Patient Finances
Presented by KMC University

The KMCU Way

- Systems that have worked 30+ years
- Basics are often the most missing items
- Training is the foundation
- Training and repeating that training, and role playing make masters

Today’s Goals

- Learn to ask the right clinical and financial questions at the first contact.
- Maximize the first impression in the initial face to face encounter with the patient.
- Implement steps to properly lay out both clinical treatment plans and financial payment plans.
- Effectively deliver important clinical and financial information to the patient.
- Automate your treatment and financial plan systems.
- Ensure your patient understands your treatment recommendations and their financial responsibility so there are no surprises.

The Numbers Add Up

- Typical Number of NP/Month: 20
- Typical NP Case Average: $1800
- Approximate Income: $36,000/month
- Patients who drop out of care due to lack of understanding of their problem or finances can = as much as 50%
- Approximate Income: $18,000/month
- Lost income over a year: $216,000
Goals of a New Patient Phone Call

• Schedule the appointment
• Schedule the appointment
• Did I mention, Schedule the appointment?
• Address financial issues if they bring them up
• Determine if they wish to use third party assistance
• Collect data for pre-verification if possible
• Oh by the way: Schedule the appointment!

Who Knows What They Have Been Told?

• Have they seen another DC?
• Did they do things correctly?
• Do they understand what Medicare covers for Chiropractic?
• Are they “set” in their thinking?

Important Concepts for Call

“Medicare expects you to cover the cost of the initial exam (and x-rays if that’s appropriate) that will be performed on the initial visit, in addition to your portion for covered chiropractic adjustments. You can expect this initial visit out of pocket to range from ______ to ______ depending on what services are performed. (The range should reflect your ChiroHealthUSA initial capped fee on the low end, and your actual estimated fees for a new patient visit on the high end.) When we see you here in the office, we’ll also tell you about ways for you to qualify for discounted fees in our office that can apply to this visit, for people just like you with Medicare that only covers part of your care in the office. Rest assured that we never turn anyone away from care due to their ability to pay, and we’re happy to work with you to make this fit into your budget so you can get the care you need.”

More Important Goals of NP Phone Call

• Develop rapport with the new patient.
• Ensure they are in the right place and the doctor has helped others like them.
• Acknowledge that you are concerned about them.
• Remain positive and welcoming.
• Determine whether they wish to use 3rd party assistance so you can be more prepared.

Goals at End of Day One

• Patient understands that they’ve come to the right place, and has developed rapport with the doctor.
• Doctor has gathered necessary clinical data to determine a DX and TX plan.
• Patient understands their financial responsibility for today’s visit and that details will happen after ROF visit
• Patient pays something toward their financial responsibility today
• Patient joins CHUSA if they wish to access discounted fee schedule, if appropriate
• Patient signs general office financial policy

Clinical Day One: Data and Rapport

• Gather data and educate
• Don’t try to do too much on visit one.
• Data collected will be analyzed to get the cause of the problem
• Touch and tell through the examination
H + E = D => TX

• History will drive the examination: ask good questions!
• Examination (including testing) with History will drive the diagnosis.
• The diagnosis will ultimately yield the treatment plan.

This is Your Goal!

This is the most thorough exam I've ever had! I've come to the right place to get to the cause of my problem!

Financial Goals of Day One

• Patient pays something.
• Patient understands general financial policy.
• CHUSA is introduced for cash paying patients who wish to access a discounted fee schedule.
• Patient understands that finances are explained after ROF.

Beginning of Visit One

• Assess the Scenario
• Begin on the right foot
• Further the concept of “This is how we do it here”
• Don’t be afraid to talk about finances in the right context

A Simple Solution

Patient Friendly Medicare Education

• Patient Friendly Language
• Looks “Medicare Official”
• Starts the process on the right foot
www.patientmedia.com/medicare
A Simple Script: At the Return of Paperwork

"I'm going to review your paperwork now and prepare your file so we can get you in to see Dr. ____. This is a brochure that explains how Medicare works with Chiropractors. (hand brochure to patient) Please take a moment while I'm working with your paperwork to review it. During your consultation, Dr. ____ will be happy to answer any questions you have about it." (Leave the patient to review the brochure while you prepare to take the patient back to the consultation room.)

