Why You Should Not Reward Your Billing Staff for Collections

Do <u>not</u> incentivize and reward your billing staff for reduced days in accounts receivable, increased collections or decreased non-contractual (bad debt) write-offs!

I bet you thought I was going to say that billers are paid to do a job and they should not be incentivized for doing the job you hired them to do.

Not true – I am not against incentivizing employees to do a job at all; most people enjoy a challenge and feel great when they reach a goal.

However, when a subset of employees in your practice is incentivized for increasing revenue, you can be sure it will create resentment and low morale for the rest of your employees. Do you think word won't get around that you're rewarding the billers? If so, you're completely wrong. There are no secrets in a medical office. People know what others make, and regardless of what your Employee Handbook might say, it is not grounds for termination for employees to share what they make with others.

What I do encourage you to do is to incentivize your ENTIRE staff to reduce days in accounts receivable, increased collections and decrease non-contractual (bad debt) write-

offs. Ultimately, your entire staff is responsible in one way or another for collections.

Consider how each person in your practice must contribute to the overall effort to make sure collections are at goal:

Front Desk: entering/verifying demographics and picking the right insurance plan for each patient; collecting the correct amount at time of service, whether it is an exact amount or an estimate of the patient's responsibility.

Phones/Scheduling: making new patients aware of financial policies and what will be expected at time of service ("Please remember to bring the credit card you'd like us to keep on file for you"); making sure that Medicare patients know the difference between an Annual Wellness Visit and a Complete Physical.*

All clinical staff including Physicians/PAs/NPs: making sure that the patient signs an Advance Beneficiary Notice (ABN) for any services that insurance will not pay for, regardless of whether the patient is Medicare or non-Medicare**, before the service is rendered.

Manager: addressing patient complaints that escalate to you quickly and efficiently, not giving a patient any reason not to pay; making sure you have an easy-to-read-and-understand Financial Policy*** explaining your collection at time of service policy.

Everyone: embracing a culture of Customer Service, making sure that patients are satisfied with their experience; sending a consistent message to patients that you are interested in bringing them **value for their dollars** and reinforcing your desire to have an ongoing relationship with them.

Complete the **Contact Form here** to request any of the free resources discussed in this post and listed below.

- *Cheat Sheet for Medicare visits
- **Non-Medicare Advance Beneficiary Notice (ABN)
- ***Financial Policy

Image by Samuel Zeller

2013 Medicare Parts A, B, C and D Deductibles and Premiums

The Part B Medicare deductible for 2013 is $147.00.

What should you do with this information? You should avoid taking a **big financial hit** in the first quarter of 2013 by collecting deductibles at time of service. How do you do that?

- Let all patients know in advance that you collect deductibles by making it part of your communication with them. Put it in your financial policy (get a copy of my preferred financial policy below), put it on your website, and let patients know when you schedule their appointment, or make an appointment reminder with verbiage like:

> ***"We look forward to seeing you at your appointment. Please bring your insurance cards and all medications to your visit. We will collect your co-pay, your deductible, and any co-insurance required by your insurance plan."***

- Explain what a deductible is. Get my sample patient handout explaining deductibles below.
- Train front desk staff on deductibles and get them comfortable discussing deductibles with patients and answering their questions.
- Do not collect deductibles for Medicare patients who also have Medicaid, or for Medicare patients with supplemental insurance as there most likely will not be a balance that the patient will owe.
- It is ideal to use a Credit Card On File program to charge the patient's credit card at time of service, or when the EOB (Explanation of Benefits) arrives in 15 days.

