Little Things That Make You More Money

by Robert E. Goff
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**
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## Little things That Can Maximize Your Income Is About Maximizing Receiving What You Have Earned

<table>
<thead>
<tr>
<th>Percentage Lost</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-15% lost</td>
<td>Uncollected patient responsibilities</td>
</tr>
<tr>
<td></td>
<td>Virtual Credit Cards</td>
</tr>
<tr>
<td>5-10% Lost</td>
<td>Under coding caused by the chilling effect of coding challenges</td>
</tr>
<tr>
<td>5-15% Lost</td>
<td>50% of rejections not resubmitted</td>
</tr>
<tr>
<td>3-7% Lost</td>
<td>50% of denials not appealed (70% of appealed successful)</td>
</tr>
<tr>
<td>6% Lost</td>
<td>Payments less than fee schedule not identified or challenged</td>
</tr>
<tr>
<td>Finding Money You Did Not Know Was Missing</td>
<td>Escheatment</td>
</tr>
</tbody>
</table>
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
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
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 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 satisfied before services

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**

<table>
<thead>
<tr>
<th>Virtual Credit cards</th>
<th>Virtual Credit cards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments from plans</td>
<td>Payment from patients</td>
</tr>
</tbody>
</table>

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 receivable
- 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:
- 5-10% from commercial carriers
- 15-20% from employers
- 25-30% from Medicare
- 40-50% from Medicaid

Source: “Better Health Care Delivery: The Importance of Data Accuracy” LexisNexis-AHIP Webinar August 2014
Don’t Overpay for Merchant Services
Hold Payers To NYS Prompt Pay

Don’t lose to the payer’s lagging processing
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.
New York State
Insurance Department

DEPARTMENT LEVIES FINES AGAINST 21 HEALTH INSURERS AND HMOs
FOR VIOLATING PROMPT PAY LAW
Companies Paid Fines Totaling $75,000

ISSUED: 10/18/2000
FOR IMMEDIATE RELEASE

Superintendent of Insurance Ned D. Lewin today announced that the Department has once again levied fines against 21 health insurers and HMOs totaling $75,000 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 Lewin to the industry earlier this year. In an earlier press release and Circular Letter number 6, both issued on January 27, 2000, Superintendent Lewin advised the Insurance Department would be initiating an 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 Lewin. “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 their basic obligations 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:

<table>
<thead>
<tr>
<th>HMO/Insurer</th>
<th>Amount of Fine</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIGNA Healthcare of NY, Inc</td>
<td>$15,000.00</td>
</tr>
<tr>
<td>Connecticut General Life Inc Co.</td>
<td>$1,700.00</td>
</tr>
<tr>
<td>Empire BCBS of Gen NY</td>
<td>$16,000.00</td>
</tr>
<tr>
<td>Enthra Health Plan, Inc.</td>
<td>$2,750.00</td>
</tr>
<tr>
<td>Group Health, Inc. (CHI)</td>
<td>$29,850.00</td>
</tr>
<tr>
<td>The Guardian Life Ins. Co. of America</td>
<td>$1,200.00</td>
</tr>
<tr>
<td>Healthcare Plan, Inc. (Vassa)</td>
<td>$2,750.00</td>
</tr>
<tr>
<td>Healthfirst</td>
<td>$1,800.00</td>
</tr>
<tr>
<td>Healthcare New York, Inc.</td>
<td>$28,200.00</td>
</tr>
<tr>
<td>Healthsource of New York/New Jersey</td>
<td>$1,600.00</td>
</tr>
<tr>
<td>Health Insurance Plan of Gen New York (HIP)</td>
<td>$37,000.00</td>
</tr>
<tr>
<td>Independent Health Association, Inc</td>
<td>$6,300.00</td>
</tr>
<tr>
<td>MHNZ Healthcare, Inc.</td>
<td>$5,000.00</td>
</tr>
<tr>
<td>Metropolitan Life Insurance Co.</td>
<td>$18,000.00</td>
</tr>
<tr>
<td>NYLICare Health Plans of New York</td>
<td>$12,750.00</td>
</tr>
<tr>
<td>Oxford</td>
<td>$215,000.00</td>
</tr>
<tr>
<td>Physicians Health Services of New York, Inc</td>
<td>$5,500.00</td>
</tr>
<tr>
<td>Provident HealthCare Plan of New York, Inc</td>
<td>$18,000.00</td>
</tr>
<tr>
<td>United Healthcare of New York, Inc</td>
<td>$7,800.00</td>
</tr>
<tr>
<td>U.S. Healthcare, Inc.</td>
<td>$116,000.00</td>
</tr>
<tr>
<td>Vytra Health Services, Inc.</td>
<td>$34,500.00</td>
</tr>
<tr>
<td>Total</td>
<td>$75,000.00</td>
</tr>
</tbody>
</table>
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!*

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
Send appeal in within 30 days of the date of the denial
Send a NYS DOI Complaint at 50 days
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

![RAC]
Recovery Audit Contractors to perform Manual Medical Reviews
ARE YOU PREPARED?
How Can You Recognize Improper Coding?

