

Navicure – Collecting From Patients

Pamela: Hello, this is Pamela Moore from Physicians Practice. For years I've heard physicians complain about payers. Mostly though it sounds like their patients are some of the worst payers, and patient revenue is playing a bigger and bigger role in a lot of practices. Here to help us explore how to explain patient collections today is Brian Koch. He is Vice President of Strategic Services for Navicure. He's a graduate of Michigan State University. He's also a certified Six Sigma Brown Belt. Brian has also held the positions of Chief Operating Officer for one of the nation's largest anesthesia billing and practice management companies, as well as revenue cycle management consultant for Ernst and Young and Reimbursement Director for Texas Health Resources. Brian, thanks for much for helping us out today.

Brian: It's my pleasure and thank you for having me.

Pamela: Absolutely. So it is my impression that patient accounts are becoming a big deal, at least in some practices. Do you have any data about what a big role patient account are playing, versus commercial or even government payers?

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Brian: Yes, that is something I've actually kept track of here over the last few years. Even as much as three years ago we weren't really seeing a big shift to the patient, whether it's through increased coinsurance or deductibles, but over the last few years we've seen a tremendous shift, especially in the higher deductible plans that patients are opting, or employers are opting in, and what that's doing is that's reverting back over to the physician practice in reduced reimbursements as a majority of the time patients pay an average 30 to 50% of the balances.

Pamela: So if you don't collect that money from the patient, you're out 30 to 50% of your total payment for any given service?

Brian: Exactly. And what we've seen within the first three months of 2009 versus the first three months of 2008, we've seen a 2% overall shift in the total balances. We've seen what was allowed and what was either paid or transferred to the responsibility of the insurance. While that 2% doesn't sound like much, it greatly differs between states. And if you take Texas for example, we've seen

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almost a 5% shift from the patient responsibility from 2008 to 2009. In Mississippi we saw a 2.2% shift and in Pennsylvania we saw a 1.78% shift. While some of those sound large, it's amazing how different it is in each one of the states and somewhat in each of the geographic regions of the states.

On average, in Texas the average patient responsibility for the first three months of 2009 was 35.92% of the balances. Most of this information was derived from the commercial carriers, and that was United, Blue Cross, CIGNA and Humana.

In Mississippi the range is from 28 to 29% and Pennsylvania was much lower at 12 to 13%, so you really need to be aware of what your practice's patient responsibility levels are so you can make the right decisions throughout your process to optimize those collections from those patients.

Pamela: Right. It's worth analyzing where your practice stands. I also feel like because the shift year to year has been, you know, 2%, 5% depending on where you stand, it does sort of have this sort of lobster in boiling water affect that you may not have noticed say, over the

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past five years what a dramatic growth there has been in patient collections or patient AR outstanding. And it often is outstanding. It's sort of hard to collect from patients surprisingly being that they should be so grateful that the physician solved their problem hopefully. Can you talk a little bit about that?

Brian: Yes. I think again we'll revert back to a few years ago when I think the majority of the practices and billing services across this country have put little emphasis on the patient because the patient's revenue, or the revenue from the patients only represented a few percentages of our total revenue. With that, I think that us as an industry has given patients the notion that they don't have to pay their balances and there's not a lot of recourse. Most of the time the physicians are protecting their relationship with the patients so collection agency efforts, credit reporting efforts are not something that was done. I think that there will be a shift to that in the future. Hopefully we can avoid that with proper education to the patient of putting in the right processes and such.

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The other thing I'll recommend is that outside of just looking at your total patient responsibility, you really need to delve into the individual plans that your practice represent and another example of that, if you look at United Healthcare in Texas, the average responsibility in 2008 for net healthcare was 40.83% in the first three months. In 2009, the same period, 70% net is responsibility to the patient. So even your specific payers, you need to be aware of those so if you're using front end eligibility calculators or eligibility screens, you can see what the deductible is; you can collect some more monies on the front end; maybe those patients you need to educate a little bit more or maybe just have a discussion with them to let them know to expect the \$200 balance or a \$300 balance. I think we need to shift that education and that responsibility back over to the patient in the mindset that they are responsible for these balances.

