Medicare, Coding, and Billing for 2018
Kathy Mills Chang, MCS-P, CCPC, CCCA
KMC University

Medicare: Simple but Risky

Provider Numbers and Medicare

Things to do:
☆ Apply for a National Provider Identification number (NPI)
☆ Every provider must enroll in Medicare to treat a Medicare patient. There is NO Opt-Out for chiropractors.
☆ Providers must enroll their corporate business entity in Medicare and attach individual provider numbers by reassigning benefits.

PART B

Enroll in Part C Plans if Desired

PART C

Decide whether to enroll with other Medicare Part C carriers. Some Part C plans may include additional coverage beyond the three covered CMT services.

NOTE: Patients who are enrolled in a Part C plan in which you do not participate are treated as any other cash paying patient.

NPI Numbers

☆ National Provider Identifier: both personal and group
☆ A unique identification number for covered health care providers
☆ HIPAA established this number
☆ Is a 10-position, intelligence-free numeric identifier
☆ The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

PTAN Numbers

☆ Provider Transaction Access Number
☆ MACs Provider Enrollment Department issues to Medicare Providers
☆ The PTAN is the same number as the previously issued Unique Provider Identification Number (UPIN)
Tax-ID Number

• With Medicare, all numbers are assigned to the group (if there is a group)
• Your Federal ID Number is the master number that identifies your practice
• All other numbers are attached to that

All Providers in the Group are Reassigned to One Tax-ID

Associate Doctors, be aware!
Physicians who reassigned their right to bill and receive Medicare payments to their employer, by executing the CMS-855R application will still be held liable for false claims submitted by entities to which they have reassigned those benefits. Always know what is being billed under your provider number and name.

Recognize Coverage

Types of Medicare Coverage: Part B

• Basic Medicare Part B coverage is what most of the senior population have
• Medicare Part B is optional
• Medicare Part B is usually the primary coverage
New Medicare Cards
April 2018

Types of Medicare Coverage: Part C
• Also known as Medicare Advantage Plans or Replacement Plans—“Managed Care Medicare”
• Redirects benefits to a private carrier
• No Part A or B

Types of Medicare Coverage: True Secondary
• Resembles eligible group health plans (GHP)
• Could be from retirement benefits
• Often behaves like a GHP rather than a supplemental

Crosswalk Feature
• Patients must request this feature from Secondary/Supplemental Carrier
• Secondary/Supplemental sends patient info to Medicare
• Medicare sends processed claim information to Secondary/Supplemental

Types of Medicare Coverage: When Medicare is Secondary
• There are many circumstances when Medicare may pay AFTER another insurance
• This entire lesson is devoted to that concept
• It’s very important to understand and execute this perfectly
Qualified Medicare Beneficiaries (QMB)

Medicare Savings Program

QMB (100% FPL)
- Payment of Medicare Part B premiums
- Payment of Medicare Part A and Part B Cost Sharing, Eligible for LIS (Prescription Drug benefits)

SLMB (120% FPL)
- Payment of Medicare Part B premiums
- Eligible for LIS (Prescription Drug benefits)

QI-1 (135% FPL)
- Payment of Medicare Part B premiums
- Eligible for LIS (Prescription Drug benefits)

Sample EOB- Qualified Medicare Beneficiary

June 18, 2017
Dr. Susan Jones, MD, 3156 1555-1234
Brevard Physical Therapy Center, 32 Main Street, Brevard, NC 28712-4587

Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 1 visit 021110

Total for Claim #62-10159-592-677
$450.00 $26.54 $22.89 $44.53 A

Notes for Claims Above
- You are in the Qualified Medicare Beneficiary (QMB) program, which pays your Medicare costs. Health care providers who accept Medicare can bill you for the Medicare costs for this item or service, but you may be charged a small Medicare copay.

Your new patient call procedure should be followed for any type of patient. We recommend the KMC University NP Phone Call Flow Sheet.

Is the caller a new patient?

Follow new patient initial phone call procedure now

Your new patient call procedure should be followed for any type of patient. We recommend the KMC University NP Phone Call Flow Sheet.
Critical initial step in the Medicare Administrative Process
- Picture ID can be checked, not copied
- Follow prompts on verification form

Verify ALL Coverage
- Confirm Medicare Part B eligibility
- Confirm secondary or supplemental eligibility
- Confirm actual chiropractic benefits for any secondary or supplemental
- If Medicare Part C, confirm all benefits

Another Reason to Use HETS

Medicare Eligibility System Will Include QMB Data
Through the HIPAA Eligibility Transaction System (HETS), CMS releases Medicare eligibility data to Medicare providers, suppliers, or their authorized billing agents (including clearinghouses and third party vendors).

Effective November 4, 2017, HETS will indicate periods during which the beneficiary is enrolled in QMB and owes $0 for Medicare Part A and B deductibles and coinsurance.

Online vs. IVR vs. Phone
- Get the answers you want from HETS
- What is the patient responsible for?
- Eligibility is one thing, benefits are another
- Secondary, Supplemental, and Part C—these are the most critical errors we see

Chiropractic and Medicare

Covered and Payable

Covered but Not Payable

Statutorily Excluded from Medicare Chiropractic Benefit

Medicare patients are not required to obtain supplemental/secondary insurance. If the patient wishes to use additional coverage, Medicare patients are financially responsible for the co-payment, co-insurance, and deductible.
Analyze the ABN Forms for...

• Are all the "D" categories filled in properly?
• What fees are included on the ABN?
• Was the appropriate option selected with the appropriate outcome? Billing?
• Does it include services excluded by Medicare?
• Stay tuned!

Voluntary Use = “MAY I?”

WHEN MAY I ISSUE AN ABN?

Voluntary ABN Uses

Medicare does not require ABNs for statutorily excluded care or for services Medicare never covers. However, in those situations, you may issue an ABN voluntarily. Refer to the “Is That Claim Reporting Modifier Do I Use?” section at the end of this booklet for information on claim modifiers associated with voluntary ABN use.

Aha!

