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Internal Medicine Coding Alert

Patient Registration Secrets to Save You Thousands

Presented by Steven M. Verno, CMBSI

The following supplement to Internal Medicine Coding Alert is the transcript of a teleconference presented by The Coding Institute. To obtain the slides for the conference, please log on to our Online Subscription System at http://codinginstitute.com/login and download the current issue, and the slides will be contained therein. If you're not sure how to use the Online Subscription System or need help downloading the issue, please contact our customer service department at 1-800-508-2582 or service@medville.com, and one of our representatives will be able to assist you.

The speaker for the teleconference, Steven M. Verno, CMBSI, specializes in medical coding and billing for emergency medicine, family practice, urgent care and pediatrics and is a Certified Master and Instructor in Medical Coding, Medical Billing, Medical Terminology, and Nursing Assistance. He is currently an emergency physician practice manager and a consultant to many more. He is on the editorial board for ED Coding Alert and Medical Office Billing Alert. Over the years, Steve has had more than 30 coding and billing articles published. He is also the moderator for the MAB forum, and is in constant demand as a consultant, speaker and A/R Recovery specialist.

Thank you very much. I would like to welcome everybody to the conference and I am sure we will have a good time over the next hour. I want to start out with the disclaimer. I am not an attorney. I just sound like one and the information I am presenting is strictly for training purposes only.

I am going to start off this seminar with a little scenario here. We are going to have a patient named Mary Jones. She has a medical complaint and she goes to one of the local emergency rooms for medical care, and in her possession she has an expired driver's license and an old insurance card that she obtained from her previous employer. I am sure some of you have met Mary Jones at some time in the past. She signs the emergency room log, she is seen by the Triage nurse, and then she is called by the hospital registrar, who takes her information and enters it into the hospital computer system. So we already know at this time that Mary Jones is giving you bad information in order to be seen. While in the emergency room, she is sent to the laboratory for tests and she is sent to the x-ray department for a series of x-rays. She has an EKG performed and is later discharged with instructions to see her primary care provider. Now, the claims for the hospital, the emergency room physician, the cardiologist that performed an interpretation of her EKG, all lab tests, and the radiologist - they are all denied because Mary Jones did not have coverage at the time of service. The bills that are sent to Mary by all of these people - the hospital, the radiologist, the laboratory, emergency room physician, and cardiologist have all been returned as a mail return, and it says moved, no forwarding order by the post office.

This scenario, I know, takes place on a daily basis. It happens in hospitals, health clinics, urgent care centers, and it happens with the ancillary providers simply because the registrar took the information that was given to them at face value without verifying it and the billing companies allowed the claim to be sent without verifying the information that they received. I know this happens on a daily basis and we will explain why later on, and how you can find out how this is happening.

Now it has been my personal experience that many hospital registrars do not verify the information they receive and they do not understand the impact that the information that they receive and input into the computer system has with other physicians or practices that interact with the hospital visit. One hospital registrar that I spoke with did not even know that the emergency room physician was not an employee of the hospital. She thought that the doctor was an employee.

Based on my personal experience, approximately 85% of the information received from the hospital contains bad information in one form or another, such as an incorrect or incomplete home address, or incorrect or incomplete

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insurance information. Now, is this because the registrar is doing a bad job? No, not necessarily. In a lot of cases, this is because the patient is giving bad information at the time of service.Based on my own personal visit to the emergency room on September 11, 2003, I just returned from a plane trip and I was experiencing some leg problems so I went to the emergency room thinking maybe I had deep vein thrombosis. So I went to my own emergency room for medical care. When I got there, I went through and signed in, saw the triage nurse and sat for about 45 minutes until the registrar called me up, and when I sat down in front of her she was on the phone talking with her friend. I gave her my current driver's license and my current insurance ID card, which is through Tricare. She was still talking on the telephone while she was entering the information into the hospital system. Then she put the phone down. She gave me the forms to sign. I noticed that I had to sign for a Notice of Privacy Practices. I asked her for a copy. I was told that there was none. I told her that I was not going to sign the form if I was not given a copy and she said that I could not go further until I signed the documentation acknowledging that I received it. I told her that I am not signing it, I told her she still had to see me, I had to be processed through so she went through, but she was very angry because I would not sign the document.

A form that she gave me told me that I would be billed separately and who would be sending me the bills. This is very, very good, but I noticed that my practice address and the phone number was incorrect, as well as the identification of the Medical Director. When I brought this to her attention, she became angrier because now she was back on the phone and I had interrupted her phone call. She said that I was incorrect with the information that was on the paperwork. I identified myself as the practice manager and she still said that I was wrong. Now how can I be wrong if I am the practice manager? So every patient that was coming into this emergency room was getting incorrect information when they came to see the registrar.