During Visit One

- Doctor refers back to brochure at appropriate intervals
- Discuss Medicare and the expectations
- Through examination, help them understand function

End of Visit One

- This is where magic happens
- This is where we can help them understand most clearly
- The tone you set here will carry through the patient's experience in your office

Definitions

1. Dual Fee Schedules
2. Improper Time of Service Discounts
   Improper Collection Policies
3. Inducement Violations
4. False Claims Act Violations
5. Anti-kickback Statue Violations

1. Avoid Dual Fee Schedules

- Charging more to insurance companies than you do to cash patients
  - Illegal in many states
  - Misrepresents charges to carriers
  - False Claims Act violation
  - May violate provider agreements
  - Triggers investigations

2. Time of Service Discounts

- Discount based on bookkeeping savings
  - May or may not be defined
  - Often not defensible or unreasonable
  - May not be permissible on Federally insured patients

Payment And Co-Pays Are Due At Time Of Service
3. Inducement Violations

- Per the OIG: "incentives that are only nominal in value are NOT prohibited by inducement law"
- No more than $10 per item or $50 in the aggregate annually
  - Even one free examination, x-ray, or therapy is a risk

Did Someone Say Groupon?

On March 28, 2013, the Minnesota Board of Chiropractic Examiners (MBCE) updated its website to clarify that Groupon-type advertising, where the amount paid by the patient is split between the advertising company and the provider, constitutes fee splitting and is prohibited. The following is taken directly from the Board's website:

"It has come to the attention of the Board that certain forms of advertising/marketing may place the license at significant risk of being in violation of the laws related to fee-splitting. Licenses should remember that certain forms of conduct that are available to the general public may be inappropriate for use by health care professionals. One such form of advertising/marketing is exemplified by online bulk-offer companies, such as Groupon and Living Social. The structure currently utilized by these and similar companies is simply not appropriate for doctors of chiropractic, as it constitutes "fee splitting," which is prohibited by the practice act.

4. 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

5. 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.
Regulated Fees

• By agreement, these fees are “imposed”
• Take the patient, take the fee
• Not considered a “discount”
• CMT only for Medicare
• WC, No-Fault and PIP defined by state guidelines

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

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 copays
  – Pulse and a spine

• Don’t confuse it with what a general discount is!! That’s what CHUSA is for!

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

Financial Hardship and Indigence Policy and Agreement

Financial Hardship Agreement Form

2014 Financial Hardship Agreement Form
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?

Goals for Day 1.5

- Doctor has completed diagnosis and treatment plan
- CA has received all pertinent info so the patient's responsibility can be determined
- The calculator you choose to assist you can be prepared in advance and ready for the FROF

Clinical Day 1.5

- Doctors must get their "work" done before the next visit.
- Treatment plan and DX is necessary for Financial ROF.
- Whatever handouts happen at ROF need to be prepared.
Goals of Insurance Verification

- Gather detail regarding coverage to assist with FROF
- Find out what codes are covered and what is the patient’s responsibility
- Confirm eligibility of the patient and their method of coverage
- Glean from Verification Bible information for benefits where possible
- Create templates for efficiency

To Begin With….

- One verification form will not work for every type of insurance
- Medicare, Personal Injury, Medicare Advantage, Medicare Secondary, Worker’s Compensation

Major Medical Verification

- Typical verification questions
- Verification of eligibility
- Checking for medical review policy
- Checking for summary plan documents-ERISA
- Setting up templates for most typical insurance plans

#1: Does Specific Medical Review Policy Exist?

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- #2: Use Diagnosis Codes That Meet Requirements

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- 3. Does the fee schedule have a maximum allowable (dollar limit) for L3030?
  - Is this maximum amount per condition or per year?
  - Is this part of a separate durable medical equipment (DME) benefit?
- 4. What is the co-pay or co-insurance?
- 5. Are there certain diagnosis codes necessary for reimbursement under the policy?
  - If yes, what are they or where can I find them?
- 6. Is a Letter of Medical Necessity/ preauthorization letter needed?
  - Does this need to be submitted prior to or with the claim?

Financial Day 1.5

- Team members must have insurance verified.
- Verification + TX Plan = FROF
- Payment plan calculations should be in place, ready for FROF
- Morning huddles ensure all is ready for ROF/FROF
Payment Plans
- Set up legal and correct payment plans.
- Once you bill/charge correctly, you can collect according to your plan.
- Set up monthly payment plans along the way so YOU control collections.
- Check with your managed care contracts for restrictions.

Clinical ROF
- Doctor gets agreement on “4 yeses”
- Last “yes” is agreement to pay for care
- Transition by passing baton to team member performing FROF
- Make the private conversation public
- Exit so team member can begin FROF

Financial Report of Findings
- Review the benefits or lack thereof
- Review the plan they just got from the doctor
- Estimate to the best of your ability
- Explain your processes
- Visit by Visit vs. payment plan

4 Yeses…4 Agreements
- Yes doctor, I understand I have a problem and want to get it fixed.
- Yes doctor, I understand that healing takes time and I will keep all of my appointments.
- Yes doctor, I want to fully participate in getting well and I will attend at least one Healthy Lifestyles Workshop
- Yes, I’m aware I’m financially responsible and will pay “X” dollars over “Y” period of time.

