Debt collection becoming more necessary for physicians

Medical debt collection is becoming more important for physician practices as large deductibles and managed care plans shift more costs to the patient. Practices should review their policies on payment and collection to ensure they are up to date with the current demands for cash flow. At the same time, experts say physician practices need to ensure their procedure for appealing denied reimbursement claims is top notch.

One of the primary problems they found was a lack of clear communication to patients about payment and debt collection policies, Gundling says. “The debt collection folks don’t know what the physician practice is telling people, and the physician practice doesn’t know what the debt collectors are telling people,” he explains. “The patient is caught in the middle because they’re going with whatever they were told, when they might be held accountable for a different set of expectations.”

This finding led to recommendations that practices improve their patient communication about payment and debt collection, educating the patient at the first opportunity, Gundling says.

Both patients and providers are struggling with the steep rise in patient-owned medical bills, driven by the growing prevalence of high-deductible plans. Uncompensated care, including bad debt and charity care, increased 12% to $46 billion in 2012, according to a January 2014 survey of 5,000 hospitals by the American Hospital Association. At the same time, two out of...
five working-age adults, or 75 million people, are carrying medical debt or had problems paying medical bills, up from 58 million in 2005, according to the Commonwealth Fund. Additionally, 30% of U.S. adults say they or a family member have put off medical treatment in the past year because of the cost, according to Gallup.

Most physician practices do not handle their own debt collection, of course, but practices should ensure that the vendor who does is compliant with industry best practices, Gundling says.

“Ask if they embrace these best practices and follow the workflow that is outlined,” he says. “The physician practice should read these guidelines and understand them too, so they can understand how the billing and collection process works after the bill leaves their offices.”

Gundling says physicians should expect patients to ask more questions about billing procedures because they are paying more out of pocket, sometimes substantially more, than in recent years. “The more physicians understand how patient financial obligations work, the better,” he says. “The physician is their face-to-face contact, and so patients are going to turn to them for answers. None of us really understand our coverage until we get to the doctor’s office and ask them to explain it.”

In addition to the debt collection process, appeals for managed care reimbursement will be most successful if you have clean, well-documented bills, says Bradley M. Seldin, JD, an attorney with the Florida Health Law Center in Davie who assists physicians with debt collection. Physicians should remember that payers will be looking for any reason to deny a claim, so they should make it as difficult as possible for payers to do so.

Emergency care is particularly difficult to obtain reimbursement for, Seldin says. A high proportion of emergency care is not fully reimbursed by payers, he says.

He also cautions physicians to take a skeptical approach when verifying insurance coverage for a patient.

“Often when you get authorization for treatment, the insurer says this is not a guarantee of payment. But you think that is just a caution and you’re confident enough of the authorization to go ahead and provide services,” Seldin explains. “Then you get a notice saying your claim was denied because the patient was not eligible at the time of service. The physician might think, ‘Hey, I was told the authorization was not a guarantee of payment and I gambled, so I lose.’ Not necessarily.”

Seldin encourages physicians not to roll over and accept that lost revenue. Question the facts behind the decision, he says. Did the patient not pay a premium due three days before the service, meaning the grace period applies? Or did he or she not make the payment six months ago?

“If it was months ago, the HMO should have...
10 best practices can improve collecting medical debt

A set of best practices is available to guide both physician practices and any company they contract with to collect medical debts.

The Healthcare Financial Management Association (HFMA) and the Association of Credit and Collection Professionals developed the best practices in conjunction with an industry task force of healthcare providers, account resolution groups, and others. The developers hope the best practices will be adopted throughout the healthcare industry, offering clear guidance on resolving financial obligations before, during, and after a patient’s visit to a hospital or other healthcare setting.

The practices are designed to improve communication between patients and providers, and to standardize and better coordinate all business practices related to medical account resolution, says Joseph J. Fifer, FHFMA, CPA, president and CEO of HFMA.

These are the 10 best practices for physicians and their business partners seeking to reduce medical debt and improve collections:

1. Lay the groundwork for successful account resolution by educating patients and following best practices for communication prior to the time of service
2. Make bills and all communications clear, concise, correct, and patient-friendly
3. Establish policies for account resolution and ensure that they are followed both internally as well as by business affiliates
4. Be consistent in key aspects of account resolution—from billing disputes to payment application
5. Coordinate account resolution activities with business affiliates to avoid duplicative patient contacts
6. Exercise good judgment about the best ways to communicate with patients about bills
7. Start the account resolution clock when the first statement is sent to the patient
8. Report back to credit bureaus when an account is resolved (in the event that an account is reported to a credit bureau)
9. Track all consumer complaints
10. Use guidelines (available from HFMA and other sources) to inform your organizational approach to medical account resolution

More information on debt collection best practices is available online at the HFMA’s website: www.hfma.org/Content.aspx?id=21231.
Proper billing for single-dose, discarded drugs

Proper billing for single-dose or single-use vials, as well as discarded drugs, has been a bone of contention for physicians and Medicare, so CMS recently issued new guidelines to help clarify its billing expectations. But you may still lose money on these drugs, so you should know your true costs.