Now, several months later, I started getting bills from the hospital. I got bills from the radiologist, from the lab, from the doctor that interpreted the ultrasounds and from my own billing company. When I looked, my name was misspelled on every bill. This was because she entered my name wrong into the computer system.

Every bill stated that the claims that they sent were denied and the reason for the denial was because the insurance company could not identify me. I saw that the registrar entered the wrong policy number. She entered the wrong insurance company. Instead of sending the claim to Tricare, she entered that I was covered by Aetna Health Insurance. Now I do not know how she entered Aetna because I never gave her an insurance card, but she entered Aetna. So I had to tell everybody that was billing me to bill Tricare. Once they started billing Tricare with the correct information, they started getting paid.

Now even when calling these providers to correct the problem, several of them - like I said - wanted my Aetna insurance card even when I told them that I was not even covered by Aetna. So they were not even listening to me. They were adamant that I was covered by Aetna. I said if I am covered by Aetna, how come you are getting the denial saying that they cannot identify me?

Now mistakes such as these are costing the medical profession billions of dollars in lost revenue and it is not just with the amount of the claim, but it is in the spending of the money, in administrative costs to code the claim, bill the claim, correct the situation, then re-bill it and then follow up on the claim.

Now Mary Jones in our initial scenario is what is called a "wolf." Now, a wolf in nature is a smart and cunning animal that preys on the weak in order to survive. Mary Jones is a patient that is a wolf and she is very smart, she is a very cunning person and she preys on the weak practices in order to receive free medical care. You have probably seen her when she comes in.

What she does is that she goes to see the practice or the hospital that that accepts information at face value. She goes to the practice that never verifies the information she gives them, and when they try to bill her or contact her regarding the bills or ask her for the correct information, if they do verify, then she becomes very threatening and intimidating. By doing this, she is confronting you and she basically wants you to the write the bill off. So you have got to watch out for the wolves that are out there. They come to your office. They go to the hospital all the time, and they are looking for the weak practice.

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Now in a typical ER visit, when a patient visits the hospital, especially the emergency room, it is not just the hospital that is affected by the information that you get from the patient. Who is affected by this? You have the hospital itself. Then you have the emergency physician group, which is usually an outside business that is contracted to provide services in the hospital, but they do their own coding and billing. You have the radiology group that may be an external company. We have many of them here in Florida that are external to the hospital, that do their own coding for x-ray interpretations. You have outside laboratories. I cannot tell you how many times I have heard complaints from outside laboratories about bad information that they receive because now they cannot get the lab test paid. You have the cardiology group, if there was an EKG that was performed, they are going to interpret the EKG. Then you have physician consultants that are called in to see the patient. If you send patients out for other tests, such as an MRI or an ultrasound, you have separate companies that do these and they base the billing and everything on the information that is received. Naturally, you have the insurance company itself because they have to take the time and effort to receive the claim that you are sending them, input it into their system and then only to deny it because the patient is not in the system, the benefits were terminated a long time ago or the patient is using a card that they should not even be using. Their benefits do not kick in for another couple of days. So there is a whole group of people that are involved with the information that is taken at the time of the visit. Even with a health clinic, you are also dealing with a collection agency if you send accounts to a collection agency.

Now, what is the cost of a typical visit to a hospital? Well, on the high end, a typical emergency room hospital visit could be up as high as $1000. The emergency room physician bill could be as high as $500 or more. The radiologist could be at least $500, the cardiologist at least $500. I know an MRI costs $1500 because that is what I was charged for an MRI. You have lab tests that could be at least $1000 and outside consultants can charge up to $3000 or more. So a typical ER visit could cost at least $8000 or more. That does not include the inpatient bill.

Now let us say that an average hospital will see approximately 250,000 patients per year through the emergency room. If you take this 250,000 and multiply x8000, which is the high end, you are looking at the cost of $2 trillion per year in medical costs. That does not even count the cost that you have to spend in administrative fees and managing this stuff. This is just the bill itself. $2 trillion at a typical hospital and, like I said, it is high-end. We are not talking about low-end.

I know that an average inpatient visit with no surgeries can cost an average of $30,000 a week. I know that for a fact because my brother was in the hospital for a week. He had absolutely nothing done to him. He just laid in bed watching cartoons and eating meals from the dining facility and his bill was $32,000. The hospital is not getting paid on his visit because they keep sending the bill to the wrong address and he keeps telling them that that. They send it to an old address that somehow they have got into the system and he keeps calling up saying, "look! I am not at this address." So if a hospital has 10 admissions a day that have a one-week stay, this could amount to $300,000 a week in revenue that could be lost due to incorrect or un-validated information. This amounts to $15,600,000 per year in lost revenue. Now we know why the cost of medical care is so high - because if they cannot make this revenue, they have got to raise their charges, that is typical in business. They have to make up their losses somehow.