<table>
<thead>
<tr>
<th>E&amp;M Codes</th>
<th>National Average*</th>
<th>Undercoder Health Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>2.7%</td>
<td>2,300 22.0%</td>
</tr>
<tr>
<td>99212</td>
<td>20.6%</td>
<td>3,500 35.0%</td>
</tr>
<tr>
<td>99213</td>
<td>63.5%</td>
<td>3,800 38.0%</td>
</tr>
<tr>
<td>99214</td>
<td>11.3%</td>
<td>400  4.0%</td>
</tr>
<tr>
<td>99215</td>
<td>2.0%</td>
<td>0  0.0%</td>
</tr>
</tbody>
</table>

Source: Ingenix, 2001

Established Patient Visits

[Graph showing comparison between National Average and Undercoder Health Center for different E&M Codes]
How Can You Recognize Improper Coding?

When we add payer-based coding information, the differences may become even clearer:
<table>
<thead>
<tr>
<th>Established</th>
<th>PHYSICIAN</th>
<th>PEER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>count</td>
<td>avg</td>
</tr>
<tr>
<td>CPT 99211</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>CPT 99212</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td><strong>CPT 99213</strong></td>
<td><strong>270</strong></td>
<td><strong>282</strong></td>
</tr>
<tr>
<td>CPT 99214</td>
<td>6</td>
<td>62</td>
</tr>
<tr>
<td>CPT 99215</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>New</strong></td>
<td>% Est+New</td>
<td>% Est+New</td>
</tr>
<tr>
<td>CPTs totaled</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Consultations</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
Variation from Peers of Dx

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTOR</th>
<th>COUNT</th>
<th>PEER RANK</th>
<th>CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acute Uri Nos</td>
<td>291</td>
<td>3</td>
<td>1</td>
<td>Routin Child Health Exam</td>
</tr>
<tr>
<td>2</td>
<td>Acute Nasopharyngitis</td>
<td>221</td>
<td>19</td>
<td>2</td>
<td>Acute Pharyngitis</td>
</tr>
<tr>
<td>3</td>
<td>Ac Nonsup Otitis Med Nos</td>
<td>148</td>
<td>38</td>
<td>3</td>
<td>Acute Uri Nos</td>
</tr>
<tr>
<td>4</td>
<td>Cough</td>
<td>147</td>
<td>13</td>
<td>4</td>
<td>Viral Infection Nos</td>
</tr>
<tr>
<td>5</td>
<td>Routin Child Health Exam</td>
<td>88</td>
<td>1</td>
<td>5</td>
<td>Otitis Media Nos</td>
</tr>
<tr>
<td>6</td>
<td>Acute Pharyngitis</td>
<td>83</td>
<td>2</td>
<td>6</td>
<td>Strep Sore Throat</td>
</tr>
<tr>
<td>7</td>
<td>Pyrexia Unknown Origin</td>
<td>48</td>
<td>17</td>
<td>7</td>
<td>Vaccin For Influenza</td>
</tr>
<tr>
<td>8</td>
<td>Vaccin For Influenza</td>
<td>36</td>
<td>7</td>
<td>8</td>
<td>Ac Supp Otitis Media Nos</td>
</tr>
<tr>
<td>9</td>
<td>Mult Birth Nos-Before Adm</td>
<td>27</td>
<td>1031</td>
<td>9</td>
<td>Allergic Rhinitis Nos</td>
</tr>
<tr>
<td>10</td>
<td>Nasal &amp; Sinus Dis Nec</td>
<td>22</td>
<td>113</td>
<td>10</td>
<td>Routine Medical Exam</td>
</tr>
</tbody>
</table>
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.
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-
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™
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?
The Joanna J Technique

- Annually go to the NYS Office of the Comptroller, Unclaimed Funds website

- www.osc.state.ny.us

- Give them the social security number of the physicians, and the Tax ID. Ask them to search for un-cashed checks, refunds, or other funds they may have that have been turned over to the State as abandoned property.
Found Money!

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

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**Found Money!**

**Nice to find, but how did the office write-off these funds?**
# OUTSTANDING UN-CASHED CHECKS

4-20-11

<table>
<thead>
<tr>
<th></th>
<th>New York State</th>
<th>NY City</th>
</tr>
</thead>
<tbody>
<tr>
<td>United</td>
<td>50,242</td>
<td>5,767</td>
</tr>
<tr>
<td>Empire BC/BS</td>
<td>88,082</td>
<td>26,159</td>
</tr>
<tr>
<td>GHI</td>
<td>89,312</td>
<td>12,661</td>
</tr>
<tr>
<td>Aetna</td>
<td>29,479</td>
<td>8,612</td>
</tr>
</tbody>
</table>
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?
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Legal Guidance

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BILLER’S PRAYER
DEAR LORD:
PLEASE LET ME FINISH
THIS CLAIM BEFORE THEY
CHANGE THE RULES
Thank You