ABN for Voluntary Use

You should only provide ABNs to beneficiaries as an additional step in your determination of whether to get services an accept financial responsibility for services Medicare does not pay. The ABN serves as proof that the beneficiary knows that Medicare might not pay. If you require the beneficiary to pay for the service, you must ensure the beneficiary understands that the Medicare fee on the service and you authorize the beneficiary to do so.

The ABN also serves as an optional (voluntary) method to ensure use to forewarn beneficiaries of their financial liability prior to providing care for services Medicare never covers. Medicare does not require you to issue an ABN in order to bill for an item or service that is not a Medicare benefit and never covered.

• When you issue the ABN as a voluntary step, the beneficiary does not check an option or sign and date the notice.

Modifier
Patient Friendly Medicare Education

- Patient Friendly Language
- Looks “Medicare Official”
- Starts the process on the right foot

The KMC University’s Guide to MEDICARE MODIFIERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description/Description of Service</th>
<th>Effect on Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>Coverage includes primary services removed from the provider’s office visit code.</td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>Example of a modifier where Medicare will pay a lower payment.</td>
<td></td>
</tr>
<tr>
<td>G1</td>
<td>Modifier indicates the service is not included in the patient’s benefits.</td>
<td></td>
</tr>
<tr>
<td>G2</td>
<td>Modifier indicates the service is not included in the patient’s benefits.</td>
<td></td>
</tr>
</tbody>
</table>

Mandatory Submission

Voluntary Submission

To Recap

4-PACK BUNDLE OF QUICK REFERENCE TOOLS

Regularly $312 for members, get yours for just $150 now through the end of January!
USE COUPON CODE: QRTBUNDLE AT CHECKOUT

Medicare Quick Reference Tool (QRT)
Documentation Quick Reference Tool (QRT)
Billing and Coding Quick Reference Tool (QRT)
ICD-10 Quick Reference Tool (QRT)

RISK MANAGED!
Purpose of Coding

- Coding describes:
  - Services/Items provided to the patient (CPT/HCPCS)
  - Condition(s)/Symptom(s) the patient has presented with (ICD)
- Coding is a global language
- Use it to describe what you do—don’t find a code first and then decide how to use it

Basic Rules of Coding

- Select the code that most closely defines the service(s) being rendered
- Documentation from the patient encounter determines the codes used
- Before using a code, be sure all required elements to satisfy the code description have been met
- Do not guess or assume codes
  - Codes must be confirmed and supported by documentation

Apply Accurate and Complete Coding

- Consistency – no matter who is paying
- Goal – high-quality health data to payers
- Appropriate code – one that best describes the service(s)
### Levels of HCPCS Codes

**Level I** – Most commonly referred to as: Current Procedural Terminology (CPT) Codes

**Level II** – Most commonly referred to as HCPCS ("Hick-Picks")

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### The Language of Coding

**Evaluation and Management (E/M) Coding**

- **New Patient E/M codes**
  - 99201-99205
- **Established Patient E/M codes**
  - 99211-99215

### Definition of a NP

- Never been to your office before
- Have never seen anyone in your practice before (other than multi-specialty)
- It's been more than 3 years since they have been into the practice

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#### New Patient Evaluation & Management

**Code Selection**

<table>
<thead>
<tr>
<th>Code</th>
<th>History</th>
<th>Examination</th>
<th>CDM Clinical Decision Making</th>
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<tr>
<td>99201</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
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<td>Expanded Problem Focused</td>
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#### Established Patient Evaluation & Management

**Code Selection**

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<th>CDM Clinical Decision Making</th>
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<td>Detailed</td>
<td>Moderate</td>
</tr>
<tr>
<td>99215</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
</tbody>
</table>
CMT Codes—Spine and Extremities

- 98940 – 1-2 Regions
- 98941 – 3-4 Regions
- 98942 – 5 Regions
- 98943 - Extremities
- 98940-98943 – the basic building blocks and best descriptions of the DC’s work
- Most comprehensive physician code to describe chiropractic services

Cervical Spine

- 7 vertebra: C1-C7
- Occiput
- Atlas = C1
- Axis = C2
- Atlanto-Axial = C1-C2
- Cervical Lordosis: refers to the curve of the spinal: could be hypo or hyper

Thoracic Spine

12 Vertebra: T1-T12
Also called the dorsal spine Kyphotic Curve
- From the Greek: hump
- AKA hunchback

Lumbar Spine

5 Lumbar Vertebra: L1-L5
Pelvic Sacrum Coccyx
Lumbar lordodic curve Many areas to understand below the belt

Extremity Adjusting – 98943

- Regions
  - Head
  - Upper extremities (shoulder to fingers)
  - Lower extremities (hip to toes)
  - Anterior ribs
  - Abdomen
  - May be billed once per visit
  - Can be billed along with spinal CMT code

Coding Physical Medicine
Supervised Modalities

- 97010-97028 DO NOT require one-on-one contact by the provider
- Billed only once per encounter
- Are not time based for billing purposes
- Expected 2-12 visits
- However documentation should include the time spent on the modality

97010 Hot/Cold Packs

- Application of hot packs, ex: hydrocollator packs or moist towels
- Application of ice packs or cryotherapy
- Often a non-covered service
- Does NOT include applying BioFreeze or any other type of topical analgesic

97012 Mechanical Traction

- Force used to create tension of soft tissue or to separate joints
- Untimed & billed only once a visit
- Intersegmental or Roller tables meet criteria, BUT check with 3rd party payer guidelines
- Flexion Distraction technique is a CMT & should be coded as an adjustment

S9090 Decompression

S9090 - Vertebral Axial Decompression, per session

Diffs from traction:
- Angle(s)
- Computer assistance
- Muscle guarding consideration
- Intent

97014 Electrical Stimulation (EMS)

- Application of Electric stimulation to a specific area for nerve or muscle disorders
- Billed only once per visit
- Some payers allow 2-4 visits
- Sometimes you must use G0283 instead of 97014 for unattended EMS
- Presently United Health Care & Medicare are the only carriers that require G0283

Constant Attendance Modalities

- 97032-97039 require direct one-on-one patient contact by provider
- Expected 6-12 visits
- These are timed based codes for billing
- Documentation should include total time spent
97032 Attended Electrical Stimulation

• Application of a modality to one or more areas; electrical stimulation [manual] each 15 minutes
• Most often combo unit
• You can’t just move the pads and call it attended!

