2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 10

A/R and Collection Concepts

Introduction

The denial and appeals process is an important step in the accounts receivables and collections of a practice. In this chapter, we will discuss the management of the accounts receivable (A/R) management and the denial process. The objectives for this chapter include:

- Identify types of denials
- List the steps to working the A/R
- Understand patient collection practices
- Review the bankruptcy concepts

Explanation of Benefits (EOB) and Remittance Advice (RA)

An Explanation of Benefits (EOB) is a statement sent by an insurance carrier to the covered individuals explaining what medical treatments and/or services were paid for on their behalf. A Remittance Advice (RA) is a statement sent by an insurance carrier to the medical provider which explains the adjudication decisions on those claims submitted by the provider. An Electronic Remittance Advice (ERA) is an electronic statement sent by an insurance carrier to the medical provider which explains the adjudication decisions on those claims submitted by the provider.

The RA and ERA include the following information:

- Identifying information for all parties including the patient, medical provider, and insurance carrier
- Claim amounts that include amount charged, amount paid, adjustments applied to the claim, and claim total
- Claim status such as paid, denied, or pending
- Explanation of decision

The EOB sent to the patient will typically have a statement stating it is not a bill.

EXAMPLE: REMITTANCE ADVICE

From:		To:	
123 Health		AAPC Physician's Group	
----------		1234 Main Street	
EDI Exchange # 000001234		Suite A	
June 30, 20XX		Anywhere, UT 12345	
Adjustment applied: $0.00			
Payment of $250.00 by Check #987653 dated June 30, 20XX			
Patient Ref #	1234567Smith	Internal Control #	8769653289
Patient Name:	Mary Smith	Paid as: Primary	
Patient MBI #	1AC2D34EF56	Claim Total:	$550.00
Date of Claim:	June 17, 20XX	Amount Paid:	$250.00
Service # 1 ----------			
Date of Service:	June 17, 20XX	Allowable:	$250.00
Place of Service:	11	Deductible:	$0.00
Procedure Code:	11042	Coinsurance:	$0.00
Units:	1	Copayment:	$0.00
Charges:	$350.00	Paid:	$250.00
Provider ID:	123456789	Reasons:	Amount above fee schedule

Service # 2 ----------

Date of Service:	June 24, 20XX	Allowable:	$0.00
Place of Service:	11	Deductible:	$0.00
Procedure Code:	99213	Coinsurance:	$0.00
Units:	1	Copayment:	$0.00
Charges:	$200.00	Paid:	$0.00
Provider ID:	123456789	Reasons:	Global period

In this example, for the service performed on June 24, 20XX, the charge amount is $200.00. The insurance company allowed $0.00. The RA also indicates that there was no payment on the claim due to the service being provided during a global period for a procedure. This would give a biller the place to start investigating the denial.

A/R Management

Accounts receivable (A/R) represents money owed to the healthcare practice by patients and/or insurance carriers. The accounts receivable cycle begins with the delivery of service and continues until payment for the service is reconciled to a zero balance.

Accounts receivable management is a system that assists providers in the collection of the reimbursement for services rendered. The functions of accounts receivable management include insurance verification, insurance eligibility, prior authorization, billing and claims submission, posting payments, and collections.

Days in A/R

The success of a practice's billing operations is often measured in A/R days. The A/R balance can be reduced by receiving payments or by entering contractual or write off adjustments. It is important to manage the A/R balance as claims become much more difficult to collect the older they become. Good management of the A/R is also imperative to maintaining a good cash flow for the business. A poor A/R process can result in loss of money to the business and result in financial strains to the owners.

If all these tasks are being done properly, the days in A/R number should be low, in contrast, high days in A/R number will most likely tell you there is a problem in your revenue cycle.

BILLING TIP

Days in A/R is a fraction. The numerator is the total A/R. The denominator is average daily charges. Average daily charges are calculated by taking the total charges over the last 2 months (can also be one month) and dividing by the total number of days in those two (or one) months.

Example:

Total A/R = $200,000

Average Daily Charge = $4,250

Days in A/R = $200,000/$4,250 = 47.06 days in A/R

Steps to Working the Account Receivables

Efficient accounts receivable management is crucial to the financial viability of a medical practice. Steps to help reduce the accounts receivable include:

- **Financial policy**—A practice must have a financial policy that is conveyed to every patient. The policy should be posted at the front desk, a copy should be given to every new patient, and the front office should clearly communicate the policy to patients. The financial policy should explain the total expected cost of the visit and convey that copayments, co-insurance, and/or deductibles are required at the time of service. The policy should also detail the insurance plans that are accepted, and the practice's policy for out-of-network insurance policies.
- **Verify insurance**—The patient's insurance should be verified every time a patient is seen. The patient may present an insurance card but that does not mean they are insured. Coverage changes are common. A patient may change insurance plans, identification numbers may change, or the copayments and deductibles may change. Prior to treatment, the insurance carrier should be contacted to confirm coverage and the amount to be collected from the patient. This can be done through

phone calls, the insurance carrier's website, or through the clearinghouse.