The guidance was included in a supplemental section of Special Edition *MLN Matters* Article SE1316. In discussing the correct billing of several anticancer drugs administered in the outpatient setting, CMS addressed the issue of billing for single-use vials and discarded drugs. The agency emphasized the importance of hospitals and other facility and professional providers billing units of these drugs based upon the dosage included in their long descriptors. (See the story below for more on the CMS guidelines.)

**CMS offers help on billing for single-use, discarded drugs**

Below is a summary of the guidance CMS recently provided on proper billing for single-use vials and discarded drugs when reporting covered drugs administered to patients in the outpatient setting.

**General Medicare billing guidelines for outpatient drugs covered under Part B:**

- Ensure that the amounts of those drugs are accurately reported in terms of the dosage specified in the long descriptors for the applicable HCPCS codes.
- Report units in multiples of the dosage included in the long HCPCS descriptor. (If the dosage given is not a multiple of the number provided in the HCPCS code description, the provider should round up to the nearest whole number in order to express the number as a multiple.)
- In certain circumstances (outlined below) Medicare will pay not only for the amount of drug in a single-use vial appropriately administered to a patient, but also for the leftover amount that is discarded.

**Special Medicare billing guidelines for outpatient drugs covered under Part B contained in a single-use vial, including discarded drugs:**

- The vial must be a single-use vial. (Multi-use vials are not subject to payment for any discarded amounts of the drug.)
- The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
- The leftover amount must actually be discarded and may not be used for another patient, regardless of whether that other patient has Medicare.

In addition, CMS reminded providers to carefully document relevant information regarding discarded drugs in the patient’s medical record, including the actual dose administered, the exact amount wasted, and the total amount the vial was labeled to contain. If the Medicare contractor requires discarded drugs to be reported with the -JW modifier on a separate line, the total number of discarded units reported should not include amounts of the drug also included on the administered line, due to the rounding up of units.

The full guidance can be found online at [http://tinyurl.com/lwkuf7d](http://tinyurl.com/lwkuf7d).
billing, so you cannot bill for the drugs separately even at cost.

“Now people are breaking even at best, or losing money on these drugs, where in the past they might have made a little bit of money,” Jorgensen says.

The CMS guidelines should answer some of the questions about billing for these drugs, but they do not introduce any new revenue from reimbursement, he says. While proper billing will ensure that physicians are reimbursed for the cost, it won’t result in any profit, Jorgensen explains.

Many physicians see the difficulty in billing for single-use and discarded drugs as just another unfortunate reality in practicing medicine, and some practices have built that assumption into their business models, Jorgensen says. That approach is not wrong, he says, but physicians should be aware of the costs of single-use vials and the expense associated with discarding the remainder of a costly drug after using only a portion for treatment.

“Now people are breaking even at best, or losing money on these drugs, where in the past they might have made a little bit of money.” —Douglas J. Jorgensen, DO, CPC

“You should know what this service is costing you and make a conscious decision, either that the reimbursement is a wash or you’re doing it in the red because you want to provide the service and your margins are good enough elsewhere to make up for it,” Jorgensen says. “But what I think is happening as the payments are shifting and they’re not getting paid for these drugs, some are unbundling in an attempt to get the reimbursement. That creates a real regulatory risk.”

Providers experienced with ACOs offer helping hand

As physicians turn toward accountable care organizations (ACO) in increasing numbers, some health systems and private companies are offering resources to help with ACO formation and startup.

From smaller startups to Aetna, the third-largest insurer in the United States, many are jumping into the game and focusing on healthcare IT support. One such ACO facilitator is the Population Health Initiatives program at Geisinger Health System in Wilkes-Barre, Pennsylvania.

Geisinger is a pioneer in ACOs, working with the concept since 2005 when it was part of the original physician group practice program, says Thomas Graf, MD, chief medical officer for population health and longitudinal care service lines with Geisinger.

Graf notes that interest in ACOs remains high among physicians as the Affordable Care Act becomes the norm and the push for cost savings continues unrelentingly. The challenge is no longer persuading physicians that the ACO concept is legitimate; instead, it’s the question of how to actually make the transition, he says.