If you are a physician practice and you provide services at the hospital, you are dependent on the information that you receive at the time of the visit. If the information is bad then you do not get paid and you spend money on administrative costs trying to get paid.

Now if you are an independent practice and you are obtaining information yourself, the patient comes into your clinic and comes up to the front desk, if you do not verify the information before the patient is seen, you stand to lose just as well. You lose a lot of money that is sitting on your system. Verification of this information is very, very important. Verifying the information that you are inputting is important to ensure that you get payment of the bill and that those that are dependent on your information will receive good information so it does not cost them time and money, and it catches the wolves at their game.

Non-verification of information: Let us say Mary Jones is covered with ABC Insurance, which is an HMO and the visit is $100. Well, you are going to spend 15 minutes entering the demographics into the billing computer. At $10/hour, this is 17 cents a minute so 15 minutes of entering is $2.55. If you enter the demographic information wrong, you just blew $2.55 for that patient. You code the claim and enter the codes in the system. It takes about 10 minutes, $1.17. You process the claim to go through everything so if you add up all the administrative costs of processing the claim - it is

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about $6.50. Now let us say that you do not get paid. 90 days later, you call the insurance company. We know for a fact that you spend a lot of time on hold. The average is about 20 minutes. Then you spend about 10 minutes checking on the claim status. This is about $5.10. The insurance company states that claim is not on file. I know that a lot of you have gotten that information from the insurance company. I have gotten it many, many times myself so you enter the notes and you re-process the claim. $6.50 again. You wait about another 60-90 days later and then the EOB arrives telling you that the patient was terminated and has no benefits. So you enter notes about the denial and you process the account to have statement sent to the patient. Now remember that Mary Jones has given you a bad driver's license so you process the statement, $6.50. They do not respond. You send them a second statement, another $6.50. They do not respond to that so you send them the third statement, $6.50. You send them a final notice letter letting them know that their account may be sent to a collection agency, another $6.50. Then you finally send the account to your collection agency so that has got to be processed by the administrative department and they put it on a disk or CD or whatever. That is about $5 of administrative cost. Now how much did you make on this visit, not a penny. How much did you spend in administrative costs? About $53.67. It is a lot of money to lose. Now you send it to your collection agency. They try to contact her, but you have got bad information going to them so they do the work that they do. They can do a skip trace and then they finally find her. She agrees to pay $100 that she owes so she pays it. The collection agency gets their 40%. You get you $60, but you spent $53.67 to collect it so you made $6.33, but you have got to spend this to enter the payment into your system and then store the data elsewhere so you have lost money on this simply because nobody verified the information.

Now let us say that she does not pay the bill. It goes to your collection agency. Not only did you lose the $100 for the visit, but you spent $53.67 trying to collect it so Mary Jones does not pay it at all - they cannot find her - so your overall loss is $153.67 and that does not count the money that the collection agency is losing in trying to collect this as well.

The cost to verify: Let us say Mrs. Smith walks in. She says that she has XYZ insurance. You go to the XYZ insurance Web site and you check eligibility. XYZ insurance says that Mrs. Smith terminated her insurance more than 90 days ago. While she is standing there or is sitting in the room, you inform her that her insurance is terminated. So she gets very, very angry and she storms out in search of another doctor that will not check her information. How long does it take? Well, I have done this online. It takes about a minute. I have gone to several of our insurance Web sites that they have set up now. I have been able to log in, enter the information that is on the screen and then in a minute it has taken me to find our whether or not she has benefits. It cost me 17 cents to do this.

So the cost of verifying versus not: The cost of verifying to find out that Mrs. Smith is a wolf costs me 17 cents, but if I did not do anything? If I took her information at face-value, we provided the care, we billed the insurance company, we called to check on the claim status, we re-sent the claim, we get the denial, we bill the patient, we re-bill the patient, we re-bill the patient, then we send the final notice letter and then we send her to collections, we spend $153.67. What would you prefer, 17 cents loss or $153.67 loss? I know some of you probably want the $153.67, but I want 17 cents.

Now, how much does the practice lose? People do not think of this. They do not because they do not see it. It is not in physical dollars that they see, but if you see 32 patients a day, that is 160 patients a week, 8,320 patients a year. If you have an average charge of $100, 10% of your patients give bad information, it is 832 patients. 832 x $153.67 means your practice lost $127,853.44 in a year. Now these are high-end numbers. These are estimated costs, but I can assure that practices lose a lot more than that, and hospitals lose millions of dollars because of the information that is taken in.