- **Registration Process**—The patient registration process is one of the most important jobs when it comes to account receivables. Accurate information must be obtained initially to avoid costly errors later. Claims can be denied by the insurance carrier if the correct information is not collected. A patient statement cannot be paid if it isn't delivered to the patient. An incorrect address can result in postal returns. Ask the patient the information in the correct way. Do not ask "has your information changed?" Instead the front desk staff should ask the patient "what is your address, phone, employment, and insurance information." Have the patient give answers to open ended questions instead of a yes or no confirmation.
- **Collections**—Copayments should be collected by the front desk at registration. It is more difficult to collect payment after the patient has received treatment. Many times, patients will leave the office without paying or state they forgot their checkbook or debit card at home. When this happens, the practice has the added cost of sending a statement to the patient to collect the money that should have been collected up front. The routine waiver of copayments can also open the practice up to liability. Many contracts also require the collection of copayments. Make it easy for patients to pay by offering multiple payment options such as accepting cash, checks, and credit or debit cards.
- **Submit Claims Correctly**—Health insurance claims are most often rejected due to inaccurate or missing information. A claim denied by the health insurance company can result in adding a few weeks to the A/R days because the patient's information must be pulled, verified, and corrected in the practice management system before the claim is resubmitted.
- **Monitor**—After an insurance carrier processes a claim, an RA or ERA is sent to the provider with payments from the insurance carriers. This should be posted immediately upon receipt. Payments should be monitored to assure that the claims are being processed and paid appropriately. It is also important to monitor that the payments are posted correctly including the amount adjusted and billed to the secondary carrier or the patient.
- **Denials**—Denials or reimbursement problems should be worked as soon as they are received from the insurance carriers. Each denied claim should be reviewed to determine whether additional information is needed, if errors need to be corrected, or if the denial should be appealed. These denials will be identified when posting the payments, reviewing remittance advice, and on aging reports.
- **Patient Statements/Invoices—**Patient statements should be sent as the remittance advice has been posted. The sooner the statement is received by the patient, the sooner it is likely to be paid. Patient statements should detail the date of service, services performed, insurance reimbursement received, payments collected at the time of service, and reason the patient balance is due.
- **Write-offs**—The financial policy should address the handling of past due accounts. A practice may automatically write off small patient balances for which processing costs exceed potential collections.

EXAMPLE OF A/R REPORT

AGING SUMMARY REPORT

TOTALS FOR ABC PHYSICIANS

INSURANCE TYPE	PATIENTS	DEBITS	CREDITS	BALANCE DUE	CURRENT	30 DAYS	60 DAYS	90 DAYS
Self Pay	5	6,500.00	0.00	6,500.00	2,000.00	1,000.00	3,500.00	0.00
Medicare	90	125,452.85	91,351.45	34,101.40	28,100.00	1,000.00	1,200.50	3,800.90
Medicaid	12	25,880.00	1,000.00	24,880.00	14,500.00	10,380.00	0.00	0.00
Private	50	85,900.00	32,120.00	53,780.00	25,850.86	12,310.00	5,619.14	10,000.00
Workers' Comp	2	6,500.00	4,250.00	2,250.00	1,250.00	0.00	0.00	1,000.00
PPO/HMO	40	62,265.00	21,452.60	40,812.40	32,152.12	8,660.28	0.00	0.00
TOTALS	**199**	**312,497.85**	**150,174.05**	**162,323.80**	**103,852.98**	**33,350.28**	**10,319.64**	**14,800.90**

The example above is a summary report. If the practice management system is interactive, clicking on the insurance carrier name will provide more detail including dates of services and patient names included in the balance. If not interactive, a more detailed report will need to be printed.

Insurance pending accounts should be worked aggressively, every month. The accounts receivable aging summary should be worked starting with the oldest claims and/or largest balances first. The longer a balance sits in the accounts receivable the less likely it will be paid. The oldest claims should be worked before the newer claims because of timely filing requirements. If for some reason the insurance carrier did not receive the claim, it will need to be resubmitted within the timely filing time frame. It is also important to work the largest balances. There will be a greater return on claims where there is a larger balance.

Some offices will set internal policies assigning certain carriers to specific employees. Internal policies will dictate which accounts are worked and in what order.

Claims Tracking

Tracking an insurance claim can allow for a quicker response time for correcting and/or resubmitting a claim. Most carriers will process a claim and make payment within 15 days. Claims can be tracked by looking the claim up on the insurance carrier website, making a phone call to the insurance carrier, or utilizing a clearinghouse claims status system. Tracking a claim can sometimes determine the status of the claim faster than waiting for the insurance carrier to respond. Once the status of a claim is determined, the biller can then follow up on the claim. Common claim statuses found when tracking a claim include:

- No record of the claim—If the claim was never received by the insurance carrier, a new claim can be submitted.
- Claim denied—If the claim was denied the denial can be investigated, corrected, and resubmitted.
- Claim pending—If the claim is pending for information from the member, this will allow the member to be notified and the provider's office can assist the member with contacting the insurance carrier and giving the additional information needed.
- Claim paid—The biller may be required to locate the check and EOB to determine if the payment was inadvertently applied to an incorrect account.

The Prompt Payment Act is a federal law that ensures federal agencies pay their bills within 30 days of receipt and acceptance of material and/or services. When payments are not made in a timely manner, interest should be automatically paid.

Denials and Appeals

Once a claim has been submitted to an insurance carrier, it is followed through until a payment or denial is received. Payments are posted to the specific date of service, along with any necessary contractual adjustments. Remaining balances are sent to the secondary insurance, or the patient is billed for the patient balance due. If payments and adjustments are not applied to the specified date of service, the effort to collect on remaining balances is greatly increased.

