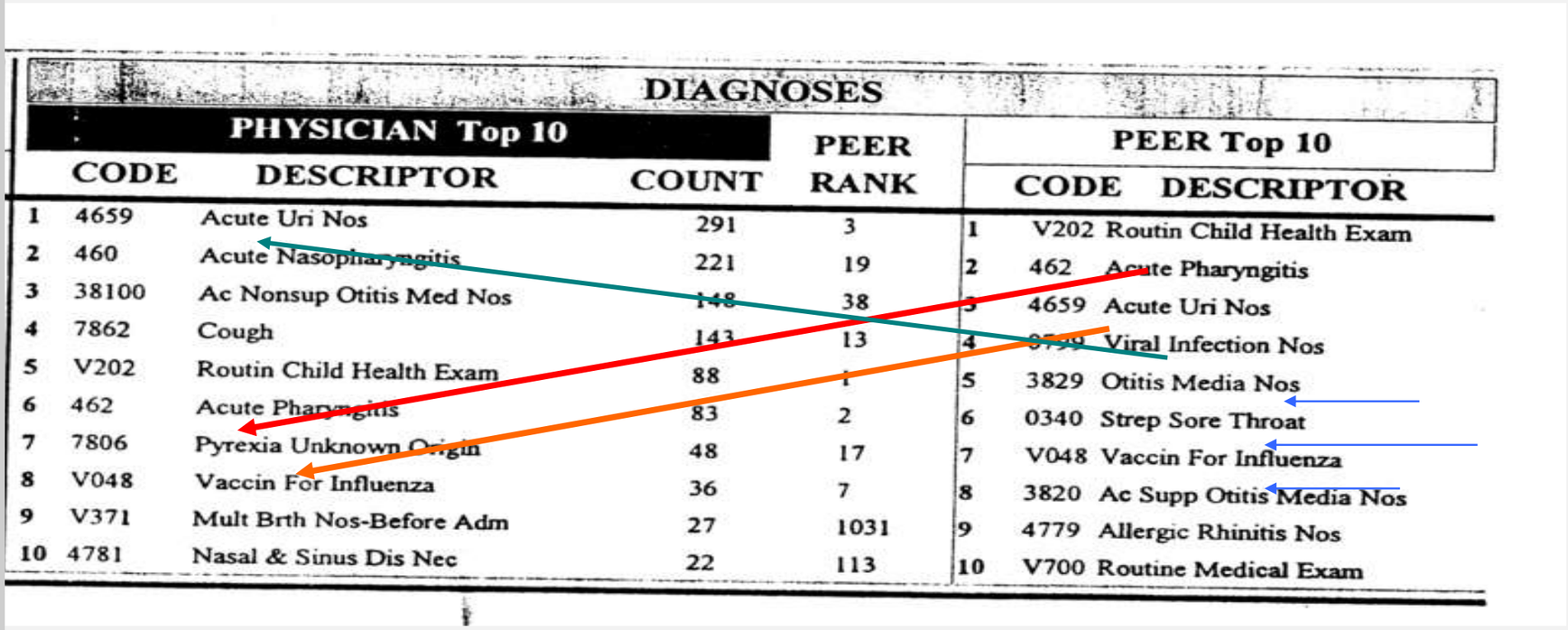
Missing Revenue



EVALUATION and MANAGEMENT

	PHYSICIAN		PEER	
Established	**count**	**% Total**	**avg**	**% Total**
CPT 99211	0	0.0%	6	1.7%
CPT 99212	0	0.0%	17	4.6%
CPT 99213	270	97.5%	282	75.8%
CPT 99214	6	2.2%	62	16.6%
CPT 99215	1	0.4%	5	1.4%
New		**% Est+New**		**% Est+New**
CPTs totaled	6	2.1%	11	2.9%
Consultations	0		2	