Other important Medicare numbers for 2013

Part A: Hospital Insurance Premium for 2013– $441.00 per month. Most 65+ patients get Part A for free if they already receive retirement benefits from Social Security or Railroad Retirement due to taxes paid during working years. Part A includes coverage for:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care – skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, dietary and home health aides (100% covered with no co-pay) for homebound patients after a 3-day hospital stay

Part B: Medical Insurance Premium for 2013 – $104.90 per month for most, but not all patients. Some patients automatically get Part B, others may have to pay more based on their IRS tax

return from 2011. Part B includes coverage for:

- Services from doctors and other health care providers
- Outpatient care (includes emergency room and observation services for physician charges)
- Home health care – services provided to a homebound patient when the patient has not been hospitalized for 3 days prior to need
- Durable medical equipment
- Some preventive services

Part C: Medicare Advantage Plans – also called a Medicare Replacement Plan because it replaces traditional or original Medicare with a plan offered by a Medicare-approved private insurance company (BCBS, UHC, etc.) Premiums vary with individual Medicare Advantage Plans. Medicare Advantage Plans:

- Include all benefits and services covered under Part A and Part B
- Usually include Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost
- Cannot be used in combination with a Medigap policy

Part D: Medicare Drug Coverage for 2013 – monthly premiums will vary based on income, and whether or not Part D is included if the patient opts for Part C coverage. Some plans have deductibles and some do not. Most drug plans have a coverage gap referred to as the "donut hole", which means coverage is temporarily limited after the patient and drug plan have spent a certain amount for covered drugs. In 2013, once the patient reaches the donut hole, they pay 47.5% of the plan's cost for covered name-brand drugs and 79% of the plan's cost for covered generic drugs until the end of the donut hole

is reached. In every successive year after 2013, the donut hole will shrink until 2020 when the donut hole will cease to exist.

Medicare Supplement Insurance (also called Medigap) – Policies are sold by private insurance companies and help pay some of the health care costs that Medicare doesn't cover. Patients have a one-time 6-month Medigap Open Enrollment Period which starts the first month they are 65 and enrolled in Part B. This period gives patients a guaranteed right to buy any Medigap policy sold in their state regardless of their health status.

Click here to receive a free copy of a financial policy and a patient handout explaining deductibles.

CLICK HERE to Download the Financial Policy and Deductible Handout!

How to Develop a New Financial Policy For Your Practice: A Short Course

I've had lots of questions about financial policies since I did a webinar on patient collections last year. Here's a short course on developing a new financial policy for your practice. The topic is addressed more comprehensively in my book.

I dislike financial policies that are long and wordy. I prefer a simple format that everyone can understand and use.

The format I recommend is one with three columns titled:

1. Your Plan
2. What You Do
3. What We Do

Here's an example of how the three columns would read:

Your Plan

Medicare

What You Do

Pay your deductible ($155 for 2010) and co-insurance (20% of the allowable.)

What We Do

We will file Medicare for you.

I use the front of the financial policy to list all the variations of plans that the practice accepts. For instance, the Medicares might include:

- Medicare
- Medicare/Medicaid
- Medicare/supplemental policy
- Medicare Advantage Plan (HMO/PPO)
- Medicare Advantage Plan (PFFS)
- Medicare secondary (MSP)
- Railroad Medicare

Lump together any like plans that you will treat the same. Then decide what you will expect from the patient at time of service or after, and what the practice commits to doing. Don't forget to address patients being seen out-of-network and self-pay patients.

I use the back of the policy to cover everything that you would like the patient to sign off on. This could include:

- Receipt of Notice of Privacy Policies
- Receipt of Advance Directives/Living Will info
- Agreement to Financial Policy
- Assignment of Benefits to Practice
- Guarantee of Payment

When you put a new policy in place, you have a number of options to educate patients. Here are some:

- Put the policy on your website.
- Send a copy of the policy to all new patients.
- Discuss the policy when you call patients to remind them of their appointment.
- Discuss the new policy at check-in and/or check-out and let patients know it will be in effect at their next visit.
- Circle the patient's plan on the front, have the patient sign the financial policy on the back, and give them a copy to take with them.

How you decide to educate the patients will depend on how much time you have between making the appointment and seeing the patient and the type of practice you have – primary care versus sub-specialty.

Also, don't forget to educate your staff. If they have not had to discuss money before, they will need some coaching and some practice.

If you'd like a free copy of my sample financial policy, shoot me an email at marypatwhaley@gmail.com.