If the claim is denied, the denial is reviewed by the biller and actions are taken based on the denial. Sometimes, a claim is denied appropriately, and it must be written off (adjusted) or transferred to patient responsibility. Other times, a claim is denied in error and a corrected claim or an appeal is sent to the insurance carrier.

Common denials include:

Incorrect information—Incorrect patient information is an extremely common denial. This denial can occur because the patient's name does not match the insurance carrier's files, date of birth doesn't match the insurance carrier's files, the subscriber or identification number or group number is missing or incorrect.

To work an incorrect information denial, it is important to review the information that was received from the patient and recorded in the practice management system. A copy of the patient's current insurance card should be placed in the patient's financial record or chart. This way, if there is a question or denial, the information can be referenced. First, verify that the information placed in the practice management system matches the information on the patient's insurance card. If an error is discovered, correct the information and the claim can be resubmitted. If the information is correct, then a call needs to be placed to the insurance company to verify they have the same information. If the information the insurance company has does not match the information that the patient has given to the practice, the patient will need to call the insurance company to correct the information. The insurance plan will then reprocess the claim.

BILLING TIP

Some insurance companies will allow incorrect information to be changed over the phone and they will reprocess the claim without a new claim being sent to them. For example, the numbers in the subscriber ID were transposed when put in the practice management system. When this is discovered, some insurance companies will allow a phone call to change this information and have the claim reprocessed. You should always try to obtain a tracking or reference number from the insurance company for any further follow up that may be needed on the claim.

Whenever you are on the phone with a patient who has an outstanding account balance, take the opportunity to try to receive payment or set up a payment arrangement.

Coordination of Benefits—If a patient is covered under more than one insurance plan, one plan will be primary and the other is secondary. Coordination of benefits is used to ensure that insurance claims are not paid by both carriers as primary, which would result in payments exceeding 100 percent of charges for covered services. This denial is used when submitting to one insurance plan after the other insurance plan has already paid, but the remittance advice was not sent with the claim. This may also be the result of billing an insurance carrier without the knowledge the patient has additional coverage.

To work a coordination of benefits denial, review the information received by the patient and recorded in the practice management system. If the patient has multiple insurance plans, all insurance cards should be copied and put into the patient's financial record or chart and put into the practice management system. If the denial is due to the carrier stating the patient has additional insurance and needs the information for the other insurance plan, a call will need to be made to the patient to get the correct information. The claim will then need to be submitted to the correct primary insurance. If the denial is due to a missing explanation of benefits from the insurance plan that paid first, retrieve the explanation of benefits, and resubmit the claim with the explanation of benefits attached. In some cases, the patient may need to be the one to contact their insurance carriers and update the coordination of benefits directly with them before they will pay on a claim.

Timely filing—Every insurance carrier has timely filing deadlines. If a claim is submitted after the filing deadline, the claim is denied. This type of denial can be appealed if you have documentation that supports the claim was originally filed within the timely filing limit. When a claim is denied because it was not filed timely, and there is no documentation for an appeal, the balance must be written off by the participating provider and cannot be billed to the patient.

To prevent timely filing denials, it is important to know the timely filing deadlines for each insurance carrier. Knowing and following these guidelines will prevent some of these denials. To work a timely filing denial, research must be done to determine if the claim was, in fact, submitted before the timely filing deadline. If it was not filed before the deadline, there will be no documentation to support an appeal. If it was determined that the claim was submitted before the deadline, the documentation needs to be submitted within the appeals process for that insurance plan.

Missing referral—Some insurance carriers require a referral from a Primary Care Physician (PCP) for a patient to receive care from a specialist. If the patient fails to receive a referral from the PCP, the claim is denied.

To prevent missing referral denials, it is important to know which insurance payers require a referral before the patient receives care. The patient should present with the referral in hand, or the specialist should obtain the referral from the PCP office prior to the patient's appointment.

Non-covered service—A claim can be denied by the insurance carrier if the service is not covered under the insurance plan. To prevent these denials, it is important to determine if the procedure is covered prior to the service being provided by checking the benefits of the patient's insurance plan. When it is a non-covered service, depending on the plan, the balance is reported to the secondary insurance carrier, or becomes the patient's responsibility.

To reduce non-covered service denials, it is important to determine if the procedure will be covered under the patient's insurance prior to performing the procedure. If the procedure is not a covered service, the patient should be notified and told the cost of the procedure. This allows the patient to determine if he or she wants to go ahead with the procedure. Unfortunately, it is difficult for a practice to know all the services that are or are not covered by all insurance plans. If a denial for a non-covered service is received, the balance due should be submitted to the patient for payment.

Prior Authorization—Insurance plans often require prior authorization for many procedures. If the provider fails to obtain the required authorization before a procedure is performed, the claim is denied.

If a claim is denied due to a missing prior authorization, it should be researched. There are certain circumstances where this type of denial can be appealed. For example, you can appeal this sort of denial in the event a patient had an emergency situation, such as an emergency cesarean section, and it was not possible to obtain prior authorization. In some of these cases, the insurance company may retro-activate or back-validate the authorization to allow the approval.

Coverage Terminated—This denial occurs when the patient does not have coverage with the insurance carrier. To prevent these types of denials it is important to verify coverage prior to the provider visit. When this denial is received, the balance is transferred to another insurance carrier, or becomes the patient's responsibility. Some state Medicaid programs require a provider to write off the charge when eligibility is not verified prior to the patient's visit.