Now let us say the average charge is $100. If you see 100,000 patients a year, that is a loss of $1,530,000; with 150,000 patients a year, it goes up to almost $2,300,000. With 200,000 patients a year, it is over $3,000,000. With 250,000 patients a year, it is almost $4,000,000. So is it worth not verifying the information? Is it worth not putting in the information correctly so you can get this money paid? Maybe if we can start doing this, we can start lowering the cost of healthcare. There are other factors involved in the loss of healthcare, but that is for another time.

Now I have heard these typical excuses for not verifying:

1. It takes too long on the telephone. Yeah, it does. It takes 20 minutes!

2. We do not have the time to do that. Well, that is very possible. I have seen practices that are very, very, very, very

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busy. Okay.

3. They say our staff is too busy to do that, and I agree. I have seen that.

4. We do not have enough staff to do this. I have been in some practices where they only have one person working up the front and this person is so busy because they are also going back and helping the doctor, because the doctor has to cut back because they are not making enough.

5. I hear this excuse that our job is to do patient care, not administrative minutia. Well, I have heard that and I do not agree with that.

6. One excuse that I hear a lot that it is easier and cheaper to do this on the back-end. Well, is it? If it is 17 cents on the front end and $153 on the back end, is it cheaper to do this on the back end? No, it is not.

7. The other excuse is that we do not want to make the patient angry. Yeah, the wolf is going to get angry because you are challenging them. So they get angry to intimidate you so that you leave them alone and you accept what is given to you at face value.

Now having been a patient myself many times, these are some of my observations during my visits as a patient. For example, I enter the hospital or the practice and I sign in and then I wait. The average waiting time I spend is between 30 and 60 minutes before I am usually called up to the front desk or over to the registrar to provide my information. The average wait time to see the physician is anywhere between 30-45 minutes or more once I get back into that little room. In a hospital emergency room, this could be several hours, so my question is that if I as a patient am waiting this long before I am even seen, why do you not have the time to verify the information that I am giving you? I mean that is a question a lot of patients have asked me. So that is a good question. If I am a patient sitting in the emergency room and I went in at 4 in the morning and there was nobody in the emergency room, it took me an hour to get through to the registrar. Once I got through to the registrar, it took another 45 minutes for me to be called into the back and then once I am in the back and sitting, watching everyone sitting at the nurse's station talking for another 45 minutes before someone walked up to me and said that we need to send you back for an x-ray because I was roller-skating and fell and broke my arm. So here I was in the hospital for 3 hours already before I was even seen and I am the only patient, so why did it take so long to do all of this? I do not know.

How can you tell that whether the information that you are given is good? Well, there are a lot of indicators before the patient is seen and these basically are the things that you can look for:

A. Look at your system and see how many denied claims you are getting. Look at your EOBs and look up the reason for the denial. I will go into these separately.

B. How many unpaid claims do you have on your system?

C. How many mail returns are you getting, as far as sending the patient a statement? If you are getting mail returns, guess what? The information you have got is bad. Especially if you saw the patient today and you send the bill out, and a week later you get it back saying "moved, no forwarding, order expired."

D. How many refund requests are you getting where the insurance company is saying that well we paid you, but we have gone back and we have looked at this and we have determined that the patient is not one of our members. And they are doing this nine months later.

E. How many patient statement mail returns are you getting?

F. Look at your account receivables to see how much money you have out there.

G. How many claims are you sending out and you are getting the claims back saying that the insurance company has

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changed their address, and the insurance company has moved, and no forwarding address?

Now looking at your denied claims - I am sure you can agree with me - these are some of the typical denials. The patient terminated prior to the date of service. The insurance company cannot identify the patient. The patient has other insurance that is primary. The date of service is prior to the start date of the policy and the procedure is not a covered service. Now all of these can be corrected very, very easily if we as a group - when the patient comes in to see us - simply get on the internet or get on the phone and make a phone call. Those few minutes of time, even though maybe it is 20 minutes, are going to save you hours of time later on down the line. If they say that the patient terminated or you see it on the Web site that the patient was terminated, you would sit there and you would look at the patient saying, "Excuse me! Do you have any other insurance that you can pay for this?" That is going to help you keep from coding it for a particular insurance company and sending the claim out the door, especially if they say that they cannot identify the patient. We see this all the time. In this case if the patient says, "I am with that insurance company," then you can put the patient on the phone and have them argue with the insurance company. If they say, "this is all I have got," and you took that at face value then you have got a problem on your hands. Have the patient sign an affidavit saying that they have no other insurance that is primary and then when it gets denied, then you go after and bill the patient. So denied claims are one of your key indicators that you can look at. Look at how many unpaid claims that you have on your system. Now my philosophy is that if you send a claim electronically and it is unpaid after 30 days then you have got a problem on your hands. If you send it by paper and it is unpaid after 45 days you have got a problem on your hands because normally most of these insurance companies pay. The small ones pay good. The big ones we have the hard time with because they do not want to pay the claim. There is a reason why, but if you follow up very, very quickly on these unpaid claims you are going to find out why. You are not going to have things sitting on your system for 120 days, 180, 360. Then you do not have to call up somebody like me who has to come in and try to clean up the mess where you have got $500,000 sitting on your system, or $3 million sitting on your system, and you are wondering why you are not making any money.

