Practice Management: Finance, Billing, and Collections

What's the Risk?

For practitioners in outpatient settings, financial stability and success are critical in ensuring the practice can continue to see, treat, and care for patients and to offer fair wages and benefits to employees. It requires knowledge of contract responsibilities with insurance companies and Medicare and Medicaid programs in addition to awareness of regulatory statutes and responsibilities. It requires comprehensive financial policies and procedures that address the performance of financial activities and careful monitoring of these activities to ensure compliance. Without a comprehensive and sound financial program, the practitioner risks financial instability, regulatory agency fines and penalties, contract breaches, and dissatisfied patients who go elsewhere for their care.

Addressing the nonpayment of patient bills is important. Overly aggressive collection techniques can alienate a patient to the point of triggering a lawsuit, particularly if the patient receives the bill after a complication resulting from a practitioner's actions, has a legitimate claim of unsatisfactory care, or has not received the billed services. Conversely, waiving fees related to treatment can result in a violation of fraud and abuse laws.

Delay in sending records or test results to the patient or another practitioner because of an unpaid bill can potentially delay treatment, which may be the basis of a claim. Juries tend to care very little about the financial aspect of healthcare delivery. If an injury results from a delay in appropriate treatment, and the delay is tied to an unpaid bill, the jury will likely be very sympathetic to the patient.

When Is This Risk an Issue?

Little can threaten the professional relationship as quickly and totally as a patient's perception of unfair billing practices. It is important to communicate the office's financial/billing policies to patients early in the relationship. Doing so informs patients of their expectations, responsibilities, and potential consequences if they do not pay. Advising patients of the potential consequences for nonpayment may help improve patient compliance with payment. It also sets the foundation for terminating the patient-practitioner relationship, should that become necessary.

Financial Policies and Procedures

Practitioners rely on their employees to carry out many required financial activities, such as billing (no-shows included), co-pays, self-pay patients, collections, insurance forms, resolving

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disputes, reporting and correcting overpayments, handling credit cards and money, and informing patients of their payment responsibilities. Nonadherence to policies and procedures may result in illegal use of protected health information (PHI), stolen credit card information, and/or stolen money in addition to noncompliance with regulations. Policies and procedures help orient employees to their responsibilities, set expectations, and assure consistency in financial practices. Ongoing employee performance monitoring is important in quickly identifying noncompliant staff.

Medical identity theft is a quality of care concern, potentially putting patients at risk for harm due to inaccurate medical records. It is also a financial hardship and an administrative burden to correct inaccuracies in billing and health records. The reception area and/or billing department may be the first line in detecting identity theft. For more information on medical identity theft, see ***Reporting: Drug Diversion & Criminal Acts***.

Financial procedures are thus far from being peripheral business activities with little bearing on the professional focus of the office. They are central to the total care of the patient and may often require practitioner involvement and intervention.

Compliance

The Office of Inspector General for the United States Department of Health and Human Services expects individual providers and group practices to implement a voluntary compliance program that will help prevent unlawful conduct and submission of erroneous claims. Providers are responsible for keeping apprised of current Medicare rules and regulations; monitoring adherence to applicable statutes, regulations, and program requirements; and ensuring that staff members are educated and continuously updated on Medicare guidelines related to coding and billing for services. Failing to meet these responsibilities could lead to acts or omissions that may expose the physician practice to civil and/or criminal sanctions and penalties. The practice is also responsible for billing errors made by a third-party billing service, even if the practice was unaware of the error. Errors can accumulate quickly and may result in significant fines or other penalties.

For specifics on corporate compliance, coding, and fraud and abuse laws, see ***Corporate Compliance***.

Collections

While some patients who do not pay bills may simply be lax, others are dissatisfied with care. If practitioners fail to review patient files before sending them to a collection agency, it is possible for the agency to contact patients who suffered complications or had quality of care issues.

Nonpayment may also be due to incorrect billing or billing for services not rendered. An investigation into the reason for nonpayment may help to identify these situations and make corrections before further billing errors occur.

Although a practitioner is not expected to give free care except by prior agreement, it is not ethical or legal for the practitioner to withhold needed treatment because a patient is derelict in paying a bill. A patient with an outstanding bill who makes appointments for additional office visits without ever mentioning the open balance may need to either be scheduled for a visit to discuss payment options or be terminated from the practice. For specific recommendations on how to terminate a relationship with a patient, see ***Terminating the Provider-Patient Relationship***.

Quality Payment Programs

Out goes meaningful use and the sustainable growth rate formula for clinician payment and in comes the quality payment incentive program known as Quality Payment Program (QPP). With the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and the Bipartisan Budget Act of 2018, reimbursement programs based on quality measures are in a constant state of change. This necessitates practitioner awareness, program knowledge, and decisions on options available to maximize bonus points and reimbursement dollars.

QPP rewards value and outcome through two programs: the Merit-based Incentive Payment System (MIPS) that offers a choice of four performance measure categories[1] and the Advanced Alternative Payment Model (APM) that gives incentive payments for high-quality, cost-efficient care that is specific to a clinical condition, care episode, or population.[2] CMS' goal is for the QPP to simplify and reduce burdens on the practitioner. While this is still being hotly debated, CMS has made it clear that it will continue to build on the programs; change, add, and/or delete measures; and adjust bonus points and performance thresholds in the years to come. Practitioners who do not keep up on these changes may find themselves receiving less reimbursement for medical services rendered.

How Can I Reduce Risk?

Practitioners can implement various strategies to reduce the risks associated with financial processes in the outpatient setting. Risk management recommendations for each of these strategies follow in the table below.

