What Does Financial Counseling Mean to You?

Presented
October 19, 2017
AR HFMA

Presenter
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Director of Business Operations
Consulting
Objectives

- Understand the importance of full financial counseling, not only for the patient but also the organization’s financial health.
- Identify the varying processes in financial clearance and counseling and how they affect overall collections.
- Gain tips on how to streamline processes and enforce accountability will be provided.
Who Has Financial Counseling?

How Do You Define It?

- Medicaid Apps?
- Collecting Copays?
- Collecting Deductibles?
- Patient Estimates?
- Patient Education?
- Charity Apps?
- Financial Assistance?
- Authorization?
- Reviewing Medical Necessity?
Defining a Financial Counselor

**Patient advocate**
- Financial educator
- Provider of the patient’s financial health

**Billing office advocate**
- Ensures services are covered
- Collects patient responsibility

Financial Clearance!

What Does Financial Clearance Mean?
- The institution or physician knows how they are going to be paid before they deliver the service
- The designated financial clearance staff reviews and ‘clears’ all patients before services
- Lack of payment is 1 of 2 things:
  - Insurance denials
  - Lack of patient payment
Patient & Provider Concerns

Q: Does this mean patients won’t be treated unless we know we will be paid?

A: No!!! It means that you understand the financial responsibility of the patient and are able to educate the patient so that you and the patient can make informed decisions.

A lack of due diligence surrounding payment for services puts both the clinic and patient at financial risk!

Financial Counseling, is it Important?

- Auth/Appropriate Use Criteria/Clinical Decision Support
  - All basically same idea – Pathways for medical necessity
- Cost sharing is on the rise
  - Estimated - $1 out of every $4 come from patients
- Kaiser Family Foundation
Help comes from all directions!

- Patient
- Authorization?
- Patient Education?
- Collecting Copays?
- Medicaid Apps?
- Charity Apps?
- Financial Assistance?

Revenue Cycle Quarterback

- Providing Coverage
- Patient Education
- Insurance Clearance
- Collecting in Dept
- Financial Counselor
- Patient
Insurance Clearance

• Eligibility/Verification
  – Registration or Scheduling responsibility
• Authorization
  – Auth team or financial counselor themselves
• Medical Necessity
  – Reviewing scheduled procedures for policy adherence
  – Providing documentation for prepayment reviews
• Denials/Rejections
  – “Those who don’t know history are destined to repeat it.”
  – Must track failures and success

Top Billing Errors

1. Duplicate claims
2. **Claim lacks required information**
3. **Lack of authorization**
4. Bundled
5. **Eligibility expired**
6. **Service not covered by insurer**
7. Claim Submission time limit expired
## Cost to Rework a Claim

<table>
<thead>
<tr>
<th>Capital</th>
<th>Cost</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back End Staff Time</td>
<td>$6.66</td>
<td>~20 min @ $20+/hr</td>
</tr>
<tr>
<td>Front End Staff Time</td>
<td>$2.50</td>
<td>~10 min @ $15/hr</td>
</tr>
<tr>
<td>Supplies</td>
<td>$1.75</td>
<td>Telephone, EMR, internet</td>
</tr>
<tr>
<td>Opportunity Cost</td>
<td>$2.00</td>
<td>What could you have done with that money?</td>
</tr>
<tr>
<td>Overhead</td>
<td>$2.00</td>
<td>Fixed costs - management, equipment, space</td>
</tr>
<tr>
<td><strong>Total to Rework Claim</strong></td>
<td><strong>~$15.00</strong></td>
<td></td>
</tr>
</tbody>
</table>

## Only as Good as Your Information

![Trash can with "In = Out" symbol](image)
Registration and Verification

• Ensure complete registration is performed ahead of patient arrival. Not just enough to get them scheduled.
• Verify patient insurance information
  – Eligibility period
  – Coordination of benefits
  – Referrals needed
  – Obtain patient benefits
  – Utilize verification software – fast!
• Allows FC to be prepared & cuts down on pt wait times

Denials Due to Authorization

• Authorization not requested or obtained
• Authorization pending, service provided
  – “I can’t wait”
• Authorization obtained but for wrong service(s)
  – Wrong codes or units
• Authorization obtained, information not on claim
  – Put information in wrong place in EHR
• Different diagnosis authorized vs billed
Centralized vs De-Centralized