97035 Ultrasound

• Ultrasound, each 15 mins. One or more areas
• Great for adhesive scars, spasm, soft tissue

Therapeutic Procedures (97110-97546)

• Therapeutic Procedures are time-based codes for billing purposes
• The patient is ACTIVE in the encounter
• Requires direct one-on-one patient contact
• Documentation should include both the total time spent and the time spent doing each activity/exercise.
• Codes are billed per 15 min increments

97110 Therapeutic Exercise

• Therapeutic Exercise, each 15 mins. One or more areas
• Incorporates one:
  • Strength
  • Endurance
  • Range of motion
  • Flexibility
• Must show functional deficit in the above during examination

97112 Neuromuscular Re-education (NMRE)

• Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
• Proprioceptive Neuromuscular Facilitation (PNF), Feldenkrais, Bobath, BAP’S Boards, and desensitization techniques
• Most likely indicated for neurological conditions

97116 Gait Training

• Direct one-on-one contact in the performance of progressively more advanced specific activities designed to help a patient with a known neuromuscular or orthopedic disorder to ambulate safely and efficiently
• Training in ambulation on even or uneven surfaces or stairs
• Parallel bar training, specialized platforms, or
• Proprioception training based on

855-832-6562
**97150 Group Exercise Code**

**Therapeutic Procedure(s), group, (2 or more individuals)**
- Once per encounter, not timed!
- Some carriers do not cover at all

**97530 Therapeutic Activities**
- Dynamic activities to improve functional performance, direct (one-on-one) with the patient (15 minutes)
- Incorporates two or more:
  - Strength
  - Endurance
  - Range of motion
  - Flexibility
- Must show functional deficit in the above during examination

**97124 Massage**

- Passive procedure used for restorative effect
- Used for effleurage, petrissage, and/or tapotement, stroking, compression, and/or percussion
- Considered separate and distinct from CMT

**97140 Manual Therapy**

- Includes soft tissue and joint mobilization, manual traction, trigger point therapies, passive range of motion, and myofascial release.
- With CMT - must be in a separate body region
- May require a -59 modifier

**Is This 97140 or 97124?**

**97140 Manual Therapy**

- To effect changes in soft tissues, articular structures, and neural or vascular systems
- To address a loss of joint motion, strength, or mobility
- Must be part of an active treatment plan directed at a specific outcome
- Daily routine visit documentation should include progress toward those stated goals
When to Use 97124

- Used to improve muscle function, stiffness, edema, muscle spasms or reduced joint motion
- When treatment is friction based, relaxation type massage that is less specific than 97140

Timed Coding Rules

The Intersection of 15 Minutes and 8 Minutes

AMA/CPT Says “Each 15 Minutes”

Medicare’s “8-Minute Rule” Meets “15 Minute Rule”

- For time-based codes, you must provide direct treatment for at least eight minutes in order to receive reimbursement from Medicare
- CMS and CPT have clarified that any timed based service, provided on its own, is not billable if performed for less than 8 minutes

Timed Treatment Codes

- For a single timed code being billed in a visit:
  - Less than 8 min = 0
  - 8 up to 23 min = 1
  - 23 up to 38 min = 2
  - 38 up to 53 min = 3
  - 53 up to 68 min = 4
  - And so on

- For multiple timed codes provided in the same session, add up the total minutes of skilled, one-on-one, time based therapy and divide that total by 15
- If eight or more minutes are left over, you can bill for one more unit
- If seven or fewer minutes remain, you cannot bill an additional unit

6 Minutes of Therapeutic Exercise

- Do not bill any CPT code
- Threshold not met
- Document the chart to include the exercise performed and note it was 6 minutes of time spent
21 Minutes of Therapeutic Exercise

- Abdominal hollowing exercises = 12 minutes
- Cervical range of motion exercises = 9 minutes
- Total time = 21 minutes = 1 billable unit
- Note the chart with all services performed and time spent on each along with total time

28 Minutes of Therapeutic Exercise

- Lumbar Isometric Exercises = 13 minutes
- Lumbar stretching = 9 minutes
- Lumbar strengthening exercises = 6 minutes
- Total time = 28 minutes = 2 billable units
- Note the chart with all services performed and time spent on each along with total time

26 Minutes of NMR & 25 Minutes of Therapeutic Exercises

- 26 minutes of various proprioceptive strengthening exercises
- 13 minutes of lumbar stabilization exercises
- 12 minutes of lumbar stretching exercises
- Total time = 51 minutes = 3 billable units
- Documentation includes all services and time spent

51 divided by 15 = 3 with 6 left over
did not make it to a fourth unit

10 Minutes of TherEx; 5 Minutes of Ultrasound and 5 Minutes of Manual Therapy

- 10 + 5 + 5 = 20 total minutes = 1 billable unit
- US and MT are each less than TE
- Bill where most time was spent
- Total time didn’t reach 23 minutes

Evaluation and Management-NP

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<th>Evaluation and Management-NP</th>
<th>Total Charges</th>
<th>Rate of Change</th>
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<tr>
<td>99201</td>
<td>0</td>
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Coding Audit To Minimize Risk
Evaluation and Management-Established Pt.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Total for CPT Code</th>
<th>Reimbursement Value</th>
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<tbody>
<tr>
<td>99211</td>
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<tr>
<td>99212</td>
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<td>$32,515.20</td>
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720 Missing Established Pt. E/M Codes (+++++)

720 X $45.16 = $32,515.20 (99212!)

CMT Ratios

<table>
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You Don’t Have to KNOW All the Answers...