Payment Plans
- Set up legal and correct payment plans.
- Once you bill/charge correctly, you can collect according to your plan.
- Set up monthly payment plans along the way so YOU control collections.
- Check with your managed care contracts for restrictions.
Offer Affordable Options

- Get your “Fourth YES” with ease
- Make care affordable for everyone
- Get your patients the help they need, when they need it
- Third Party care/credit cards can make the difference

The Three Most Important Considerations

- You must CHARGE correctly...use the correct fee schedule
- You must BILL it correctly...use the right fee whether billing patient OR carrier
- You can COLLECT according to your policies

What Makes a Payment Plan Compliant?

- Use of proper fees to calculate patient responsibility
- Appropriate estimate of medically necessary care to be paid by 3rd party
- Automated payments from credit card handled properly
- No discounts given on 3rd party reimbursable portion of care

Medicare Payment Plans

- Once you have charged and billed correctly, you may collect according to your written policy
- OK to allow them to pay their portion on a monthly payment plan
- OK to incentivize excluded services 5-15% if prepaid...but we discourage this

Payment Plans = Opportunities

- Patients on payment plans:
  - stay under care longer
  - tend to get all the care they need, including rehab and other items
  - are more likely to have family under care

Financial Report of Findings

- Mr. Pitt, after verifying your insurance, we discovered that you do have some insurance support for your financial responsibilities, and that is great news! Your insurance carrier will shoulder the majority of the cost of your care.
- For additional financial assistance with your prescription of care, I am recommending membership with ChiroHealthUSA (CHUSA). You will be able to access discounted fees on all services that may not have other coverage and it will be a huge savings for the $39 annual investment for full family coverage.
- As you can see, your total estimated responsibility is only $960 (9-60). This $960 (9-60) includes all of the services Dr. Brown has recommended for you, including your pillow and other items necessary to complete your treatment. In our office, we offer three options for taking care of your balance.
Option One: Pre-Payment

- Mr. Pitt, option one is our most popular option. Dr. Brown would like to pass along some savings to you for allowing us to forego the bookkeeping responsibilities of collecting throughout the course of your treatment.
- She has decided that if you are able and willing to take care of this estimated balance today, we will pass along a 10% discount on your non-insurance services. In this case, your savings would be an additional $81 dollars. How does this sound?

Option Two: Monthly Budgeted Payments

- Mr. Pitt, sometimes our patients need to spread their payments out a little further. Because of this, we are willing to in-house finance your balance across several months to make it easier to fit into your budget.
- As you can see, we have calculated this at 6 months and with a down payment of $160 (1-60) today you could stretch this over 5 additional monthly payments of $160 (1-60). This will allow you the opportunity to spread this across several months, without any interest, and it is easier for us to process your payment only once a month. We will keep a credit card on file, and with your authorization, process your payment once a month. Is this option best for you?

Option Three: External Care Card

- Mr. Pitt, we have partnered with a great health care financing company called The HELPCard. What we love about The HELPCard is that we can help you get your monthly payment to an amount small enough that will meet your monthly budget's needs and it will act just like a credit card.
- The best news is, if you pay it off within an appointed amount of time, that can be as long as 12 to 18 months, there is no interest. This is like using someone else's money free of charge. As you can see here, we have calculated that your payment would be $80 (80) if we stretched your monthly obligation out as far as 12 months. Would that work better?

Objection: Wants to wait till next visit

- It's not a problem Mrs. Jones, if you need to speak to your husband. I know that I wouldn't want to make a decision like this without my husband present, either. That is why we hoped he would be able to attend this visit so that he could better understand what's going on with your care.
- Let's go ahead and take care of your balance to date, so we can start with a clean slate on the next visit. After you've had a chance to visit with Mr. Jones we'll be able to recalculate a payment plan that will work well in your budget. Today's charges added to yesterday's balance will be $150 (1-50).

Objection: Wants insurance only

- (CA) I understand Mr. Smith. I am not authorized to change your prescription of care; let me get Dr. Jones since that is different from what he said.
- (DC) Mr. Smith, I understand what you may be thinking. However, receiving only the care covered by your insurance would be a tremendous disservice to you. Your third-party coverage was never meant to cover all of your care. That's the reason that we became a provider for ChiroHealthUSA (CHUSA) to be able to extend a contracted discounted to you for the portion of your care that is an out of pocket expense.
- I would much rather look at how we can spread this across more time and work with your monthly payment, than have you consider not following all of my recommendations. The portion of care covered by your insurance will only be acute-focused care. To stop your care at that point would be like taking your braces off after just a couple of months of treatment. Again, that's the reason why we work to make this affordable.