Pamela: Okay, so in shifting that mindset really your first suggestion then is to do careful eligibility at the -- really at check-in or before check-in so that when that patient does show up at check-in the front desk person

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is able to educate that person about their responsibilities right there at the time of service.

Brian: Exactly.

Pamela: What other...? Go ahead.

Brian: And there's a slew of different products out there, again here at Navicure. We offer two components. A front end eligibility screening process or program. We also offer a kiosk that patients can log in, swipe their insurance card and the computer actually will notify the patients that their deductible is X; their responsibility potential for today is Y; also and if they're not using the kiosk, the same information's available at the desk.

Pamela: Boy, it'd be great if you could use those things to really collect at the time of service.

Brian: Exactly.

Pamela: Do you have advice if you're -- what if the practice is not able to collect at the time of service and

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does have to bill the patient? Any advice in terms of billing cycle time or when to send patients to collections?

Brian: Yes. I think there's some key components within this whole collection process from the patient. One is education, and I'm going to keep probably hitting that as most as I can. The other is to make sure that your billing cycle is as reduced as possible so that you're getting the statements to the patient as quickly as possible. Your statement should be clear and concise. They should again, educate the patient on what was performed, why they're responsible. A majority of the invoices you see out there will have a CPT code, a diagnosis code and then a dollar owed, for example. And I think a lot of patients just don't understand this foreign language of medical billing to be able to say, you know what? I am responsible for that. So it's our duty to educate them a bit more. (Overlap.) Another thing that is... I'm sorry?

Pamela: I was going to ask, when you try to keep the billing cycle tight, how many days are we talking?

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Brian: If you look on the national average, and my experience with the large anesthesia practice that I was responsible for, our average turnaround from date of service to date of bill was three days. So we have claims out the door within two to three business days. We typically had payments back from the major carriers within fourteen to seventeen business days, and then we had dropped, immediately dropped statements to the patient. Very similar to what we can do here at Navicure for most of our clients.

Pamela: Great. Thanks. What was your other piece of advice going to be?

Brian: Well I think the establishment of a financial policy, you know, stipulates a practice's policies and procedures for the balances that are owed by the patient. And that can include a whole variety of things from what the claim submission -- what their claim submission policies are for if they're in network, out of network; what their referral requirements are; is the patient responsible for bringing in the referral that has been preauthorized? Are the patients responsible for being preauthorized? Do they have worker's comp and auto plans?

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What's the self pay? What to expect in that, and then the last but not least; the methods of payments that they're willing to accept. I think it's very good for practices to be up front that they're willing to accept payment plans, especially with these increased deductible plans that are going out.

And then the last but not least, and this is an ugly subject of this whole world, healthcare world, is the collection agency and collection policies. I think it should be clearly stated for every patient that walks in for services, they should sign that document accepting and understanding so at least when you're going back to them, it's not an out of the blue type of situation.

Pamela: And when it comes to money, the fewer surprises the better.

Brian: Exactly.

Pamela: Another thing that I've seen some practices include in a financial policy statement is at what point, or whether or not, a patient who does not pay will be dismissed from the practice. What's your opinion on that?

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Brian: My opinion on that ranges drastically because I think if you talk to a whole wide variety of physicians you're going to get so much different feedback. A lot of them are so protective of their patient base because that is their referral source. That is where a majority of their revenue comes from. But then you'll talk with other physicians, maybe in anesthesia, that don't have that patient interaction that says, you know, I want patients to be responsible and after two cycles I want them to go to collections. What I think you ought to do obviously is find that happy medium where you are educating the patients. You're doing everything you can. You're answering your phones when they're calling; you're sending out a letter to them to let them know they're going to collections and then follow up on the policies, because until we do that, patients are still going to feel that they're not responsible or they're not obligated to pay these balances.

Pamela: So before you go there, make sure you're doing all the other things you suggested. You know, collecting at the time of service as much as you can, truly

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educating the patient at the time of service as well as through a written policy.

Brian: Exactly. Yes.

Pamela: Great advice, Brian. Thanks for helping us out today.

Brian: You're welcome.

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