- Follow Official Coding Rules and Guidelines
- Have current coding resources available
- Ongoing training is essential

Coding and Billing Compliance is Critical

- Your billing must match your documentation
- Understanding how to report timed codes = peace of mind
The Billing Process for Maximum Reimbursement and Minimum Risk

• The seven-step reimbursement cycle every office should understand and become proficient at
• How missteps at the beginning of the cycle cost us money at the end
• The steps necessary with your billing software to ensure a clean, organized claim

Patient Finances

• Remember, we’re running a business
• While it is healthcare, it’s still a business
• Healthy business = ability to help more people
• Doesn’t help anyone if there is not money coming in
• Money ≠ greed

DISTRACTIONS
DISTRACTIONS EVERYWHERE
• One of many different work flows
• More appropriate for the 3rd party side of reimbursement
• Can also be a model for combo ins/pt. claims

Administrative Time

• Administrative Time:
  Time spent on prevention and implementation that is not directly related to a service. Time spent during trainings, meetings, general planning, and time OFF the floor.
• One of the biggest offenses to organization
• Doctor admin time: marketing, Day 1.5, team meetings, planning

General Team Member Admin Time

• Insurance Follow Up
• Posting Payments
• Reactive and Proactive Calls
• Verification
• Collections Calls
• Recalls
• Doctor’s PRN or Monthly Duties
Charge Collection/Entry

- Garbage In/Garbage Out
- Use a routing slip
- Use in your balancing process
- Know the trouble spots for data entry

Leaky Bucket—The Doctor to Front Desk Communication Line

- Lack of the use of a routing slip
- Supplies given out without FD knowing
- New service performed other than TX plan, not communicated
- Upgrade of frequency of visits and not scheduled

Why Careful Charge Entry Matters

**Doctors**

- Services which are performed will be billed
- Supplies will not walk out the door
- All the T’s are crossed and I’s are dotted

**Team Members**

- Systematic daily entry will ensure that you don’t get behind
- Checks and balances will make sure you don’t miss anything
Financial Data Charting

- Refers to organizing the patient chart and preparing it for billing
- Create systemized steps or checklists
- Applies to reactivations, new conditions, and NP as well

Organize and Systematize

- Copy of picture ID
- Copy of insurance card
- Diagnosis
- Treatment plan
- Verification
- History
- Consultation
- Exam forms

Important To Get It Right

- Perfect the information in the computer account
- Add all necessary data
- Final set of eyes before it goes out
- Add this process to your SOP manual

Billing Timelines

- Can vary by carrier
- With Electronic Billing can be very quick
- Paper billing takes longer
- EFTs mean your money gets to you faster
Follow-Up Begs for a System

- A place for everything and everything in its place
- A system belongs to the practice, not the CA
- The set up of the system begins with the proper intake of payments and posting of checks

Start with the Organization of this Department

- Systematize your system
- What goes in the front correctly, starts the proper flow
- Collecting the mail starts your flow
- Sort it into your system for success

Control the Intake of Material

Set Up Your Work Space
Successful Follow Up is an A-R-T

• Follow this recipe for success:
  • A = Attack Immediately
  • R = React Proactively
  • T = Tickle Relentlessly

A = Attack Immediately

- A = Attack
  - Time Management / Schedule
  - Appointments
  - Reconciliation
  - Follow-Up and Collections
  - Verification
  - Charge Entry
  - Data Charting and Billing

- R = React

- P = Collections and Follow Up Start Here
  - With Folders 2, 3, & 4

- T = Tickle

Received/Date Stamp on All

- RECEIVED
- 30 NOV 2019

- Everything gets stamped with the date it was received
- It immediately gets sorted into one of the “four folders”
- Folders = Piles if you wish
- Oldest to the front and newest to the back

A = Collections and Follow Up Start Here With Folders 2, 3, & 4

- The insurance company returns an Explanation of Benefits (EOB)
- Sometimes it is paid correctly and sometimes not
- If incorrect….ATTACK IMMEDIATELY!

R = React Proactively

- Reactive and Proactive Calls

- Phone calls are the name of the game
- You must set aside time for outbound calling
- Things will not always just come to you
- Both types of calls are necessary
  - Reactive Follow Up
  - Proactive Follow Up
Reactive Call File

- Always put newest to the back
- Based on receive date, oldest always in the front
- Attack them one at a time, to completion
- Once complete, OK to discard, or use 8.5 x 11 tickler (more later)
- Can also use PENDING file for physical copies

Every Follow-Up Requires A Phone Call or an Action

Understand the Purpose of Reactive Calls in Your System

If it doesn’t apply perfectly....

- A service is denied
- The entire bill is denied
- The amount paid doesn’t seem right
- Patient responsibility doesn’t seem right
- Anything that is not what is expected to happen
Coding Errors

- Are all the modifiers attached correctly?
- Is this service allowed for this patient per their benefit verification?
- What have you agreed to with your Provider Contract?

Medical Necessity Denial?

- Has the insurance denied this service for medical necessity review?
- How many visits is this into the episode of care?
- If so, you must prepare your documentation to send to them...appeal.

The Beauty of the System

- Reactive items are stored together and in order
- Depending on flow, they are staged and ready for working
- Leadership can easily check on progress
- Notes on the item remind us why we’re following up

Internal Financial Notes

- Find a place in your software where you can keep internal notes
- What if you win the power ball?
- Less is NOT more in this situation
- “And then I said, and then he said, and then I said...”
Now For Something Different...

• Proactive follow up is often missed
• "Not enough time"
• Identify unpaid claims many ways
• Proactive = A/R Aging Report or Unpaid Claims List

Chase Down the Money

• Not all money comes back in without any effort
• Unpaid claims list must be worked
• Reasons bills go unpaid:
  • Never received
  • Pending information from the insured
  • Denied and you didn’t get the denial notice

Proactively Work it!

• Work the aging/unpaid claims list according to payer class
• Sort by carrier if you can
• Sort by highest balance if you’re just starting to work these lists
• Systematically move through these unpaid claims

Internal Financial Notes

• Find a place in your software where you can keep internal notes
• What if you win the power ball?
• Less is NOT more in this situation
• “And then I said, and then he said, and then I said…”
Proactive Follow Up Generates...