Centralized
• Greater control of the process for whole organization
• More coverage options for PTO, cross cover
• Basic pro – Efficiency

De-Centralized – In the clinic/department
• Greater specialty knowledge
• Direct relationship with clinic/dept
• Clinic can take some ownership in process

Own or Oversee Authorization
• No procedure should be performed without authorization
  – Clinic staff must verify prior to procedure
• All procedures must have authorization clearance
  – Those not requiring auth must have “No Auth Required” in the medical record to inform clinical staff
• All authorizations must be verified for completeness and appropriateness
  – Verify all codes available and units correct
  – Verify auth period is still eligible
  – Ensure auth letter is available for follow up team
Verify Medical Necessity

• Create list of non-covered items that are payer specific
  – This will be known when reviewing denials
• Non-covered items must be brought to physician attention
  – If decision is unchanged, bring to medical director
• Develop policy for off-label/script orders
  – Physician control board to review and approve off-label use

Providing Coverage

• Look for commercial coverage!
  – Some patients can pay, just don’t have insurance
  – Premiums may be less than out of pocket costs
• Interest free or low interest loans
• Medicaid – Requires proof of income, Retro 3 months
• Financial Assistance – Free drug, copay assist, charitable foundations
• Charity – Discount policy based on federal poverty guidelines
Medicaid Eligibility Criteria

Affordable Care Act of 2010 Expands Medicaid Eligibility in 2014

- The Affordable Care Act of 2010, signed by President Obama on March 23, 2010, creates a national Medicaid minimum eligibility level of **133% of the federal poverty level** for nearly all Americans under age 65.

Other Eligibility Criteria

- In order to be eligible for Medicaid, individuals need to satisfy federal and state requirements regarding residency, immigration status, and documentation of U.S. citizenship.

Retroactive Eligibility

- Medicaid coverage **may start retroactively for up to 3 months prior to the month of application**, if the individual would have been eligible during the retroactive period had he or she applied then. Coverage generally stops at the end of the month in which a person no longer meets the requirements for eligibility.

Review for Patient Assistance

- Bill payment
  - Copayment assistance
  - Foundation grants
  - Drug manufacturers
- Social programs
  - Housing
  - Transportation
  - Meals
- Drug replacement programs through manufacturers
2017 HHS Poverty Guidelines

- For all states (except Alaska and Hawaii) and for the District of Columbia. Published in February each year
- For families/households with more than 8 persons, add $4,160 for each additional person.

<table>
<thead>
<tr>
<th>Number in Family</th>
<th>Poverty Guidelines</th>
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<tbody>
<tr>
<td>1</td>
<td>$12,060</td>
</tr>
<tr>
<td>2</td>
<td>$16,240</td>
</tr>
<tr>
<td>3</td>
<td>$20,420</td>
</tr>
<tr>
<td>4</td>
<td>$24,600</td>
</tr>
<tr>
<td>5</td>
<td>$28,780</td>
</tr>
<tr>
<td>6</td>
<td>$32,960</td>
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<tr>
<td>7</td>
<td>$37,140</td>
</tr>
<tr>
<td>8</td>
<td>$41,320</td>
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Charity

Medically indigent adults "(MIAs)" in the health care system of the United States are persons who do not have health insurance and who are not eligible for other health care coverage, such as Medicaid, Medicare, or private health insurance.

- Does your facility have a charity policy?
- Typically based on federal poverty guidelines
- Could be full or partial forgiveness
Patient Education

• Educating on Insurance
  – Most patients don’t understand their benefits and responsibilities
• Providing Estimates
  – Based on procedures to be performed and billed
  – Use charges and allowables
  – Apply patient benefits to this for estimate
• Follow up
  – For extended tx, follow up periodically
  – Review previous balances in other departments

Coding Templates: Estimates

• Based on practice patterns of physician
• Estimate charges via coding/charge templates
• Utilizes charge amounts, Medicare allowable rates for area and commercial allowables if known
  – Updated contract management module is key
• Estimate:
  – Charge amounts
  – Allowable amounts
  – Patient responsibility based on benefits
### Treatment Estimate Worksheet