Variation from Peers of Dx



DIAGNOSES

	PHYSICIAN Top 10 CODE	DESCRIPTOR	COUNT	PEER RANK	PEER Top 10 CODE	DESCRIPTOR
1	4659	Acute Uri Nos	291	3	V202	Routin Child Health Exam
2	460	Acute Nasopharyngitis	221	19	462	Acute Pharyngitis
3	38100	Ac Nonsup Otitis Med Nos	148	38	4659	Acute Uri Nos
4	7862	Cough	143	13	[illegible]	Viral Infection Nos
5	V202	Routin Child Health Exam	88	1	3829	Otitis Media Nos
6	462	Acute Pharyngitis	83	2	0340	Strep Sore Throat
7	7806	Pyrexia Unknown Origin	48	17	V048	Vaccin For Influenza
8	V048	Vaccin For Influenza	36	7	3820	Ac Supp Otitis Media Nos
9	V371	Mult Brth Nos-Before Adm	27	1031	4779	Allergic Rhinitis Nos
10	4781	Nasal & Sinus Dis Nec	22	113	V700	Routine Medical Exam

Mis-coding can mean more than restitution to a plan

- A federal judge sentenced a corporation headed by prominent dermatologist N G to five years' probation yesterday for overbilling Plan more than $178,000 for acne procedures.
- U.S. District Judge J. M Seabright also ordered NG, M.D. to pay a $316,642 fine and $39,720 in restitution. In a plea agreement with federal prosecutors last year, G pleaded guilty on behalf of the corporation to billing Plan for about 20,000 acne surgeries when Plan members received less expensive cryotherapy procedures.
- His lawyer B H said the overbilling was the result of G's office staff using the wrong billing code. G pleaded guilty because he did not properly supervise the staff to use the proper code

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Wrong coding can cost you even more

A sad but true tale - Patients with Oxford were complaining to the billing company about being billed for a copay for well-woman visits, when the benefit plan requires no such copay.
The billing company response, “you own the co-pay, $15, we checked with Oxford, and you are responsible”

Ignoring this patient’s complaint, besides being bad for customer relationships, can cost the practice big.

Why was there a copy to begin with?
The practice was billing the well-woman visits as 99214, rather than 99396.
The difference – being paid $69 vs. $109
Leaving $40 on the table for each visit.

Moral of the story– learn from patient complaints, don’t be quick to dismiss them, and find a billing company that will help you , not hurt you.
For this group of 5 OB/GYN – the estimated hit was in excess of $40,000 annually

Money on the margin

If you get paid 100% of billed – you may be leaving money on the table

Plans pay the LOWER of the amount billed or the allowable fee

If you don’t fill in the dollar amount on the claim, you will be paid -0-

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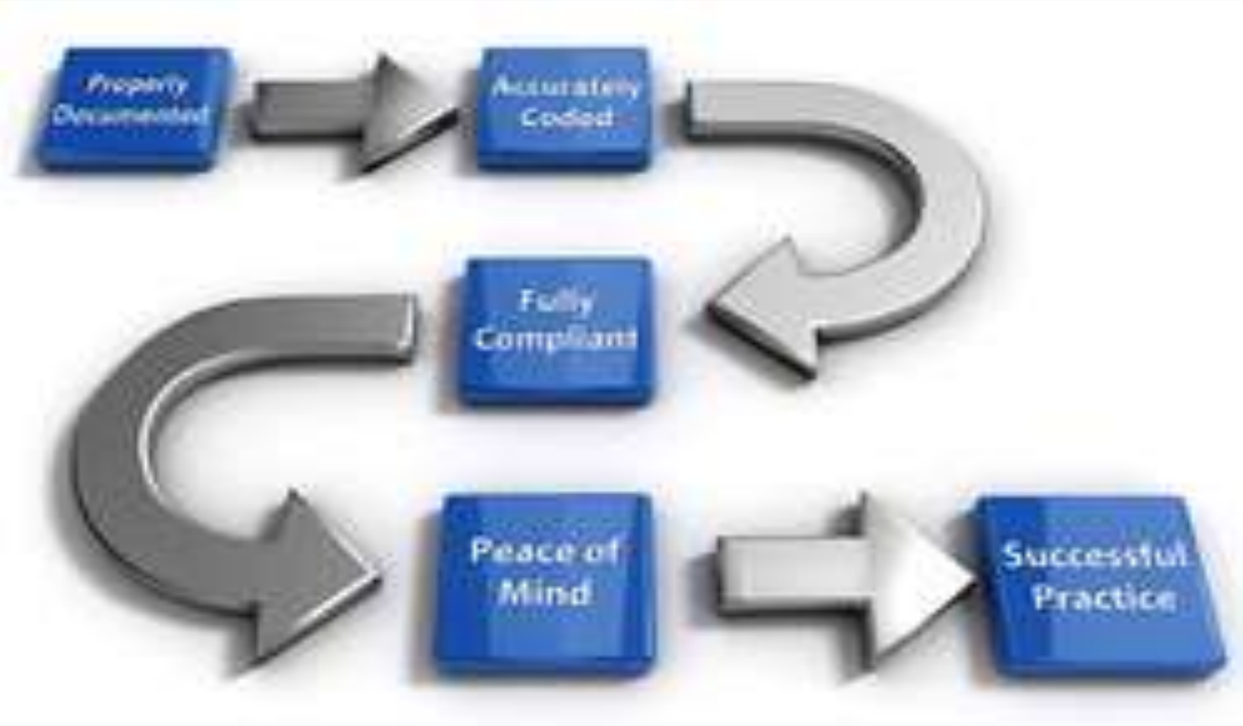
Now You Have Been Paid Your Done – Right? Wrong

