How To Be A Billing Advocate for Your Patients

Most patients would be shocked to know that experienced medical office billing staff struggle with understanding the detailed complexities of coding, billing and insurance reimbursement. Even though there are standards for translating services and diagnoses into codes that identify the medical event, insurance companies **each have their own rules** for how they accept and/or pay for those codes- rules that are subject to change with minimal notice.

I have to admit that at one time I felt strongly that patients needed to take responsibility for understanding their medical benefits plan and advocating for themselves. Everything has become much more complex though, and I have come to believe that as the experts it is our job to understand patients' benefits and help them receive them. Patients have difficulties understanding their own coverage for a myriad of reasons:

Reasons Why Patients Don't Understand Their Benefits:

1. The benefit book is not written in a way that many subscribers can understand.
2. Most subscribers will not take the time to read the benefit book and ask questions about the plan at the time they receive the benefit.
3. The benefit book is usually accompanied by a sheet or two of paper that alters the verbiage in the basic book to describe the exact information for the patient's plan.
4. Not all businesses have an assigned employee to translate benefit books for the staff.
5. Many employers change their plans annually.
6. Most plans do not send representatives to workplaces to

review plans with new employees.

To be sure there is the self-serving aspect of advocating for the patient in that we have less to collect from the patient, but I believe it is our job to minimize the patient’s out-of-pocket for them.

Who Are The Stakeholders?

The employer, the insurer/payer, and the healthcare service provider each have different motivations when it comes to paying for patient’s medical service. There is little motivation for each to communicate and collaborate for a good outcome for all. Assuming we are taking for granted each of these entities’ desire to make sure the patient receives excellent quality care, what is the viewpoint of each of these stakeholders?

The **employer** is concerned with keeping monthly health insurance premiums affordable, and minimizing claims experience. Employers try to keep premiums from increasing at a rapid rate so they can afford the coverage and satisfy employees.

The **insurer/payer** is concerned with paying out less money in claims than it collects in premiums. Because most insurance companies are for-profit, there is extreme pressure to deliver dividends to shareholders and bonuses to executives.

The **healthcare service provider** is concerned with charging an amount that does not leave any money on the table, making up for the underpayments of Medicare and Medicaid by the charges to other insurance companies, and keeping expenses as low as possible to offset decreasing reimbursement.

The **patien**t is the ultimate stakeholder and the one responsible for paying an average of 30% of the contracted charge. The patient is typically the least knowledgeable and the least able to walk the maze of terminology and rules to

achieve the needed outcome.

How Do Insurers Avoid Paying Claims?

1. Pre-existing condition (if no proof of continuous coverage exists)
2. Other payer responsible (worker's comp, auto accident, liability)
3. No pre-certification or pre-authorization
4. Did not advise of emergency within 24 hours
5. Not medically necessary
6. Medical records must accompany claim
7. Provider not in network
8. Ineligible on date of service
9. Untimely filing – did not file within deadline which is different for every insurer
10. Non-covered service
11. Not enrolled within timeframe (babies)
12. Escalating premiums to the point that employers seek other coverage.

What Can Medical Offices Do to Advocate for Patients?

1. Provide patients with a brief handout explaining health insurance terminology. Have this information on your website.
2. Compile information about each insurer and each plan that your patients have. A wiki is ideal for this, but a good old-fashioned 3 x 5 card file will do. Yes, the patient has the agreement with the insurer so technically knowing their plan is not your job, but who loses if the insurer doesn't pay? Yep, you do.
3. Use eligibility software or call the insurers to get the plan information and document this in your master file AND on the patient's record. Include deductible, co-pay, co-insurance, network information and non-covered services.
4. When the patient arrives in the office, let them know

you’ve checked on their plan and what you found out that will relate to this visit. If you find out something that will alter the patient’s payment requirement, call them before the appointment to let them know about it and give them a chance to cancel or reschedule. No surprises!

5. Thoroughly explain any waivers or ABNs (Advance Beneficiary Notice for Medicare patients) you have patients sign for services that their insurers may not pay for.
6. Make sure that any test or service (including lab work) that you send the patient for is provided by an entity approved by their insurer.
7. If you are scheduling the patient for a procedure with your provider, give patients complete information on your charges. Also give them information on estimated charges from any other provider involved in the procedure (assistant surgeon, physician assistant, radiologist, anesthesiologist, pathologist) as well as any facility charges from the hospital or ASC (ambulatory surgery center.) Help patients to check on physician/practices to make sure they are approved for the patient’s plan.
8. If you plan to send the patient a statement for any services, give the patient a sample bill and review how to read it. Have the same thing on your website for patients to refer to.
9. Encourage patients to call, email or make an appointment to talk to you face-to-face about their billing questions. Make it clear your office is glad to help them. Do not become defensive if a patient asks about their bill or questions if it is correct.
10. Don’t be afraid to admit to the patient that your office made a billing mistake if indeed you did. Everyone makes mistakes and as long as you apologize and do not try to shift the blame to the patient or the insurance company, all should be well.

11. If need be, help the patient take the next step in filing a complaint against their insurance company if the company is not fulfilling their responsibility in paying the claim. As the insurance companies often do, arrange a three-way call to discuss the patient’s claim and why it is not paid. Medicare patients receive a quarterly notice that lists claims for the previous 90 days and lists appeal details on the back of the notice.

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