If you have an unpaid claim, you have got a problem when the patient asks you to send them a statement instead of requiring the patient to pay at the time of service, especially if you have a non-contract with the insurance company. So if the patient says, "I cannot pay. I do not have the money to pay my co-pay. I do not have the money to pay my deductible." Or, "I am not contracted, but I do not have the money to pay." Well, I do not believe that because after they see you where do they usually go? They go to the pharmacy and the pharmacy demands that they pay before they give them a prescription. Or they go shopping, I know for a fact that they do. My wife does all the time.

More than 90% of self-pay patients do not pay their medical bills and that is a fact. Take a look at how much you are sending to the collection agency. Take a look at how many times you are sending claims over and over and over and over and over again to the patient. If you send the patient a statement and they do not respond to the first one and they do not respond to the second one, why keep sending them statements? They are not going to respond. Now as far as your patients are concerned, make sure you have a practice financial plan and you have the patient read it with each visit. If it is a patient that keeps coming back and forth over and over and over again, have them read it the first time. If you make any changes to the practice financial plan then have them read it again, but make sure that they understand the financial plan. Education of the patient is the key. If your plans say payment is due at the time of service why are you sending patient statements? Obviously, you are wasting your time with making a nice sign and you are not collecting it. One practice that I went to for follow-up care had this beautiful bronze sign "Payment is due at the time of service." Well, they did not verify my information that I gave to them. They are sending the bills to the wrong insurance company and I have got a co-pay. They never asked me to pay the co-pay. When I walked up, when I left, I handed her my credit card and said that here this is to pay my co-pay, they never asked me to do it but I wanted to make sure that I did pay my co-pay.

If a patient asks you to send them a statement, inform them that they will be sent one statement at a fee that you have in your financial plan and that fee is payable immediately. You are going to catch the wolves with this. So they will say never mind, I will pay my bill right now or they will pay you the $6.50 fee that you have established for sending them the bill. Tell them that you are only going to get one statement and that if the payment is not made in 30 days, their account is going to be sent to the collection agency. Why send them three statements and a final notice letter? Send them one. If they do not pay, get them off to the collection agency. Get them out of your hair. Let them worry about it.

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Claim mail returns: Make sure that your billing software database is restricted and limited to who can make changes, otherwise, you can have at least 60 entries for one insurance company and I have seen that in some databases, for Aetna you have got 50 million Aetnas in there. Make sure that you have the right addresses in your system and that if you get the mail returns back, you give it to the person that is handling the claims mail return and they enter the data into the system to make sure that you cannot use that address again, if you get that information over from the hospital or the patient presents that insurance card again. Periodically, about every six months or so, contact the insurance company, verify the claim's address, the claims manager and their fax number. It is easy to do this. If they say, "what do you need the fax number for?" Just simply say, "today is my first day on the job. If I do not get this information, I am going to get fired." Play the wounded duck and then they will give you that information because you can use the fax number to fax any paper claims that you need to send to them if you are going to be doing an A/R recovery. Within today's society, you can send claims electronically so use that to your benefit so you do not have any claim mail returns.

Refund requests: The refund being returned is because the carrier states that the patient has other insurance that was primary or benefits were retroactively terminated. Now if you verify this before providing the service, you can deny the request for a refund, you can demand that they do not have your permission to off-set or reduce payment from the claims in their system and if you are contracted, make sure that this is a provision to be added in your system, otherwise, you are forced to return the money per the terms of the contact. But you can fight these refund requests, especially when you verify. They said that the patient had coverage and now they want the money back stating that the patient did not have coverage. There are some states that have laws that protect you on this, that say that if you have verified ahead of time they will have to pay you and they cannot ask for their money back.