6% of claim dollars are lost to payments less than the allowable



Audit your payments

Build a comparison chart

Use an automated tool - RightRemit™

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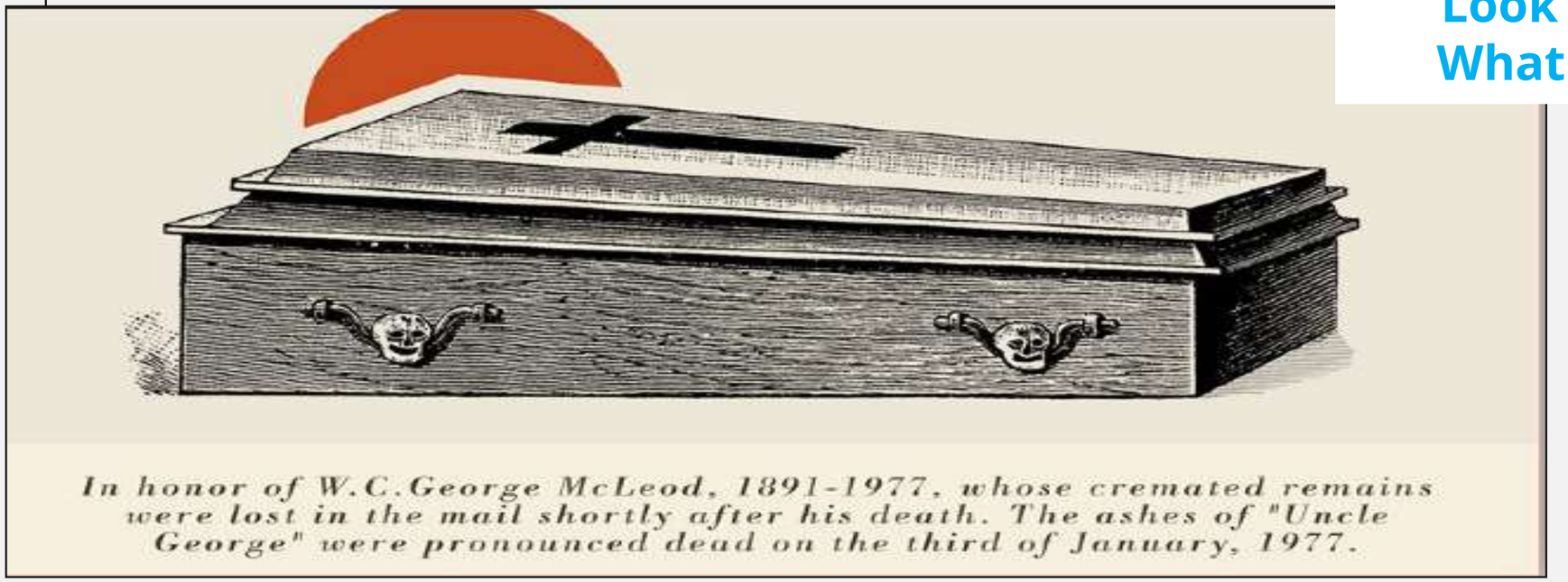
What becomes of the un-cashed check?