Develop a Billing Policy

Create a written policy

- Develop financial-related policies for the practice in respect to at least the following matters:
  - Billing processes and procedures.
  - Collecting and handling copays.
  - Using a collection agency.
  - Determining if and when it is acceptable to waive copays, balances due, and other amounts. Recommend consulting with legal counsel.
  - Estimating fees, payment plans, and/or other financial options for self-pay patients.
  - Accepting credit cards.
  - Assigning responsibility for insurance forms (office or patient).
  - Determining patient responsibility for resolving payment disputes regarding services, tests, treatments, and procedures not covered by insurance.
  - Billing for no-shows and late cancellations with less than a specified time of notice.
- Review the policy for auditing and monitoring accuracy of claims submissions and for reporting and correcting overpayments.

Train employees

- Ensure a process is in place for orienting employees to the policies and procedures they are responsible for and for monitoring compliance.

Inform patients

- Develop a method to inform patients about billing practices before their first appointment.

Post policy

- Post the billing policy in the reception area so that it is visible to patients and on the practice's website.
- Include billing policies for patients in the practice's welcome brochure or welcome packet.

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Develop a Billing Policy

Notify physician or designee

- Ensure that billing staff promptly notify the physician or designee upon receipt of any letters, phone calls, legal documents, or other indications that a patient may be unsatisfied regarding a bill or the care received.

Discuss Financial Policies and Fees

Discuss fees

- Discuss fees up front, preferably at the first visit. Conduct this discussion tactfully. Adequately inform patients so they are not surprised at the amount when they receive a bill. Be sure to discuss costly or unusual out-of-pocket expenses before rendering treatment.
- Encourage patients to discuss with the office manager or practitioner any financial issues or concerns that may affect their ability to comply with the billing policies so a plan can be developed.

Explain payments

- Estimate fees and explain payment expectations prior to entering into a long-term relationship and/or performing expensive procedures not covered by insurance.

Establish a written plan for self-pay patients

- Develop a written payment plan or other financing option that both practitioner and patient sign. Retain the original payment plan in the patient's medical record and give the patient a copy of the plan.

Develop a Collection Process

Review files

- Develop and implement a process for physician and/or designee review of the patient's chart before referring a bill for collection.

Call first

- Ensure that the practice manager calls the patient to determine the reason for the unpaid bill before turning the bill over to a collection agency, as this

Develop a Collection Process

	may uncover problems related to patient dissatisfaction.
Ensure letters are polite	• Ensure that collection letters are polite and written in plain language. Invite the patient to call to arrange a favorable payment schedule. In the interest of fostering good patient relations, consider special payment arrangements for patients with a true financial hardship.
Monitor the agency	• Select collection agencies that neither employ abusive and threatening practices nor add an additional surcharge for collections. Periodically monitor the collection agency's activities. Instruct the collection agency to obtain written permission before filing a suit regarding an uncollected debt.
Continue to treat	• Never deny treatment to a current patient because of an unpaid bill. Never delay releasing medical records or test results to the patient or another physician because of an unpaid bill.

Address Medical Identity Theft Prevention and Detection

Train staff on identifying red flags	• Instruct registration personnel to look for identifications that appear altered or forged, photos that don't match the person presenting for care, information given that doesn't match information on file, a Social Security number or insurance card that duplicates one already used for another patient, and duplicate demographics.
	• Train billing staff to identify red flags with billing discrepancies:
	  ○ Patient complaint regarding a bill for services the patient did not receive.
	  ○ Insurer denials due to inappropriate or impossible charge (e.g., appendix removed

Address Medical Identity Theft Prevention and Detection

	on patient that had previously had an appendix removed). ○ Patient bills returned as undeliverable even though healthcare charges continue to accrue. ○ Mail sent to known patient but returned despite address verification.
Inform patients	• Educate patients about medical identity theft through information sheets or posters. Inform them how to prevent and detect potential identity theft (e.g., inaccurate EOB statements from insurers, inaccurate medical record information, and bills for services never received).
Investigate and respond	• Develop clear policies and procedures for investigating suspected medical identity theft.

Be Informed Regarding Quality Payment Programs

Review criteria for participation	• Determine if you meet the qualifications for participating in one of the Quality Payment Programs (e.g., Merit-based Incentive Payment System or Alternative Payment Models).
Review options available	• Determine what performance categories best suit your practice, patient population, and available resources for submitting data.
Meet the reporting deadlines	• Keep up to date with the reporting deadlines and ensure your data is submitted on time.
Share performance data with office staff	• Share performance reports with office staff to promote awareness of successes and opportunities for improvement.
Keep abreast of the changes	• Review and monitor changes made to the program and the performance measures at least annually.

Contract With and Monitor Third-Party Billers

Contract with billers

- Consider the following when contracting with a third-party biller:
  - Contract only with a firm or group that provides a written guarantee that none of its employees have been excluded from any federal payer program.
  - Create written protocols detailing the third-party biller's collection obligations.
  - Do NOT make payments dependent upon percentage of collections.
  - Specify in the contract that the biller has no authority to change practitioner codes.
  - Write into the contract that the practice has the authority to inspect the biller's records at any time.
  - Include a hold harmless clause in the contract.

Perform audits

- Ensure the third-party biller performs and reports on audits, corrections, updates, and issues identified for the practice.
- Monitor third-party biller activities and perform random audits. Correct any coding and billing problems discovered during the course of such an audit.
- Ensure the third-party biller has developed and implemented a compliance plan. Review the compliance plan and ensure employees understand their roles and responsibilities.

References:

1. American Medical Association. Quality payment program specifics: learn how medicare payment & delivery is changing. AMA website. https://www.ama-assn.org/practice-management/medicare/quality-payment-program-qpp-specifics. Accessed 6/14/2019.
2. Centers for Medicare & Medicaid Services. Quality payment program. CMS website. https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html. Accessed 6/14/2019.