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>Qty</th>
<th>Charge</th>
<th>Medicare</th>
<th>Commercial</th>
</tr>
</thead>
<tbody>
<tr>
<td>77263</td>
<td>Clinical Tx Plan</td>
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<td>$600</td>
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<tr>
<td>77290</td>
<td>Complex Simulation</td>
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<td>$2,000</td>
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<td>$500.00</td>
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<tr>
<td>77334</td>
<td>Complex Tx Device</td>
<td>1</td>
<td>$500</td>
<td>$140.50</td>
<td>$150.00</td>
</tr>
<tr>
<td></td>
<td><strong>Totals</strong></td>
<td></td>
<td>$3,100</td>
<td>$761.29</td>
<td>$825.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Commercial Insurance</th>
<th>$825.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible to pay</td>
<td>$300.00</td>
</tr>
<tr>
<td>Balance</td>
<td>$525.00</td>
</tr>
<tr>
<td>Coinsurance 20%</td>
<td>$105.00</td>
</tr>
<tr>
<td><strong>Estimated Patient Responsibility</strong></td>
<td>$405.00</td>
</tr>
</tbody>
</table>

### Delivering the Message

- Use a worksheet
- Discusses every factor in decision
- Gives the FC a template for the discussion
- Stress this is an estimate!
- Explain how underpayments or overpayments are handled
- Script initial discussion:
  - “You are estimated to owe $XXX, how would you like to handle that today? We take cash, credit or check.”
  - “What can you pay today?”
- You’ll be surprised at what they can pay!
### Benefits and Estimated Patient Responsibility

**Patient Information**
- **Date:**
- **Patient Name:**
- **Patient DOB:**
- **Oncology Physician:**

**Insurance Information**
- **Insurance Co Name:**
- **Secondary Ins or Supplement:**
  - **Prescribed Needed Drugs:** Yes / No
  - **Prescribed Needed Imaging:** Yes / No
  - **Prescribed Needed Rad Onc:** Yes / No
- **Referral Required:** Yes / No

**Policy #**
- **Group #:**
  - **Effective dates:**
    - **To:**
    - **From:**
      - **Yes:**
      - **No:**

**Benefits**
- **Estimate Charges:**
- **Estimated Patient Responsibility:**
- **Payment Agreement:**
- **Date:**
- **Signature:**

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**Estimated responsibility is based on a tool which averages the financial responsibility for Baptist patients who have the same or a similar insurance plan. Your particular financial responsibility may vary from this estimate based on your physician's plan of treatment for you. Any account credits created by overpayment of actual incurred responsibility will be applied to other Baptist accounts with outstanding balances. Account credits in which all balances have been paid to Baptist will be refunded. Any deficits between collected payments and incurred balances will be sent to the patient in statement form.**

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### Advanced Beneficiary Notice

**Patient agrees to pay if Medicare denies the claim**

**Must be signed prior to performing the procedure**

**Considered fraud by CMS if form is signed after services**

**GA modifier is necessary to indicate an ABN signed**

**Prohibited from issuing ABNs on a routine basis**

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Collecting in the Department

- Copays
  - Create policy requiring collection of these
  - Will need policy for deviation of this
- Deductibles
  - Some require entire deductible up front
  - Up to each facility
- Coinsurance
  - Payment plans

Proactive Payment Plans

- Per facility policy. Typically already have one for accrued balances
- Have guidelines to follow with ability to deviate based on patient situation.
  - How much is due now
  - Varying levels of balance and how far out they can be paid
- Determine amount, date and route of collection
  “$100 per month. Will pay by credit card”
- Put credit card on file, request permission to bill with frequency
- Agreements with local banks for low interest loans

“Older accounts receivable are the most difficult to collect.”

Collection of Payments

- Accept credit card, cash and check payments
- Have policy and procedure for payment collection
  - Receipts for patients
  - Secure location to hold money
  - Posting to patient account
  - End of day batching (2 person sign off)
  - Reconcile postings to deposit

Measuring Success

Direct

- Denials – Trended by denial reason
- Department collections
- Patient assistance – free/replacement drug, copay assist

Revenue Cycle

- Net collection rate
- AR days
- Payer mix shifts
- Patient satisfaction surveys
**Financial Counseling Tips for Success**

- Separation of physician and finance
- Create a policy manual and follow it
- Know your MAC's Local Coverage Determinations (LCD) and payer policies
- Weekly meetings with business office to discuss denial trends specific to front office
- Track patient collection amounts and set goals
- Discuss patient collections during weekly staff meetings
- Continuous education for financial counselors

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