What becomes of the returned check

If you don’t know its missing
do expect the payer to tell you?

Look pal, we lose a *lot* of mail
What makes yours so special?



In honor of W.C.George McLeod, 1891-1977, whose cremated remains were lost in the mail shortly after his death. The ashes of "Uncle George" were pronounced dead on the third of January, 1977.

More Money on the Margin

The Joanna J Technique

- Annually go to the NYS Office of the Comptroller, Unclaimed Funds web site
- www.osc.state.ny.us
- Give them the social security number of the physicians, and the Tax ID. Ask them to search to un-cashed checks, refunds, or other funds they may have that have been turned over to the State as abandoned property.

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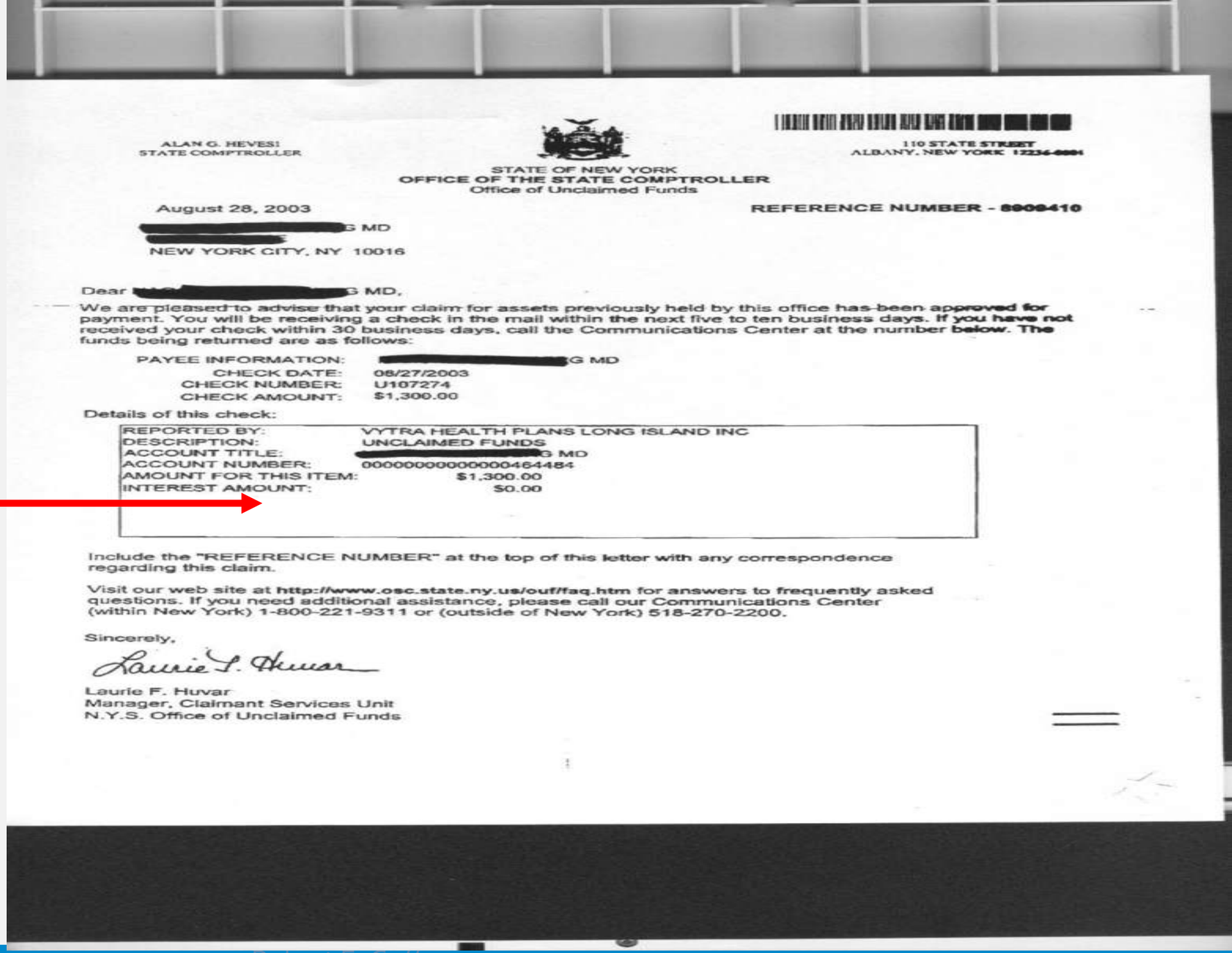
Found Money!