Objection: Too far out of my budget

- Yes, Mary, I understand that this amount may be outside your budget. The truth is that it sounds like you have two problems. You have a health problem and a financial problem. We know you're in the right place for your health problem. In order to help you with the financial problem, help me understand what you think you can afford.
Pros of Treatment Plan Automation

- Scheduling out to first re-examination ensures it gets done. Doctors must assist here!
- Nothing slips through the cracks.
- Even if patient won’t commit, placeholders are used.
- Find a section of the schedule for reminders.

Pros of Payment Plan Automation

- Automation makes it easier for front desk
- Automation helps patients keep their commitments of appointments and care plans
- Payments become budget sized
- Payments of the patient portion could open the door to payments from 3rd party otherwise not available
- The cycle of care may change: no need to change payment plan
- At the end of treatment, it all evens up

Who Has to Worry about PCI?

- If you transact credit card business, you have to worry about it.
- Merchants (that’s you doctor) and 3rd party providers (CashPractice™) who process, transmit, or store cardholder data are required to adhere to certain data security standards.

Consequences of Non-Compliance

- Forensic Investigation
- Steep monetary fines ($25k per incident) levied by the card industries
- Lawsuits
- Damage to reputation
- Bad publicity
- Revocation of credit card business privileges

Payment Card Industry (PCI) Data Security Standards

- Mandatory compliance program resulting from a collaboration between credit card associations to create common industry security requirements for cardholder data.
PCI-DSS Expectations

Build and Maintain a Secure Network
1. Install and maintain a firewall configuration to protect data
2. Do not use vendor-supplied defaults for system passwords and other security parameters

Protect Cardholder Data
3. Protect stored cardholder data
4. Encrypt transmission of cardholder data and sensitive information across open public networks

Maintain a Vulnerability Management Program
5. Use and regularly update anti-virus software
6. Develop and maintain secure systems and applications

Implement Strong Access Control Measures
7. Restrict access to data by business need-to-know
8. Assign a unique ID to each person with computer access
9. Restrict physical access to cardholder data

Regularly Monitor and Test Networks
10. Track and monitor all access to network resources and cardholder data
11. Regularly test security systems and processes

Maintain an Information Security Policy
12. Maintain a policy that addresses information security

Healthy Lifestyle Workshop (HLW)
- The Healthy Lifestyle Workshop is the continuation of the ROF/FROF process.
- It gives you the opportunity to share the chiropractic story, get family support for your new patient/new practice member
- Your relationship is strengthened when a patient understands the importance of their Nervous System …to their health, well-being and day to day functioning.

100% Attendance
- Guarantee 100% attendance at your Healthy Lifestyles Workshops by using the psychology and the power of persuasion
- Explain that all NP are required to attend
- Explain it will save them time and money
- Get a written agreement – they write it
- 1 day prior - call the patient and their guest

What’s In It For Me?
- “I find that my patients who attend at least one Healthy Lifestyles Workshop get better faster, stay well longer, and care tends to cost less money”
The Financial Touch Base

• When we initially speak to the patient in the Financial ROF, we must remember they are in pain.
• When a patient is in pain, their ability to remember is impaired.

Components of the Financial Touch Base (FTB)

• Introduce yourself, including your title.
• This helps set the tone as a formal meeting.
• Remember, the patient may not remember your name.
• Great opportunity to incorporate team member business cards.

Components of the Financial Touch Base

• Explain that it is possible that an insurance check could be sent to their home address in error.
• When accepting assignment, make sure that the patient knows to immediately bring any insurance checks into you specifically.
• That way you can apply the payment to their account.

Components of the Financial Touch Base

• Tell the patient how often you will submit claims to their insurance company.
• Show them a CMS-1500 insurance billing form so they become familiar with it.

Components of the Financial Touch Base

• Show the patient several HIPAA scrubbed examples of Explanation of Benefits (EOB) from the various insurance companies.
• Tell them they may receive EOBs at home and that they should bring them into the office so you will have a copy for their file.
• "Sally, sometimes the insurance company sends you information, and they forget to send us a copy. Please bring in any correspondence for my review."
Components of the Financial Touch Base

- Engaging the patient in the Financial Touch Base allows the Financial Counselor to build rapport.
- Once rapport is built, asking for referrals becomes effortless.

Questions?
info@kmcuniversity.com