Through xG Health Solutions, a spinoff company that assists with healthcare transformation such as ACO startups, Geisinger provides two of the most important services for fledgling ACOs. The first is care management services, such as training and management programs for care management or outsourced solutions. Even more important is the data analytic support.

“They’re the only organization that goes back to 2005 working with CMS data in an accountable care program to understand what the data is, what it doesn’t have, where the challenges are, and what the likely issues are when the CMS data doesn’t check out,” Graf says. “It’s a unique combination of Geisinger’s clinical skill with the long track record of robust data analytics in a CMS environment.”

When physician groups consult Geisinger about ACOs, Graf says the top concerns are always the same. Physicians worry, rightly so, that they don’t fully understand the ACO concept and how they fit into it. Physicians also want assurance that they will not be forced to provide rationed or substandard care to their patients.
“Everyone has horror stories from the ‘90s, and they’re concerned that they’re going to lose the ability to appropriately clinically manage their patients,” Graf says.

Physicians seeking guidance on ACO startups should bring these concerns up when consulting an experienced ACO provider like Geisinger or a private company offering ACO consulting, he suggests. Don’t be afraid to acknowledge what you don’t know and what your fears are, he says.

ACO mentors, meanwhile, should not focus exclusively on managing costs, even though that can seem to be the primary focus of accountable care, Graf says. Instead, they should concentrate on how to improve quality in ways that likely will result in cost savings.

The distinction is important, he notes, because simply focusing on cost management will take physicians right back to the difficult times of the ‘90s.

“Everyone has horror stories from the ‘90s, and they’re concerned that they’re going to lose the ability to appropriately clinically manage their patients.”

—Thomas Graf, MD

“Readmissions are the best example. No one would see going back to the hospital within 30 or 90 days of an index stay as a good thing, from the physician’s or the patient’s viewpoint,” Graf says. “It also is not good from a cost of care standpoint, so you look at how to eliminate chronic disease management failures. But you do it from the perspective of what is good medicine and best for the patient, and you know that cost savings will follow.”

Other initial tasks include the makeup of the ACO, from physicians and hospitals to all the other types of providers that may be involved, and the savings distribution. Graf says it is very important to nail down the latter topic early in the process.

“It is much easier to talk about money when it is theoretical and much harder when it’s real. You want to immediately determine the savings distribution, participation levels, who gets the money and how much.”

—Thomas Graf, MD

Physicians seeking guidance from ACO facilitators should have some idea of how those factors will be determined before seeking help, Graf says. The physicians’ plan can be assessed and changed as necessary, but the facilitators will be of more use if you come to them after having considered those issues.

ACO facilitators also should help physician groups understand how to work with CMS and accountable care data, Graf says, noting that most physicians are not in a position to properly handle CMS data.

“We have found that it is incredibly important to have timely, complete, and actionable data around utilization to sustain an ACO,” Graf says. “They also need someone to translate that data and really turn into meaningful information, and how they can use that data to make changes in their practices.”

The first year of ACO formation often is consumed by trying to get physicians to understand the data, says Tony Reed, Geisinger’s director of operations for the Keystone ACO & Proven Wellness Neighborhood. Once they understand what the data mean, physicians can begin implementing the protocols designed to change those numbers.

“The first step is getting physicians to understand the opportunities. The second step is getting them to buy into the ways to make changes and yield better data in the future,” Reed says. “Doctors are very accepting of it all once they understand where the opportunities are, but that can take more than just one morning of presenting data to them.”

Questions? Comments? Ideas?

Contact Editor Greg Freeman at gafreeman@bellsouth.net or 770-998-8455.
Medical practices favor informal integration over formal mergers

More than 40% of medical practice executives responding to the MGMA Medical Practice Today: What Members Have to Say research indicated that they have or are planning to informally integrate their practice with other healthcare organizations.

This includes clinical integration with a hospital or health system, as well as forming or joining an accountable care organization, physician/hospital organization, or independent practice association. Only 27% of respondents indicated that they have or plan to formally integrate by merging with another physician-owned practice or by selling practice ownership to a hospital or health system, says Susan L. Turney, MD, MS, FACP, FACMPE, MGMA president and CEO.

“It’s not surprising that medical practices are exploring ways to accommodate patients and combat mounting administrative pressures—and are looking beyond the walls of their organization to do so,” Turney says. “Physician practices are seeking ways to work better with other care providers, and affiliating informally or clinically integrating with other organizations allows practices to adapt as needed and position themselves for success in a value-based environment.”

Respondents also revealed their biggest daily professional challenges to MGMA and disclosed their struggles to adapt to rapid changes, legislative pressures, and fiscal uncertainty. According to 542 respondents, the most applicable and intense challenges of running a group practice include preparing for the transition to ICD-10 diagnosis coding, dealing with rising operating costs, and preparing for reimbursement models that place a greater share of financial risk on the practice.