Nice to find, but how did the office write-off these funds?



ALAN G. HEVESI
STATE COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236-0001

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER
Office of Unclaimed Funds

August 28, 2003

REFERENCE NUMBER - 8900410

[redacted] MD
NEW YORK CITY, NY 10016

Dear [redacted] MD,

We are pleased to advise that your claim for assets previously held by this office has been approved for payment. You will be receiving a check in the mail within the next five to ten business days. If you have not received your check within 30 business days, call the Communications Center at the number below. The funds being returned are as follows:

PAYEE INFORMATION:	[redacted] MD
CHECK DATE:	08/27/2003
CHECK NUMBER:	U107274
CHECK AMOUNT:	$1,300.00

Details of this check:

REPORTED BY:	VYTRA HEALTH PLANS LONG ISLAND INC
DESCRIPTION:	UNCLAIMED FUNDS
ACCOUNT TITLE:	[redacted] MD
ACCOUNT NUMBER:	00000000000000464484
AMOUNT FOR THIS ITEM:	$1,300.00
INTEREST AMOUNT:	$0.00

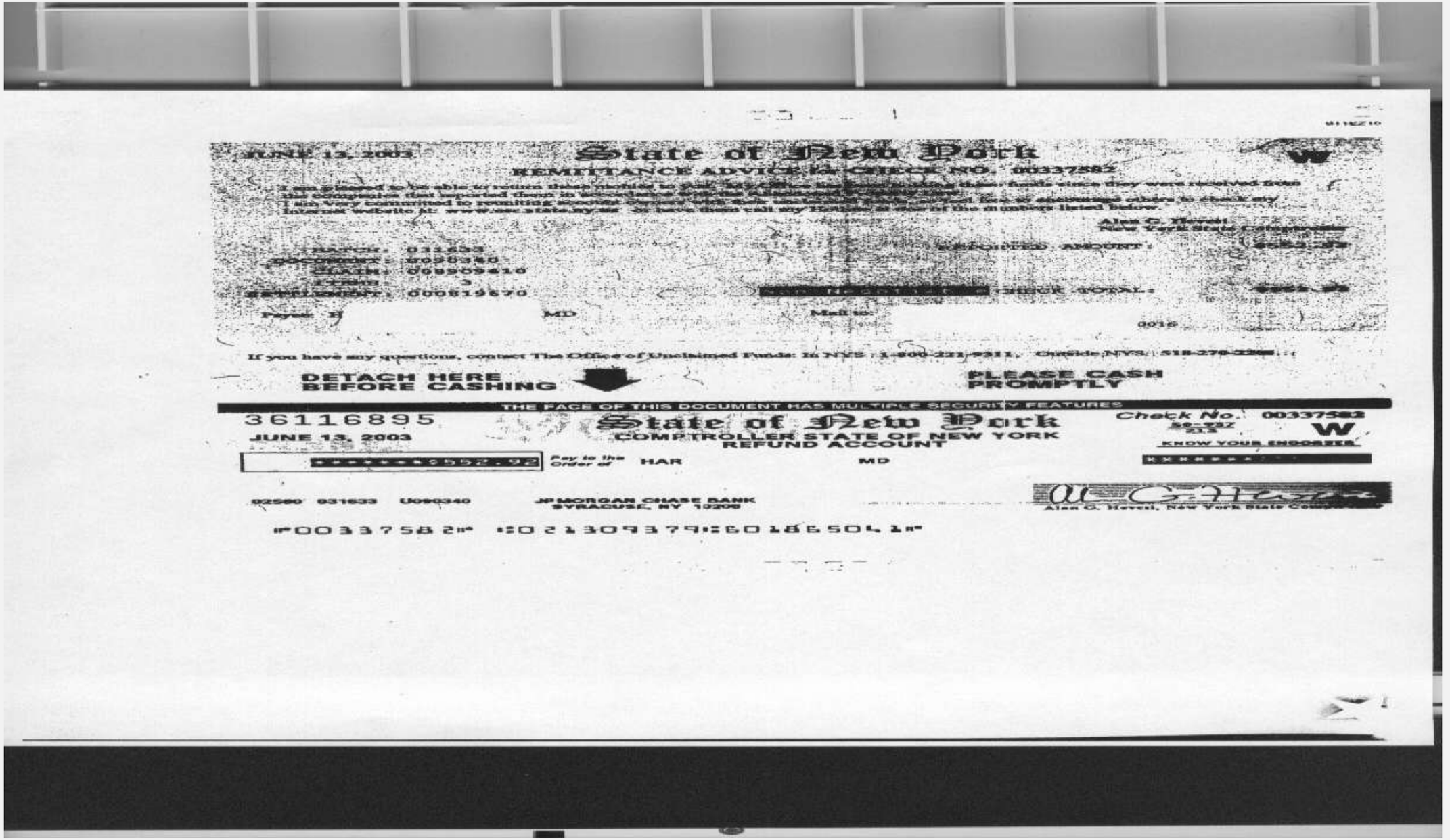
Include the "REFERENCE NUMBER" at the top of this letter with any correspondence regarding this claim.