To work a coverage terminated denial, contact the patient to determine if the practice has the wrong insurance information, or if the patient indeed has no insurance coverage. If the patient is covered by a different insurance plan, a claim needs

to be submitted to that insurance plan. If the patient does not have insurance, a statement should be sent to the patient for payment.

Not Medically Necessary—The carrier has determined, based on the information (procedure and diagnosis code(s)) submitted on the claim, that the procedure was not medically necessary. When a claim is denied due to medical necessity, the medical record should be reviewed to determine if the documented diagnosis was correctly assigned. If the diagnosis was not assigned correctly, the information needs to be corrected and the claim can be resubmitted. If the information was reported correctly, the provider can either appeal the claim or write off the amount. The biller should consult the medical policy, LCD, or NCD for the procedure, if available, from the insurance carrier. Depending on the insurance carrier contract, if the patient has signed an ABN prior to the procedure, the balance may be transferred to patient responsibility.

Pre-existing Condition—A pre-existing condition is any medical condition that was diagnosed and/or treated within a specified period prior to the enrollee's effective date of coverage in a new health insurance policy. A pre-existing condition can be anything from a serious condition such as heart disease, high blood pressure, diabetes mellitus, and asthma to a minor condition such as hay fever or a previous accidental injury. As of January 2014, the ACA eliminated pre-existing conditions clauses. A person cannot be denied coverage, charged higher premiums, or denied treatment based on their health status. A payer can no longer deny payment based on pre-existing conditions.

If a denial for pre-existing condition is received, it should be appealed. More information can be found at https://www.hhs.gov/healthcare/about-the-aca/pre-existing-conditions/index.html.

Lower Level of Care—Lower level of care is a denial that applies when the following occurs:

- Care provided on an inpatient basis is typically provided on an outpatient basis
- Outpatient procedure could have been done in the provider's office
- Skilled nursing care could have been performed by a home health agency

When this type of denial occurs, a letter should be written explaining the reason why the higher level of care was required. Along with the appeal letter, the documentation from the patient's chart that supports the level of care should also be submitted.

Working a Denial

Claims are denied by insurance carriers for many different reasons. Sometimes it will be a simple fix and other times it will take some additional work to correct the claim. After a claim has been denied it is important to work the denial. The following are some steps to take when working the denial.

Determine why the claim was denied—The first step in working a denied claim is to understand why the claim has been denied. Insurance carriers will use different denial codes on the remittance advice. Contact the insurance carrier if unable to determine why the claim has been denied. Denial codes may also be referred to as adjustment codes. This code communicates why a claim might be paid different than billed. There are national adjustment codes found on the Washington Publishing Company's website (www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/).

Contact the insurance carrier with questions—Sometimes, if the error is a processing error by the insurance carrier, a call to the insurance carrier may resolve the denial. If you are unsure of the reason for denial, contacting the insurance carrier may help to identify what needs to be corrected.

Correct the information—If the claim is denied due to incorrect information on the claim, the claim is corrected.

Resubmit or appeal the claim—Once the claim has been corrected, the biller submits a corrected claim. If the information on the claim is correct, but the claim should have been paid, the biller submits an appeal. Check with the insurance carrier to determine the next course of action. Some carriers have specific forms and appeal processes to follow.

Track the details and stay organized—Make sure you are tracking the denials. Stay organized so that you can follow up on the claims easily. Any action taken by the biller on an open claim should be documented in the patient's account. Some practice management systems will allow the biller to attach notes to a specific charge or date of service.

Section Review 10.1

1. Which denial is when the patient is covered under another insurance?

   A. Coordination of benefits
   B. Timely filing
   C. Incorrect information
   D. Non-covered service

2. Which is the best way to handle a denial for incorrect information?

   A. Do nothing and resubmit the claim
   B. Review the information, make sure it's correct and if it matches, resubmit the claim
   C. Contact the insurance company and the patient to figure out where the error is and get it corrected
   D. Bill the patient and let them figure out what's wrong

3. Which of the following is a statement sent to the patient from the insurance carrier explaining services paid for on their behalf?

   A. Remittance Advice
   B. Patient Statement
   C. Explanation of Benefits
   D. Patient Ledger

4. What is the first step in working a denied claim?

   A. Resubmit the claim
   B. Contact the carrier
   C. Appeal the claim
   D. Determine and understand why the claim was denied

5. What is a lower level of care denial?

   A. Service coded at a higher level than documentation supports
   B. Care provided on an inpatient basis is typically provided on an outpatient basis
   C. Outpatient procedure could have been done in the provider's office
   D. Both B and C

Appeals

Appeals are made by either providers or an employee of the healthcare provider or facility. It is a formal request for a third-party payer or insurance carrier to reconsider a decision about a denied claim. An appeal is filed when the provider disagrees with the determination made by the insurance carrier to deny a claim.

Before submitting an appeal make sure all of the documentation needed to perform the appeal is gathered. The following documents are needed to successfully appeal a denied claim:

- Copy of the remittance advice for the denied claim
- Copy of the medical record (supporting documentation)
- Copy of the original claim
- Letter (or form specified by the insurance carrier) detailing why the claim should be paid

Every insurance carrier has an appeals process and some carriers will identify when a claim should be sent as a corrected claim or appealed. Some insurance carriers may have a specific form to complete when appealing claims. Most insurers have multiple levels of appeals. Here are some examples of different appeals processes.