Additional Follow-Up!

Tickler Reminder System!

T = Tickle Relentlessly

• Follow up on your follow up
• This is the crux of a system
• It’s not person dependent
• It’s your brain in a box
• Electronic/Outlook
• Card file/hanging file

What Exactly is a Tickler File?

• A conventional physical tickler file consists of 43 folders or dividers: 12 for each of the months of the year and 31 for each of the days of the month.
• Uniquely designed to organize and keep pieces of paper or reminders

Choosing to Use Bins for Your File System

Electronic Tickler File

Choosing to Use Bins for Your File System
Why Appeal?

- Not appealing looks like you are billing fraudulently
- Appealing improves the practice’s bottom line
- Improves communication between providers and insurance companies
- Defends your services

The Appeals Process

- Create and use template letters to send to the insurance company
- Have all of your documentation, research and other supporting records gathered and organized for easy review

Why Wouldn’t You Appeal?

- WASHINGTON – More than half of all Medicare claims denial appeals are overturned by administrative law judges according to a recent report by the Office of Inspector General.
- Examining some 40,000 Medicare appeals filed in the 2010 fiscal year, the OIG found about 35,000, or 85 percent, were filed by hospitals, physicians and other providers, with about one-third filed by 96 “frequent filers” appealing at least 50 claims. One unnamed provider filed more than 1,000 appeals.
- About half of all appeals made it to the third appeals level of administrative law judges, or ALJs, the penultimate authority on Medicare claims appeals, following two levels of Medicare contractors and preceding the Medicare Appeals Council.
- The OIG found ALJs reversed 56 percent of appeals in favor of appellants, overturning appeals rejections by qualified independent contractors (QICs).

Practice Makes Perfect

- The more confident you are in yourself and the policies and procedures of your office, the more effective you will be at collecting.
- Be confident, smile, be firm and look them in the eye.

Raise Your Hand If...
Annual Compliance Training
for Workforce Members

Why Does Compliance Matter?
- Healthcare is a highly regulated industry
- It is different than working in a retail store or a restaurant

Types of Compliance
- HIPAA Compliance
- OIG Compliance: Fraud and Abuse
- OSHA Compliance
- CLIA Compliance
- Financial Compliance
- PCI Compliance

A Common Denominator
- All types of compliance rely on policy and procedure
- AKA Standard Operating Procedure (SOP)
How are They Similar?

• Policies and procedures are customized and scaled to your practice
• All staff must be trained on your policies and procedures
• Policies and procedures should be reviewed annually to ensure that they are still relevant and effective
• Staff must receive annual refresher training

Benefits of Policy and Procedure

Policies and procedures:
• Allow management to guide operations without constant intervention.
• Are the strategic links between the vision, and day-to-day operations.
• Are designed to influence and determine all major decisions and actions; all activities take place within their boundaries.

What is the Difference?

Policies
• Are general in nature.
• Identify company rules.
• Explain why they exist.
• Explain when the rule applies.
• Describe who it covers.
• Show how the rule is enforced.
• Describe the consequences.
• Are normally described using simple sentences and paragraphs.

Procedures
• Identify specific actions.
• Explain when to take actions.
• Describe alternatives.
• Provide emergency procedures.
• Include warnings and cautions.
• Offer examples.
• Show how to complete forms.
• Are normally written in an outline format.

What is HIPAA?

• HIPAA – Health Insurance Portability and Accountability Act
• Or…Helping Increase Paperwork Across America

HIPAA Has Rules!

Reason for the Rules

HIPAA Has Rules!
What is PHI?

• Individually identifiable health information held/transmitted by a covered entity or its Business Associate, in any form or media, whether electronic or verbal
• Past, present, or future physical or mental health, healthcare services provided, or payment for health services
• All demographic info that identifies or can be used to identify the individual

Examples of PHI

• Name and address
• Name of employer
• Any date, including birth
• Telephone or fax #
• Email addresses
• SSN
• Medical Records

Rule #1 HIPAA Privacy Rule

• Protection for the privacy of Protected Health Information (PHI)
• Sets the standards for how to maintain privacy for personal info and focuses on confidentiality

What Can You Disclose?

TPO
Treatment, Payment, Healthcare Operations

- Coordination of care
- Billing and collections activities
- Business management-Healthcare Operations

What’s Treatment?

Treatment generally means the provision, coordination, or management of health care and related services by health care providers or by a health care provider and a third party; consultation between health care providers regarding a patient; or the referral of a patient from one health care provider to another.

What’s Payment?

• Determining eligibility or coverage & adjudicating claims
• Billing and collection activities
• Reviewing health care services for medical necessity, coverage, justification of charges, etc.
• Using review activities
• Disclosures to consumer reporting agencies (limited to specific identifying information about the patient, his/her payment history, & identifying information about the covered entity).
What's Healthcare Operations?
“...certain administrative, financial, legal, and quality improvement activities that are necessary for a covered entity to run its business and to support the core functions of treatment and payment.”

What is the Minimum Necessary Standard
To avoid and limit unnecessary or inappropriate access to and disclosure of PHI.

Use & Disclosure Requested Restrictions
The patient has the right to restrict the use or disclosure of PHI:
• For TPO
• To other persons involved in health care
• For payment of health care
• To family members
Patient must establish restrictions of PHI in writing

Know Your Patient Rights
• Access to PHI
• Accounting of disclosures of PHI
• Amending PHI
• Filing complaints
• Restrictions to permitted uses of PHI

Your Notice Of Privacy Practices-NPP
NPP must include:
• Breach notification guidelines
• Patient rights concerning disclosures to health plans
• Use of PHI for Marketing Purposes
• Process for Requesting Medical Records

Acknowledgement (Notice of Privacy Practices)
A clinic must make a good faith attempt to obtain a written acknowledgement from the patient that s/he has received a copy of its NPP.
Who Handles Complaints?