Visit our web site at http://www.osc.state.ny.us/ouf/faq.htm for answers to frequently asked questions. If you need additional assistance, please call our Communications Center (within New York) 1-800-221-9311 or (outside of New York) 518-270-2200.

Sincerely,

Laurie F. Huvar

Laurie F. Huvar
Manager, Claimant Services Unit
N.Y.S. Office of Unclaimed Funds



JUNE 13, 2003

State of New York

REMITTANCE ADVICE & CHECK NO. 00337582

If you have any questions, contact The Office of Unclaimed Funds: In NYS 1-800-221-9311, Outside NYS 518-270-

DETACH HERE BEFORE CASHING

PLEASE CASH PROMPTLY

THE FACE OF THIS DOCUMENT HAS MULTIPLE SECURITY FEATURES

36116895

State of New York

JUNE 13, 2003

COMPTROLLER STATE OF NEW YORK
REFUND ACCOUNT

Check No. 00337582

KNOW YOUR ENDORSER

Pay to the Order of HAR MD

02580 031633 U090340

JP MORGAN CHASE BANK
SYRACUSE, NY 13208

Alan G. Hevesi, New York State Comptroller

OUTSTANDING UN-CASHED CHECKS
4-20-11

	New York State	NY City
United	50,242	5,767
Empire BC/BS	88,082	26,159
GHI	89,312	12,661
Aetna	29,479	8,612