Medicare Appeals Process

Healthcare professionals who are participating providers can appeal Medicare (Parts A and B) denials. Under original Medicare there are five levels of the claims appeal process. All requests for appeals must be in writing.

Level 1 – Redetermination

The first level of appeal after initial determination on a claim is the redetermination. A redetermination is an examination of the claim by the MAC personnel. The personnel who review the redetermination is different from the personnel who made the initial claim determination.

A redetermination request must be filed within 120 days from the date of receipt of the remittance advice, which lists the initial determination. There is not a minimum monetary threshold required to request a redetermination.

The request for redetermination must be a written request or be filed on Form CMS-20027. The instructions are provided on the remittance advice and the form can be found on the CMS website at https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html.

The following elements listed below are required for the redetermination:

- Beneficiary's name
- Medicare Health Insurance Claim (HIC) number or Medicare Beneficiary's Identifier (MBI)
- Specific service(s) and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the authorized or appointed representative of the party

In addition to the above information on the written request, the supporting documentation should also be attached to the request. Generally, the decision on the issue will be sent within 60 days of receipt of the redetermination request. You will receive notice of the decision via a Medicare Redetermination Notice (MRN) from your MAC, or if the initial decision is reversed and the claim is paid in full, you will receive a revised RA

Level 2 – Reconsideration

If dissatisfied with the redetermination decision, a reconsideration by a Qualified Independent Contractor (QIC) can be requested.

The request for reconsideration must be filed with a QIC within 180 days of receipt of the redetermination. This request must be submitted on the standard CMS-20033, which is sent with the Medicare Redetermination Notice (MRN) or with a written request including the following information:

- Beneficiary's name
- Beneficiary's Medicare health insurance claim (HIC) number or Medicare Beneficiary's Identifier (MBI)
- Specific service(s) and item(s) for which the reconsideration is requested, and the specific date(s) of service
- Name and signature of the party or representative of the party
- Name of the contractor that made the redetermination

The request should clearly explain the disagreement with the redetermination and include any and all documentation that supports the service. A copy of the MRN also needs to be included. Generally, the decision will be sent within 60 days of receipt of the reconsideration.

Level 3 – Administrative Law Judge

If the reconsideration is still not acceptable, the next step is to request a hearing with the Administrative Law Judge (ALJ) within 60 days of receipt of the reconsideration decision. To request a hearing, the amount remaining in controversy must meet the threshold requirement, which is updated annually.

The reconsideration letter includes the details regarding the procedure for requesting an ALJ hearing. The Request for an Administrative Law Judge (ALJ) Hearing or Review of Dismissal – OMHA-100 (Office of Medicare Hearings and Appeals) form may be used to file a request.

The ALJ hearings are generally held by video-teleconference or by telephone; however, you may ask for an in-person hearing. The ALJ decision will generally be issued within 90 days of receipt of the hearing request.

Level 4 – Appeals Council

When dissatisfied with the ALJ's decision, a request for review by the Medicare Appeals Council is the next level. There are no requirements regarding the amount of money in controversy. The request must be submitted in writing within 60 days of receipt of the ALJs decision and must specify the issues and findings that are being contested. The Appeal Form DAB-101 should be submitted. Generally, the decision will be issued within 90 days of receipt of a request for review.

Level 5 – Judicial Review

The final level of appeal for Medicare is to request a judicial review in federal district court. This level also has a threshold requirement, which is updated annually. A request must be made within 60 days of receipt of the Medicare Appeals Council's decision.

Blue Cross Blue Shield of Illinois Appeals Process

After adjudication of a claim, additional evaluation may be necessary. In this instance, a request for claim review should be completed. To request the review, the Claim Review Form (https://www.bcbsil.com/pdf/education/forms/claim_review_form.pdf), should be completed with information such as claim and provider data, the reason for the review, and documentation.

The appeals process is an official request for reconsideration of a previous denial issued by Blue Cross Blue Shield of Illinois Medical Management area. Appeals may be submitted in writing or by telephone. A routing form with relevant claim information and supporting documentation must be included with the appeal request. The peer review process takes 30 days and a written notification of appeals determination will be sent.

UnitedHealthcare Appeals Process

Request for Reconsideration is the first step in the appeals process at UnitedHealthcare. The Reconsideration Form, (https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Claims%20&%20Payments/UnitedHealthcare%20Request%20for%20Reconsideration%20Form/ClaimReconsiderationRequestForm.pdf) needs to be completed and mailed to the address on the back of the patient's ID card. UnitedHealthcare also allows reconsiderations and appeals to be filled online through claimsLink (https://www.uhcprovider.com/en/claims-payments-billing/claimslink-self-service-tool.html).

When further consideration is warranted, an appeal letter needs to be submitted in writing to the address on the back of the patient's ID card.

Medical Record Request

Insurance carriers will request medical records when they need additional information to process a claim. The following steps should be followed when a request for medical records is received:

- Make a copy of the medical record only for the specific date of service requested.
- Review the medical record to make sure the services billed are accurate. If the provider referenced documentation from another area of the record during the encounter, make sure this information is copied and sent with the date of service information.
- Document in the computer system indicating a copy of the record was sent to the insurance carrier.
- Attach a copy of the medical record claim and the remittance advice.
- Send all of the gathered information to the insurance carrier.

Patient Statements

A patient statement policy should be developed for the practice. The method for submitting patient statements will vary based on the size of the practice and the type of system used by the medical practice.