Know who in the practice formally handles and responds to patient complaints. **HINT:** This information should be in the Notice of Privacy Practices.

Is it okay???

- **Postcard Reminders**
  - Answering machine appointment reminders

- **NEVER** leave PHI (e.g., test results) on an answering machine.

Practice Common Sense

- **Not required:**
  - Private or Soundproof rooms
  - Encrypted telephones
- **Suggested:**
  - Have patients wait a few steps back from counter
  - Curtains or screens
  - Speaking quietly
  - Files turned backward
  - Folders marked confidential
  - All faxes/email contain confidentiality statement
  - Fax machines in secure locations

Know Your Disclosure Restrictions

- **Patient present?**
  - OK without signed authorization as long as patient has chance to object.
- **Patient not present?**
  - NOT OKAY – only disclose information that is in the patient’s best interest
  - **Note:** Patient may allow disclosure of PHI to someone, other than close friend or family member.

Follow the Rules!

- “You can’t just walk in and ask to access patient records. HIPAA would call that fantasizing.”

ALWAYS Verify Identity of Individual Requesting PHI

- Request documentation, statement, or representation (where applicable) to confirm identity
- **When in doubt, don’t give it out!**
EOB’s and COB’s

- When coordinating benefits, conceal any other patient’s PHI on EOB
- Remove or conceal anything that does not pertain to the claim

Marketing

- Selling protected health information to third parties for their use and re-use.
- Disclosing protected health information to outsiders for the outsiders’ independent marketing use

Incidental Uses and Disclosures

- Patients overhear phone conversations while at the front desk.
- A patient passes another room where treatment is taking place

Identify the Internal and External Risks of PHI Disclosure

HEADS UP!

Accidental Disclosures

- Faxing or emailing PHI to the wrong destination
- Disclosing PHI to an unauthorized person
  If harmful, must be disclosed to the patient.
  It should always be included in non-TPO Disclosure logs

Rule #2 Breach Notifications
What is a Business Associate (BA)?

“A person or entity—other than a member of the workforce of a covered entity—who performs functions or activities on behalf of the practice, or provides certain services to a covered entity and that involves access by the Business Associate to protected health information.”

Examples of Business Associates (BAs):
- Billing Company
- EHR Software Company
- IT Specialist
- Audit or Compliance Specialist (KMCU)
- Accountant or Law Firm

What is a Business Associate Agreement?

• An agreement between a Covered Entity and its Business Associate that provides satisfactory assurances PHI is secure.
• Each party agrees to develop and implement policies and procedures to safeguard PHI

Rule #3 HIPAA Security

Protect ePHI (Electronic Protected Health Information)
- Confidentiality
- Integrity
- Availability

Security Rule vs. Privacy Rule

- Access Control
- Minimum Necessary Standard
- Audit Controls
- Access Permissions
- Integrity Controls
- Who can change PHI?
- Transmission Security
- Use and Disclosure for TPO
- Workstation and device security
- Workstation and device privacy

What is “Individually Identifiable”?

Email address is: 123xyz@gmail.com
✓ The patient’s name is not included in the email
✓ There are no identifying numbers or information

So it’s not identifiable, right?

NO!
The description of ePHI states, “all email addresses, no matter what, are identifiable”; someone, somewhere, by some means has the ability to link them back to the individual.

Security Safeguards

MOST clinic policies are built on these safeguards.
Administrative Safeguards

Administrative Issues
• No designated Security Officer
• Workforce is not trained
• Workforce unaware of security policies

Safeguard Actions
• Designated Security Officer
• Workforce training begins at hire
• Workforce training conducted regularly and frequently

Physical Safeguards

ISSUES
• Computer equipment is easily accessible to the public.
• Portable devices are not tracked and/or are not locked when not in use.

SAFEGUARDS
• Offices are locked. Screens are shielded from secondary viewers.
• Log created for all devices.
• Encryption installed on all devices. Laptop locks applied.

Technical Safeguards

ISSUES
• No measures in place to keep electronic patient data from improper changes
• Electronic patient information exchanges are not encrypted or otherwise secured

SAFEGUARDS
• Secure user IDs and passwords are used, and appropriate role-based access is provided
• Data is encrypted

Organizational Safeguards

ISSUES
• No breach notification or associated policies exist
• Business Associate (BA) agreements have not been updated in several years

SAFEGUARDS
• Create a Breach Notification process
• Conduct regular agreement reviews and update as necessary

Policy & Procedure Safeguard

ISSUE
• Generic template policies and procedures were purchased but not followed

SAFEGUARD
• Written and tailored policies and procedures are implemented and staff is trained

BE HIPAA AWARE
Stay ALERT! Follow the Rules!

Rule #4 - Enforcement Does it Really Happen?

Massachusetts provider settles HIPAA case for $1.5 million

Massachusetts provider settles HIPAA case for $1.5 million
Massachusetts Eye and Ear Infirmary and Massachusetts Eye and Ear Associates, Inc. (collectively referred to as “MEEI”) has agreed to pay the U.S. Department of Health and Human Services (HHS) $1.5 million to settle potential violations of the HIPAA Privacy and Security Rules. MEEI has also agreed to take corrective action to improve policies and procedures to safeguard the privacy and security of their patients' protected health information and retain an independent monitor to report on MEEI's compliance efforts. OCR's investigation followed a breach report submitted by MEEI, as required by the HIPAA Breach Notification Rule, reporting the theft of an unencrypted personal laptop containing the electronic protected health information (ePHI) of MEEI patients and research subjects. The information contained on the laptop included patient prescriptions and clinical information. OCR's investigation indicated that while MEEI's management was aware of the Security Rule, MEEI failed to take necessary steps to comply with the requirements of the Rule, such as conducting a thorough analysis of the risk to the confidentiality of ePHI maintained on portable devices, implementing security measures sufficient to ensure the confidentiality of ePHI that MEEI created, maintained, and transmitted using portable devices, adopting and implementing policies and procedures to address security incident identification, reporting, and response.