Respondents also cited “engaging patients to improve outcomes” and “leveraging new technologies to enhance patient communications through patient portals, emails, websites, and video conferencing” as highly applicable in running a medical practice.

More results from the survey are available online at http://tinyurl.com/mt8dj4b.

Physician prices trend better than hospital costs

From the patient’s perspective, physician practices tend to be a better deal than hospital outpatient services, according to the results of a recent survey.

Hospital outpatient prices for standard blood tests, cancer screening, and other services varied widely and were sharply higher, on average, than prices charged by ambulatory clinics and independent doctors, say the authors of a study based on 2011 health plan spending by Chrysler, Ford Motor Co., General Motors, and the United Auto Workers. The results were published by the National Institute for Health Care Reform.

The price disparities were substantial for care that accounted for $68 million in claims that year, including blood work to test cholesterol levels, colonoscopies, and physical therapy. Hospital outpatient prices even varied widely among competitors within the same city, suggesting that hospitals with more market clout may be using leverage to set higher prices.

Knowing that sicker patients account for more healthcare spending than others, the authors investigated that influence on the study results. Interestingly, the study found no difference in the extent of sickness for patients who received MRI of the knee or who underwent colonoscopies, regardless of the treatment location.

On average, hospital outpatient prices were 52% higher than community prices for knee MRIs and ranged from $1,518 at the top to $513 at the bottom. Average hospital colonoscopy prices were two times as high as ambulatory prices. The average hospital colonoscopy price was $1,383 compared with $625 in community clinics.
The top hospital outpatient prices for colonoscopies, based on three diagnoses, ranged from $2,048 to $2,716 at the high end and from $890 to $1,256 at the low end. Blood test prices at hospitals were as much as 14 times greater than those charged by community clinics. The price of metabolic panels for the costliest hospital outpatient laboratories, for example, was $103 compared with $15 among the top-priced community clinics. Hospital outpatient prices for therapeutic exercise were 41% higher than identical services in community clinics. Manual therapy prices were 64% greater for hospitals than ambulatory clinics.

More information on the study is available online at http://tinyurl.com/p9tj503.

Gap separates payer and physicians on value-based arrangements

Distrust of payers is cited by physicians as a leading reason they say they are not currently in a value-based relationship, according to a recent survey by FTI Consulting, a healthcare firm in Washington, D.C.

The results suggest a stumbling block in the transition to the new and much-heralded value-based relationships between them, the researchers conclude. According to the study, 41% of primary care physicians say distrust of payers is holding them back from entering into value-based arrangements with them. The study also found that only 16% of all physicians surveyed were willing to accept the financial risk—a key element of many value-based relationships sought by insurers, says Kenneth Barker, senior managing director and global leader of the Health Solutions practice at FTI Consulting.

“As today’s healthcare environment continues to evolve, both payers and providers will need to cooperate in order to keep up with the critical challenges facing the industry,” Barker says. “The business arrangements between both parties must align with the interests and incentives of both parties. This study indicates that payers and physicians still have a long way to go to reach that goal.”

This lack of trust will be a huge hurdle for payers to overcome because provider buy-in and engagement are critical to the success of any value-based arrangement, says Phil Polakoff, MD, senior managing director and chief medical executive of the Health Solutions practice at FTI Consulting.

“The two groups are still significantly distant in attitudes towards value-based arrangements—a difference that can stand in the way of creating new forms of payment,” Polakoff says.

Risk-sharing is not the only perceptual disconnect between payers and providers. Payers seeking to partner with providers in value-based arrangements have identified capabilities they wish potential partners would possess, Polakoff notes.

Payers want to see providers invest in healthcare IT, especially in software and systems supporting clinical integration and population health management (PHM), he says. Eighty percent of payers say they would be likely to contract with a clinically integrated hospital and provider system. However, only 50% of healthcare providers report that their organizations have implemented new technology or software to support PHM and value-based reimbursement; 32% have not, and 18% either “don’t know” or are “unsure.”

Oct. 1, 2015, is final for ICD-10

HHS issued a rule recently finalizing Oct. 1, 2015 as the new compliance date for healthcare providers, health plans, and health care clearinghouses to transition to ICD-10. This deadline allows providers, insurance companies and others in the health care industry time to ramp up their operations to ensure their systems and business processes are ready on the go-live date, a CMS statement says.

Earlier this year, the acting head of CMS, Marilyn Tavenner cited concerns that were raised by the American Medical Association (AMA) and instructed CMS to re-examine the timeline through a rule making process.