One method is the alphabetic split. Statements are split into groups such as last names that start with A through M and submitted the first week of the month. Last names that start with N through Z are sent the third week of the month.

Electronic systems can be programmed to generate statements monthly. After a payment is posted to a charge, and a balance is transferred to patient responsibility, a patient statement will be generated. With this system, if the patient balance is not paid after the first statement another statement will be generated within 30 days.

Refunds

Establish a refund policy. If a patient has overpaid resulting in a credit balance on a patient's account, it must be refunded to the patient. The credit needs to be investigated to determine why there is an overpayment. According to chapter 30 of the Medicare Claims Processing Manual, any refund due to a Medicare recipient must be made to the beneficiary within 30 days. Knowingly and willfully failing to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. Each state also has escheat laws, which require businesses to turn over unclaimed funds and other property to the state after a dormancy period (time during which there is no contact with the rightful owner of the money or activity on an account). This law would include credits on patient accounts. The dormancy periods vary from state to state.

Also make sure before the overpayment is refunded that there are no outstanding claims that may result in the patient owing a balance. Sending a refund to the patient and then turning around and sending them an invoice will cost time and money and create confusion for the patient.

When it is determined an insurance carrier has overpaid for a service, or paid a service in error, the amount of the overpayment should be refunded as soon as discovered and verified. Failure to refund an overpayment to an insurance carrier violates the Reverse False Claims Act (see Chapter 1).

Professional Courtesy /Discounts/Financial Hardship

Each practice or facility should have a written policy for a professional courtesy, discounts, and financial hardship.

Professional courtesy is a long-standing tradition in medical practices. The American Medical Association's (AMA) first code of ethics created an obligation among doctors to reciprocate medical care and to extend the courtesy to physician family members. The AMA recognizes professional courtesy as a long-standing tradition, but not an ethical requirement.

Before a provider extends professional courtesy for free or discounted medical care to the public, an attorney should be consulted. Fraud and Abuse laws, Anti-Kickback Statute, Stark Laws, and False Claims Act may apply.

Helpful Link: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

Provider offices and facilities may also choose to give discounts to financially needy individuals or for other reasons. A policy should be developed on how discounts and financial hardship will be determined. A provider who practices routine write-offs of copayments and deductibles is at risk for violating insurance carrier contracts or federal and state laws. When a patient covered by insurance is offered a discount at the time of service, often referred to as a prompt pay discount, the insurance company must also be offered the same discount.

The practice must document financial hardship. It is recommended that the practice gather income tax returns, patient's household income, assets, and expenses. This information should be considered when determining financial hardship eligibility.

When it comes to patients without insurance, a cash or prompt pay discount may be possible. This policy must be used consistently. A prompt pay discount is typically a percentage of the standard fee schedule and should not be more than any discount given based on insurance contracts.

Patient Collection Practices

Each office or facility should have a written patient collection policy. This policy details how the practice attempts to collect debts and what actions to take when the patient does not pay. Dismissal of a patient for nonpayment, payment plans, and use of a collection agency should be addressed in the policy.

Patient Ledger

The patient ledger is an account of service descriptions, charges, payments, adjustments, and current balances. A patient ledger should also include the patient's demographic information. A patient ledger can be in a paper or manual form if a practice management system is not used. A patient ledger that is part of the practice management system can be viewed on the screen or printed to paper.

Itemized Statement

An itemized statement is a detailed statement (bill) sent to the patient or responsible party reflecting the patient's responsibility. A patient statement should include the practice name, address, phone, email address; patient name, address, identification number; date of statement; date of service; provider; description of service; charges; payments; adjustments; and balance due. Patient statements need to be clear, understandable, and patient-friendly.

AAPC Physician
1234 Main Street, Suite A
Anywhere, UT 12345

For billing inquiries, please call: (123) 456-7890
or email: aapcphysician@abc.com

Mary Smith
678 First Avenue
Anywhere, UT 12345

Make checks payable to:
AAPC Physician

Dates of Service	Description	Charges	Insurance Payments	Insurance Adjustments	Patient Payments	Amount Due
08/01/20XX	Office visit	70.00				
08/20/20XX	Insurance payment		40.76			
08/20/20XX	Accept assignment			13.85		
08/30/20XX	Patient payment				15.39	
09/04/20XX	Office visit	60.00				
09/25/20XX	Insurance payment		35.34			
09/25/20XX	Accept assignment			12.51		
						12.15

Collection Account

Many times patients who have been turned over to a collection agency for an unpaid balance call or come in for an appointment. According to the Federal Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395, which is a separate section of the more comprehensive 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA), mandates minimum standards for emergency care by hospital emergency rooms. The law requires that all patients who present with an emergency medical condition must receive treatment to the extent that their emergency condition is medically "stabilized," regardless of their ability to pay for such treatment.

An emergency medical condition is defined under federal law as one that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbance, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in the following:

- Placing the health of the individual (or unborn child) in serious jeopardy
- The serious impairment of a bodily function
- The serious dysfunction of bodily organs

Doctors have a general right to refuse treatment if an individual is seeking routine medical care or scheduling a doctor's appointment for non-emergency medical problems and the individual has no insurance or any other means of paying for the care provided.

Patients who have a collection balance should be notified prior to the appointment to be reminded of the practice's collection policy. A practice may require payment of the collection account before appointment for non-emergency treatment or may require a percentage of the amount owed to be paid before the appointment.