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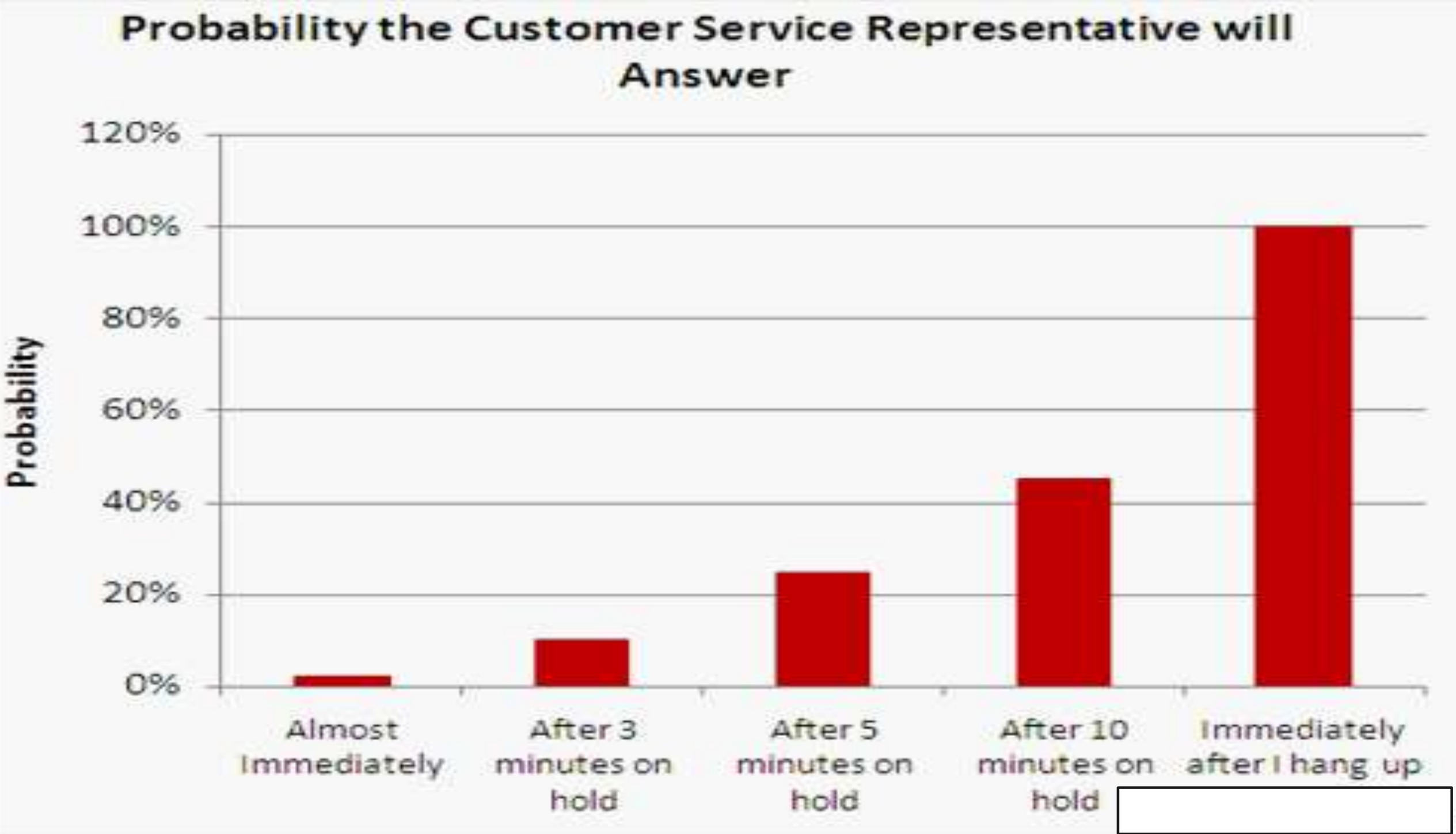
What important lesson can be learned from found money?

- Recovering money from escheatment means a failure in your accounts receivable management
  - How did this money get by your practice?
  - Who wrote it off?
  - What happened that these funds were lost?


Probability the Customer Service Representative will Answer
120%
100%
80%
60%
40%
20%
0%
Probability
Almost Immediately
After 3 minutes on hold
After 5 minutes on hold
After 10 minutes on hold
Immediately after I hang up

BILLER'S PRAYER

DEAR LORD:

PLEASE LET ME FINISH THIS CLAIM BEFORE THEY CHANGE THE RULES

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Thank You

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