As far as patient's statement mail returns go, if you send a statement that comes back saying moved or forwarding order expired, the patient lied to you. They do not live at that address. They have not lived there for more than a year. For these types of patients, if they are insured have them pay for all co-pay and deductibles at the time of service that we do not have to send them a statement. Have the uninsured patient pay at the time of service. They have got the money to go out shopping and they have got the money to pay for their medicines, they should have the money to pay you, especially if they are calling you to make an appointment. You can tell them on the phone. How do you plan to pay for this at the time of service? They will say, "Well, I am an uninsured patient." "Well, you need to pay for it when you come in." That way they are educated and know ahead of time. I know that it is hard in a hospital. It is almost impossible to do this. You are probably going to have to bill these patients afterwards, but at least you can have the patient sign an affidavit stating that the information they have given you is correct. That way they cannot come back and use it against you.

Demand two copies of a legible and current picture ID. This is important today with identity thefts that are taking place all the time. I cannot tell you how many times people who live in these retirement communities are letting their neighbors who do not have Medicare Part-B use their Medicare Part-B card when they go to the hospital. They simply show it, for example it is Aunt Tilly's card, but it is not Aunt Tilly that is using the card when they go to the hospital. Make sure that you have got two copies of legible and a current picture ID. Make a copy of them and put them in the medical record. This way if the patient comes back and states, "that is not me that was seen," you can have them send you a copy of their ID card and then compare it with the information that you have got.

Have the patient sign an affidavit attesting to the accuracy of the information given to you. Ask them for a copy of their credit card and tell the patient that if you send them a statement and no payment is received in 30 days, you are going to apply the payment to their credit card. Ask them for three telephone numbers. This was brought to my attention by my collection agency because it is difficult for the collection agency to try to contact the patient. Ask them for a home phone number, a work phone number and an emergency phone number. The emergency one is going to be very, very important especially down the line in trying to contact them because you may find out that that home phone number is in reality the local Burger King. The work phone number is some office that the patient does not even work at, they have never heard of him. If you have got the time, call each number to verify. It is better to find out if the number is disconnected than to provide the service for free. You can call the patient back with, "Excuse me! The phone number you gave me is disconnected." Oh Okay! You will find the wolves really easy when you are doing that.

Look at your account receivables. Look at your A/R to see your financial situation. If you have anything outstanding more than 90 days from the date of service, you have got a problem. So your A/R is an indicator. I am usually called in

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to take a look at some of these problems and one doctor I went to recently was crying because she was not making any money. She has got a sign up that says that she has discontinued her malpractice insurance because she cannot afford it. She has one staff member. She has got an A/R of $750,000 and she has also got very bad insurance contracts. She is only making $5 a patient after she takes out how much discount she has given to the insurance company, plus what she is not collecting in co-pays and deductibles, plus the bad information that is given to her at the time of service, the patients who have lied to her, and she is getting all these mail returns back. She is only making 5 bucks/hour. That is it. I told her to quit, stop being a doctor, go to work for Burger King and you will make more money, or go work for WalMart. I am working with her to try to help her out.

The verification process is key. Remember if I am sitting in your hospital for 45 minutes to an hour and I am the only one in there or we are all sitting in there waiting, why cannot you get on the phone and call; or if I am sitting in front of you, pick up the phone, get on the internet. The verification begins when the patient makes an appointment - when they call you and say, "I want to make an appointment." You are a health clinic. You say, "Okay, how do you plan to pay for the visit?" "I have got ABC insurance." "All right, may I have their phone number? I need your policy number. I need the name of the insured. I need to know the date of birth, blah, blah, blah..." You get that and you say I am going to put you on hold. Then you call or you get on the internet and then you look and all of a sudden the internet says "Sorry, patient does not have benefits." Then you pick the phone up. "Sorry, but your insurance says that you do not have any benefits. How do you plan to pay?" Next thing you know you hear the phone disconnect. These are the wolves trying to find you out.

If you are a hospital or a hospital-based physician practice, you cannot verify it before the patient is seen. It takes place before you send the claim. So make sure that your billing department has the correct insurance information and all the correct patient information so they can verify before they send the claim out. I am told that this is impossible to do. Well, I am saying that it is not because I have done it. I have been there with my billing company that I used to work for many, many years ago and one of the things that they used to do in the morning time, when we got the hospital download, we would input it into the computer system and then it would go through the system. We would have the coders code, and then we would have an insurance coder who would transfer the information from the hospital code to our code so that we had the right insurance information in our system and then they would break it down and coders, chart processors, and everybody would stop working and everybody would be given about 10 patients and then you would get on the phone and you would start making the phone calls. It would take about 1-1.5 hour for you to get done. Because you would go in, you would see the patient is 'self-pay', but the patient had Medicaid the last visit so you would get on the phone and you would call Medicaid and find out if the patient still has Medicaid, so you enter the Medicaid information. Instead of sending a patient three statements, a final notice letter and then to collections and then a year later the patient calls up saying, "oh by the way, I have got Medicaid." You could have found that out in less than 30 seconds. So verify it before you send the claim if you cannot verify it at the time of service.