A practice needs to have a collection policy in place that addresses how they will handle these situations. To be effective, this policy then must be understood by all employees in the practice and enforced by the practice.

Telephone Etiquette

Apply the medical practice's telephone etiquette policy when making patient collection calls. A telephone etiquette policy may include the following:

- HIPAA Privacy information
- Instructions on how to complete a collection call, such as:
  - Plan the call—Have all the information that needs to be relayed to the patient ready before the call is made.
  - Introduce yourself—The caller should introduce themselves with their name and the company name when the patient or responsible party is on the phone.
  - Use a telephone voice controlling the volume and speed
  - Use good listening skills
  - Use the correct tone
  - Suggest a solution that can be agreed upon
  - End the conversation with an agreement on what is to happen next
  - Thank them
- Instructions on how to respond to an angry patient.
- Payment plan guidelines

BILLING TIP

A biller may contact someone other than the patient (for example, spouse or guardian) as necessary to obtain payment for healthcare services. In this instance, it is necessary for the covered entity or business associate to apply the minimum necessary standard and reasonably limit the amount of information disclosed. All reasonable requests for confidential communication from the patient or any agreed-to restrictions on disclosure of PHI must be adhered to.

Payment plans

Medical bills can become overwhelming for patients. One way to assist the patient is to offer a payment plan. The medical office or facility should have general guidelines for payment plans.

EXAMPLE

Balance Due	Monthly Payment
$25.00 - $100.00	$25.00
$100.00 - $250.00	$50.00
$250.00 - $500.00	$75.00
$500.00 - $1,000.00	$100.00
$1,000.00	$150.00

In lieu of a payment plan, some medical offices and facilities offer credit. If credit arrangements are available for patients, they must be consistently offered to all patients in accordance with the following federal laws:

Consumer Credit Protection Act (CCPA) was developed in 1968 to ensure fair and honest credit practices. This is a consumer law that includes:

- Equal Credit Opportunity Act—prohibits discrimination for providing credit based on personal characteristics such as race, religion, etc.
- Fair Credit Reporting Act—protects information collected by the consumer reporting agencies such as the credit bureaus, medical information companies, and tenant screening services. Organizations that provide information to consumer reporting agencies also have specific legal obligations including the duty to investigate disputed information.
- Truth in Lending Act—Requires lenders to disclose credit terms and for the creditor to use uniform methods for computing the cost of credit. This allows borrowers to fully understand how much it will cost to borrow money.
  - Fair Credit Billing Act—requires a creditor to promptly credit your payments and correct mistakes without affecting your credit score. The creditor is required to provide written acknowledgment of consumer billing complaints within 30 days of receipt of the complaint. The creditor must investigate and resolve the billing error within two complete billing cycles (no later than 90 days).
  - Fair Credit and Charge Card Disclosure Act—requires a creditor to disclose terms on the credit such as the annual percentage rate (APR) and annual fees.

Another regulation a medical office or facility should be aware of if offering credit to patients is the Fair Debt Collection Practices Act (FDCPA). The FDCPA states that third-party debt collectors are prohibited from employing deceptive or abusive conduct in the collection of consumer debts incurred for personal, family, or household purposes. Collectors are not allowed to threaten legal action that is not actually contemplated, contact debtors at odd hours, subject them to repeated telephone calls, or reveal to other persons (including family and employers) the existence of debts.

When allowing payments via a debit card, the office must also be familiar with the Electronic Funds Transfer Act. This act requires the office or facility to disclose specific information before completing a transaction.

Because payment is considered one of the core healthcare activities defined in the Privacy Rule at 45 CFR 164.501, when patients are provided with a credit plan option, steps must be taken to assure that HIPAA Privacy regulations are followed

relating to the methods healthcare providers may use to obtain payment for their services.

Collection Agency

When all means of collecting payment from a patient have been exhausted by the medical office or facility, the account may be considered delinquent based on the practice's policy. Once an account is considered delinquent, it may be turned over to a collection agency. A collection agency is a business that pursues payments of debts owed by individuals for a percentage of the amount collected. It is important to have a specific policy for when a delinquent patient will be turned over to a collection agency. For example, the policy may include the following steps:

1. Submit a statement for the outstanding balance.
2. Submit a second statement that states past due.
3. Make a collection call to obtain payment.
4. Mail the first collection letter to the patient.
5. Make a second collection call to obtain payment.
6. Make a third collection call to obtain payment.
7. Mail the final collection letter stating the account is being turned over to a collection agency.
8. Submit the account to a collection agency.

Make sure to document each action that you take. Patient accounts should be turned over to collections based on the policy created by the practice. Each collection agency will dictate which documents need to be provided to the collection agency to assist with their collection process. Once a debt is turned over to the collection agency, it is typically written off with a code that specifies it has been sent to an outside collection agency.

Bankruptcy Concepts

Bankruptcy is a legal proceeding involving a person who is unable to repay outstanding debts. The process begins with a petition filed by the debtor. There are two main chapters of bankruptcy seen in medical practices and facilities:

Chapter 7—Liquidation. The person's assets are sold, and the payment is made to debtors. In the case of Chapter 7 bankruptcy, most medical debt is discharged. In this case, the provider will write off the amount owed by the patient.