Yes! Even on the ‘small’ stuff!

HHS Settles with Health Plan in Photocopier Breach Case

Under a settlement with the U.S. Department of Health and Human Services (HHS), Affinity Health Plan, Inc. will settle potential violations of the HIPAA Privacy and Security Rules for $1,215,780. OCR's investigation indicated that Affinity impermissibly disclosed the protected health information of up to 344,579 individuals when it returned multiple photocopiers to a leasing agent without erasing the data contained on the copier hard drives. In addition, the investigation revealed that Affinity failed to incorporate the electronic protected health information stored in copier's hard drives in its analysis of risks and vulnerabilities as required by the Security Rule, and failed to implement policies and procedures when returning the hard drives to its leasing agents.

Not Worth the Risk!

Team Member PHI Disclosure Violation

• Severity of violation
• Intentional vs. unintentional
• Pattern of improper use, disclosure, or release of PHI
• Misuse of computing resources

• Unaware of violation - $100 to $50,000
• Reasonable cause violation – $1,000 to $50,000
• Willful neglect – $10,000 to $50,000
• Willful neglect – $50,000 to $1.5 million
• Multiple HIPAA violations - surpass $1.5 million

Get to Know Your HIPAA Official

ASSETS

• Knowledge of the HIPAA Privacy & Security Rules.
• Committed to the practice’s compliance effort
• Capable of facilitating change as needed.
• Capable of creative and/or innovative solutions to HIPAA issues.
Do Your Homework!

Finding {Time} for HIPAA

Who is the OIG?
The Office of Inspector General’s (OIG) mission is to protect the integrity of the Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

OIG Compliance
• Monitored by the Office of Inspector General of the Department of Health and Human Services
• Contains policies and procedures that relate to the detection and prevention of fraud, waste, and abuse in the office
• Primarily concerns documentation, coding, and billing

Why Mandatory?
Integrate policies and procedures that are necessary to promote adherence to federal and state laws, statutes, and regulations applicable to the delivery of healthcare services into the physician’s practice

OSHA
• The Occupational Safety and Health Administration (OSHA) governs workplace safety
• Many states have their own version of OSHA that may have stricter rules and/or resources
• OSHA will conduct a free, onsite audit to help you get to legal
Blood Born Pathogens

- Even if your doctor does not offer acupuncture or venipuncture this must be addressed
- OSHA has direct minimum guidelines
- Your policy should address:
  - How to handle blood or other body fluid spills
  - Treatment for open wounds or lacerations
  - Hepatitis B vaccinations and/or declination for employees who might come in contact with body fluids (even if your doctor is anti-vaccine)
  - What to do in the event of a needle stick and/or contact with body fluids
- “If it is wet and not yours, DON’T TOUCH IT”

Federal Oversight of Financial Compliance

- One of the most highly regulated issues
- One of the four areas OIG noted as worthy of focus
- Critically important to get it right

Financial Transactions in Healthcare

Bottom Line: Be Careful!
Policies and Procedures Address THESE Risks

Today’s Focus

• Apply the process for setting your fees legally and compliantly and according to federal regulation
• To be compliant, know the policies of ALL your carriers
• Properly administer desired discounts without running afoul of the federal and state regulations
• Implement legal hardship discounts, if desired, using the federal guidelines to appropriately verify hardship

Start with Policy and Procedure

• Procedures are the specific methods employed to express policies in action in day-to-day operations of the organization.
• Together, policies and procedures ensure that a point of view held by a governing body of an organization is translated into steps that result in an outcome compatible with that view.

What is the Difference?

Policies
• Are general in nature
• Identify company rules
• Explain why they exist
• Tell when the rule applies
• Describe who it covers
• Show how the rule is enforced
• Describe the consequences
• Are normally described using simple sentences and paragraphs

Procedures
• Identify specific actions
• Explain when to take actions
• Describe alternatives
• Show emergency procedures
• Include warnings and cautions
• Give examples
• Show how to complete forms
• Are normally written using an outline format

What is the Difference?

Policies
• A Policy is a predetermined course of action, which is established to provide a guide toward accepted business strategies and objectives as well as compliantly operating

Procedures
• A procedure is a fixed, step-by-step sequence of activities or course of action (with definite start and end points) that must be followed in the same order to correctly perform a task
• Procedures provide the reader with a clear and easily-understood plan of action required to carry out or implement a policy
Your Policy/Procedure vs. Theirs

Find Medical Review Policy

- Whether Par or Non-Par, you must know the rules
- Begin with your carrier’s website, portal or Google Search
- Search for chiropractic, PT, other Medical Policy

Important Contract Details

- Rules of collections
- Copays must be collected at time of service?
- OK to allow payment plan?
- Do they allow for hardship discounts on deductible or copayments?

Your Policy and Procedure Must Govern Your Practice

Who’s Watching?

State and Federal Policy

- Not always specific guidance
- State policy usually superseded by Federal...maybe
- Opinions vs. written rules
- Set policy and procedure based on the best information you have
Know the Rules that Govern Healthcare

Avoid Dual Fee Schedules
What is and isn’t a dual fee schedule? Get the facts straight
• Misrepresents charges to carriers
• False Claims Act violation
• May violate provider agreements

Compliant Time of Service Discounts
Discount is based on viable bookkeeping savings
• May or may not be defined
• Often not defensible or unreasonable
• May not be permissible on Federally insured patients

Inducement Violations
• Per the OIG: “incentives that are only nominal in value are NOT prohibited by [inducement law]”
• No more than $15 per item or $75 in the aggregate annually
  – Even one free examination, x-ray, or therapy is a risk

False Claims Act Violations
• Establishes liability when any person or entity improperly receives from or avoids payment to the Feds
• Prohibits “knowingly presenting or causing to be presented, a false claim for payment or approval”
  – Examples:
    • Waiving deductibles or co-payments and not reporting to carriers
    • Up-coding for higher reimbursements
    • Down-coding based on payer type

False Claims Act Violations
• Prohibits “knowingly presenting or causing to be presented, a false claim for payment or approval”
Do Not Take This LIGHTLY!