Do not send anything out the door until the information you have been given has been verified. That is very, very important. Many state laws and physician contracts allow a minimum of 30 days to send the claim. With Medicaid and Tricare, you have got a year to submit the claim to them. Medicare allows 18 months to send the claim. If you have got 90 days in your contract or 30 days or 180 days, why are we in such a rush to get the claim out the door? I know that we want to get it paid, but take a look at our A/R. If we have got $3 million on our A/R in the 120+, obviously we have got a problem on our hands. Why cannot we get that down to something that is manageable to around $100,000 and then increase our revenue by that $3 million.

My law of claims processing is very, very simple. Treat your claim as if it were your paycheck because it is. Some people do not understand where their paycheck comes from. The paycheck comes from the claim that has been paid or the patient that has paid. The doctor does not have a money tree out back that he can go to and start popping off a couple of $100 bills to pay you. If the doctor does not get paid, the doctor goes out of business and this is what happened with this doctor I am working with right now. She canceled her malpractice insurance. She got rid of her staff of six. She is down to a staff of one. She had to fire five people because she is not making any money. She is living off credit cards because she is not getting it in. Treat your claim as if it were your paycheck. Plain and simple.

In today's society there are two ways to verify information. On the telephone and on the internet. One of the two. Downfall of using the phone, you have got 20 minutes on hold and the person you need to speak with is never in the

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office. I know for a fact that they are never in the office. How do they get work done if they are never in? But they never seem to be in and your voicemails are never returned. So that is a downfall of using the phone. Using the phone for a minimum of 20 minutes is going to cause you $3.40. Using the internet - I have done it many times - takes about 1 minute to check eligibility and check information, and it costs 17 cents. The reason I came up with 17 cents is because it is $10 an hour and thus 17 cents a minute. So by using the internet you save $3.23/patient. That is a savings of $28,000 a year by checking the information on the internet. Plus, you may be able to find out that the patient's name is not spelled the same as far as how they gave it to you versus what the insurance company has in the system. You may have the patient's name as Robert Cruz, but in the computer system their name is Robert Cruz-Mendez. The patient did not tell you that they also use the name Mendez when they registered with the insurance company. So that is going to help you out immensely. They may have a different policy number than what was given to you, so check this out. Which way would you prefer? Checking eligibility before the patient is seen, using the internet at the cost of 17 cents to find out that the patient does not have benefits, then ask the patient how they are going to pay, which causes the patient to walk out angrily because you caught them at their game. Or, take the information for granted, provide the service, spend the time putting the information into your system, the information could be put in incorrectly, you code the claim, you send the claim by paper, you wait and wait for payment only to find out the patient had no benefits. You bill the patient only to have the patient ignore you. You send the account to collections. You lose not only the cost of the visit, but all the time and effort and money put into getting this thing paid and then losing money on top of it. Which one would you prefer? I would prefer the first one.

By using the internet today, you can check patient eligibility in about 1 minute. You can print the eligibility page and put it into the medical record. This is your proof. You have written proof of eligibility. You have got a foundation now in case they decide to deny it or submit a refund request to you. Using the internet saves you time today. It is minutes versus months. It reduces your overhead costs. It reduces your administrative expenses. It reduces your denied and unpaid claims. It reduces your A/R and increases your revenue. It gives you the documentation you can use later. It pays you faster. You get paid in weeks. If I submit a Medicaid claim electronically on Wednesday, the following Wednesday I have got a check. It is beautiful. So if I do not get paid in 30 days; if I have got these unpaid Medicaid claims on my system in 30 days, I have got a problem and I need to identify that early. By verifying, you are keeping the wolves at bay.

Proper patient registration: I am not saying that all registrars are bad. A lot of them are good. There are some out there that are the greatest in the world and I have used the information that they have put into the system to fight the insurance company. They have done an excellent job in that, but there are some out there that are not doing the job that they should be doing, and that is what is costing us a lot of money. I as a patient wonder why I am getting statements when I gave correct insurance information? That is a question that comes up all the time. If I gave correct insurance information why the heck am I getting the bill? Why is not my insurance company paying for the claim? Proper patient registration, however, primarily ensures the claim is clean. I recently had to give a bunch of medical billers a test. They wanted to be hired. They had a simple task. The task was fill out three claim forms. They were given a super-bill with all of the information typed out. All they had to do was transfer it to the CMS-1500 form. Not one person got the claim form correct and where they got it wrong was they put the name wrong on the claim form, they put the wrong insurance as primary, even though I had the insurance listed saying here is primary and here is secondary. They had put the secondary as primary on the claim form. They had the wrong policy number on the claim form. And I am saying to myself, if these people are getting these wrong what are they going to get wrong if I hire them? So they did not get hired. But proper patient registration - entering the information in the system correctly ensures that the claim is clean, it will ensure that your claims are paid and they are paid quicker. You are going to get your payment in weeks or days versus months or never. It helps other providers who are dependent on the data that you get.