Chapter 13—Adjustment of Debts of an Individual with Regular Income. The debts owed by the debtor are combined and the monthly payment is potentially reduced for the debtor. Under this filing, a provider or facility has the potential to receive a portion of the debt owed. Instructions for filing a claim against the bankruptcy are found on the back of the bankruptcy notice.

When a medical provider or facility receives notice a patient has filed for bankruptcy, the following steps should be taken:

- If notice is received from the patient, ask for the case number. If a notice is received from the bankruptcy court, the case number will be on the notice.
- Verify the case filing with the bankruptcy court.
- Verify the medical provider or facility is listed as a creditor.
- For providers listed as a creditor, stop all collection efforts on balances incurred prior to the filing of bankruptcy. The provider or facility may continue to collect balances due from the insurance companies.

Dismissal of Patient Due to Nonpayment

A patient can legally be dismissed from a practice for nonpayment. It is important to avoid a claim of abandonment and make sure patient care is not neglected. Before dismissing a patient, the following steps should be taken:

- Document any issues with the patient. A patient should be notified of the problem and given the opportunity to pay the balance. Meet with the patient privately to discuss the issues if possible. Document the meeting, the issues discussed, and the patient's response. Determine if the patient is eligible for financial hardship.
- If no agreement can be reached, follow up, in writing, explaining the patient will be dismissed from the practice unless payment is made.
- Give the patient sufficient time to find a new provider. There may be state specific laws regarding minimum notice periods.
- When terminating a patient, send an official letter stating they will be terminated. The letter should include:
  - A specific date after which the patient will no longer be seen by the provider.
  - An explanation for how the patient can obtain copies of their medical records. Include a summary of health issues in the letter.
  - An offer to assist the patient in finding a new physician or provide a list of suggested physicians and their contact information.
  - Document the date the letter is sent. Send the letter by certified mail and keep a record of the receipt of the letter.

Section Review 10.2

1. Can a patient be refused treatment due to inability to pay for the service?

   A. No, a patient can never be refused treatment.
   B. Yes, a provider can refuse to see any patient for any reason.
   C. Yes, a provider can refuse to see a patient when it is not an emergency situation.
   D. Yes, if a patient owes more than $5,000.

2. Which of the following is the highest level of the appeals process of Medicare?

   A. Reconsideration
   B. Judicial Review
   C. Appeals Council
   D. Administrative Law Judge

3. Based on this statement, how much was the accept assignment write-off amount for the two dates of service?

Dates of Service	Description	Charges	Insurance Payments	Insurance Adjustments	Patient Payments	Amount Due
08/01/20XX	Office visit	70.00				
08/20/20XX	Insurance payment		40.76			
08/20/20XX	Accept assignment			13.85		
08/30/20XX	Patient payment				15.39	
09/04/20XX	Office visit	60.00				
09/25/20XX	Insurance payment		35.34			
09/25/20XX	Accept assignment			12.51		
						12.15

   A. $130.00
   B. $76.10
   C. $26.36
   D. $27.54

4. Which federal act states that third-party debt collectors are prohibited from employing deceptive or abusive conduct in the collection of the debt?

   A. Fair Credit and Charge Card Disclosure Act
   B. Truth in Lending Act
   C. Fair Credit Reporting Act
   D. Fair Debt Collection Practices Act

5. Which are the two main types of Bankruptcy seen by medical practices and facilities?

   A. Chapters 7 & 13
   B. Chapters 11 & 13
   C. Chapters 12 & 15
   D. Chapters 7 & 15

Glossary

Bad Debt—A bad debt is accounts receivable or money owed that will likely remain uncollectable and will be written off.

Bankruptcy—Bankruptcy is a legal proceeding involving a person who is unable to repay outstanding debts.

Coordination of Benefits—Coordination of benefits is used to ensure that insurance claims are not being paid multiple times.

Coverage Terminated—This denial occurs when the patient does not have coverage with the insurance carrier.

Fair Debt Collection Practices Act—The Fair Debt Collection Practices Act (FDCPA) states that third-party debt collectors are prohibited from employing deceptive or abusive conduct in the collection of consumer debts incurred for personal, family, or household purposes.

Fair Credit Reporting Act—The Fair Credit Reporting Act protects information collected by the consumer reporting agencies such as the credit bureaus, medical information companies, and tenant screening services.

Fee-For-Service—Fee-for-service (FFS) is a payment model where payment is made to a provider for each individual service rendered to a patient.

Itemized Statement—An itemized statement is a detailed statement (bill) sent to the patient or responsible party reflecting the patient responsibility.

Ledger Card—Ledger card is an account of service descriptions, charges, payments, adjustments, and where current balances are posted.

Non-covered service—A claim can be denied by the insurance carrier if the service is not covered under the insurance plan.

Prior Authorization—A prior authorization is sometimes required by insurance plans for many procedures.

Prompt Payment Act—The Prompt Payment Act is a federal law that ensures that federal agencies pay their bills within 30 days of receipt and acceptance of materials and/or services.

Relative Value Unit—Relative Value Unit (RVU) is a standardized way to determine the value of a service. RVU considers the work done by the physicians, practice expense, and the cost of malpractice.

Resource Based Relative Value Scale—Resource Based Relative Value Scale (RBRVS) is a payment system that considers the work done by the physicians, malpractice insurance, and practice expenses. Practice expenses include overhead, supplies, equipment, and staff salaries.

Timely filing—The claim must be filed within a certain time designated by the third-party payer in order to be processed.