Anti-Kickback Violations

A person who offers or transfers to a Medicare or Medicaid beneficiary any remuneration that the person knows or should know is likely to influence the beneficiary’s selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for civil money penalties (CMPs) of up to $10,000 for each wrongful act. The statute defines “remuneration” to include, without limitation, waivers of copayments and deductible amounts (or parts thereof) and transfers of items or services for free or for other than fair market value.
And Now for the Double Whammy!

Oelwein Chiropractor and Clinic Agree to Pay Nearly $80,000 to Resolve False Claims Act Allegations Involving Free Electrical Stimulation

Bradley Brown, D.C., from Oelwein, Iowa, and his clinic, Brown Chiropractic, P.C., have agreed to pay $80,000 to resolve allegations Brown violated the False Claims Act by improperly billing Medicare and Medicaid for chiropractic adjustments after providing free electrical stimulation to beneficiaries. The settlement is in addition to civil penalties levied against Brown under the Anti-Kickback Statute and the Stark Law.

Not Necessary to Mess with the Rules!

Fees, Wonderful Fees!

• One of the most common areas of non-compliance in practices
• Start at the beginning—do you set your fees compliantly?
• Understand the rules that apply to fees within healthcare

A Typical Chiropractic Fee System

ACTUAL FEES

DISCOUNTED FEES

IMPOSED DISCOUNTS

ELECTIVE DISCOUNTS
Who Pays Actual Fees?

- What you bill is what you expect to collect
- Personal Injury Claims
- Cash Patients
- Out-of-Network Patients

Cash Patients

- You should be charging your actual fee
- 5-15% discount guidance from the Feds
- Three states have rules on the books for TOS allowances
- Your fee is your fee is your fee

Out of Network Patients

- If you represent full fee to the insurer, the patient must pay full fee
- What you bill is what you expect to collect, outside of any agreements/contracts
- Charge correctly, bill correctly, collect according to your office policy

What you charge may not be what you collect

- PIP Fee Schedule
- Contracted Rates
- Inappropriate reductions
- Attorney requests for adjustments
Contracted Fees Are Not a Violation

- By contract, you agree to the fee schedule
- The write-off happens automatically by agreement
- Not a dual-fee schedule by definition
Clear Understanding of Hardship Fees

- Do you need a hardship fee schedule?
- Your hardship agreement can co-exist with other fee schedules
- You must set the standard up front, have qualifying factors, and verify eligibility.
- Utilize a standardized form and system

Co-Pay or Deductible Waivers for Hardship

- The waiver is not offered as part of any advertisement or solicitation;
- Waivers are not routinely offered to patients;
- The waiver occurs after determining in good faith that the individual is in financial need;
- The waiver occurs after reasonable collection efforts have failed.

Mistakes and Blunders

What may NOT be financial hardship?

- No insurance
- High deductible
- I don’t wanna pay that much
- My other doctor didn’t charge my co-pays
- Pulse and a spine

2 + 2 = 5
**Set Hardship Policy**

**Hardship Fees for Qualifying Patients**

- The policy of this office is to offer set hardship discounts in qualifying systems. The following are the policy guidelines as follows:

- The hardship policy is applicable to all patients referred to our financial hardship fund.
- All patients who meet the criteria for hardship will be offered a discount on their treatment plan.
- The discount amount will be determined based on the patient's income level and other relevant factors.

**Income Level**

- **100%**
- **125%**
- **150%**
- **175%**
- **200%**

**Verification Method Accepted**

- Last two check stubs from family wage earners
- Most recent tax return
- Proof of public assistance, food stamps, WC, Medicaid, or SSI
- Bank Statements
- Letter from employer verifying income
- Proof of bankruptcy settlement

**What About Professional Courtesy?**

- **Who do you offer courtesy to?**
- **Staff?**
- **Other DCs? Clergy? Military?**
- **What about when insurance is involved?**
- **Is it in writing?**
Define Your Policy

Insert Practice Identifying Information
Sample Policy for:

Professional Courtesy

It is the policy of this office to only offer legal Professional Courtesy arrangements. In keeping our policy legal, we adhere to the following guidelines:

- The policies listed below are offered to all members of the stated groups without regard to volume or value of referrals;
- May include only those services regularly offered by the practice;
- Are included in written policy and have been approved by top practice management;
- Cannot be offered for copay waivers unless the insurance company paying the bill is informed in writing or there is documented and verified financial hardship; and
- Does not violate anti-kickback laws or claims submission rules and regulations.

Define Your Policy

We offer discounts to the following groups at the following levels:

- Staff members or (insert practice name), are offered treatment in the office at (insert percent) discount.
- Durable medical equipment, nutritional supplies, or other hard goods are offered to staff members (shown at doctor cost, or regular discount, or other noted).
- Immediate family members of top staff or (insert practice name) are offered treatment (insert are applicable discount or consideration).
- For the purpose of this policy, immediate family members are considered to be (other, such as spouse and children, parents, etc).
- Follow standard payment per contract and are offered treatment in the office at (insert discount or conservation of discount).

NOTE: In circumstances where auto accidents, worker’s compensation accidents, other personal injury or other medical legal situations occur, where reporting actual fees is necessary, and the party resolving the claim is responsible for paying treatment at this office, the party may dispute the amount of the fees and elect to be charged our full and actual fee at that time. The party or person into writing what the office is directed to do, and at that time the party is fully responsible for and expected to pay full fees in order to have them reported to a third party for medical-legal reasons.

Unfortunately, if the party who qualifies for Professional Courtesy wishes to use third-party health insurance for any reason, they must opt out of this policy, because the office will collect 100% of the copayments, co-insurance, and any asset deductible, as with any other patient.
Managing Discounted Fees in Software

- Set a fee schedule
- Keep actual fee and then use "specific write-off" entries
- Assign patients as necessary to that fee schedule
- If working with copay/deductible, use write off sparingly