Remember if you are working in a hospital and you have got others behind the scenes that are dependent on the information you are giving them. It reduces losses to your practice and to the hospital. I cannot tell you how many millions of dollars are lost at a hospital and how many hundreds of thousand dollars - if not millions of dollars - are lost to a physician practice because of data that is entered incorrectly. If you are a clinic, if you verify the information while the patient is there, it keeps these wolves at bay. They are going to walk out indignant, they will walk out angry and then they are going to look for the weak doctor. They are going to find him and they are going to be with him for a little bit so they can finally move on and find somebody else, because when they are caught, you make sure that they pay or they get up and leave.

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There was a doctor in Rockledge where we retrained his front desk clerk to make sure that she asks for this information and she verified it while the patient was standing there in the window. You will be amazed at how many patients got really angry because she got on the phone to verify and then told them, "Sorry but you do not have benefits, your insurance company says you terminated months ago." They would get angry and would walk out. The doctor said, "why are they walking out?" Because they are not going to pay you. They do not have insurance. Well I will see them anyway. So you want to provide free care? Well that is okay with you, but I am telling you how you need to do it. Verifying keeps the wolves at bay. It also keeps your administrative expenses to a minimum because you have got to look at the dollars you are not seeing. Look at how much you are losing by making the phone calls, entering notes, re-keying things to go back out the door again, spending the time and money to reprint or retransmit and then waiting for a denial that is going to come across to say that the patient did not have benefits or is denied for another reason. So proper patient registration is very, very important and the key to getting yourself paid. At this time this is all I have for the conference and we have got about 10 minutes for questions so I want to open up the lines for any questions that you may have.

Q & A Session:

Question: Yes, I wonder where the 90% statistical data comes from as far as self-payers that do not pay. Is that based on just personal experience or is that based on national standards?

Answer: No, It is based on experience. I have been in this business for 32 years and I have worked with many, many practices. I have worked in hospitals, I have managed clinics; and when I have gone in to take a look at the systems, this is basically what I have found. Other companies that I have talked to, for example, my own billing company, they verified that data is pretty accurate. It is based on personal experience.

Question: Hi Steve. This is actually Lorrie Dorin from Lab 1. I was just wondering what kind of advice you would give to an independent lab that does not always have the opportunity to see the patients in person to collect the information?

Answer: Where do you get your information from?

Question: From the physician offices.

Answer: Then the best thing is to go back to that physician office and if the information you have been given is bad then you need to start letting that physician office know that the information that they are providing you is not valid. Once they start getting more and more calls from you then they should start getting the idea that they need to improve the process of getting the information from the patient, as far as getting more accurate information goes. I know it is hard for you to do. Like I said, labs are one of the most difficult groups of practices out there that depend entirely on the information that they get from the provider. So if the doctor is constantly giving you bad information, you need to contact that doctor and start talking to him.

Question: Hi Thanks. If there is no Internet verification or online verification possible with the payer, what are some tips on dealing with these phone issues or the downfalls of using the phone, such as being on hold and those types of things?
Answer: Now, I am going to answer your question with a question here. Are the services you providing emergency?

Question: We are a large multispecialty group practice.

Answer: Because you see in some cases you do not have internet accessibility with a lot of the carriers and a lot of the them are the small ones, right?

Question: Right.

Answer: With big ones like Aetna, Cigna, United Health Care and Blue Cross Blue Shield, all have online eligibility. The

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best thing to do is, when the patient calls you to make an appointment, put the patient on hold -in this case, you have no choice but to call the insurance company - and if the insurance company cannot verify the information then you go back to the patient and say, "excuse me, but we cannot verify the information you are giving us. How do you plan to pay for this?" If they keep saying, "well I have insurance," then you have to put the onus on the patient. Have the patient call their insurance company and then ask them to tell the insurance company to contact you, otherwise, I would not make an appointment for these patients. Because all you are going to do is you are going to get the patient in, you cannot verify the benefits, you are going to go through this whole process and you are going to end up giving free medical care and you are going to lose money in the end. That is a typical answer that I can give you, but that is one of the best answers that I can give. Put the onus back onto the patient if you are having any problems with their insurance company.

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