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INCREASING THE SUCCESS RATE OF COLLECTIONS EFFORTS

Ensuring timely, patient-friendly collections can be difficult. Disagreement over a bill can be very disruptive to the physician-patient relationship, and arguing with a payer over reimbursement can cause stress for both the psychiatrist and the patient.

To avoid unnecessary pitfalls, you must first and foremost develop a clear understanding of the patient's insurance, including what it does and does not cover and any restrictions against billing the patient. As noted in Chapter 15, this information should be requested from the patient during or before the first visit and confirmed with the insurer for accuracy as soon as possible. Remember, you cannot rely on the patient's understanding of her coverage or on your own knowledge of what the same insurer covered for another patient.

If patients do not have adequate insurance to cover the necessary treatment, inform them immediately and work with them to develop an alternative arrangement that is mutually acceptable. Before you do this, however, you'll need to review any contractual agreement you may have with the insurer to confirm that the arrangement is allowable. Many payers do not allow in-network psychiatrists to balance-bill the patient for services that are not authorized.

Patients should be made aware of the practice's collections policies in writing and as soon as possible, ideally at the time treatment begins. Describe all of the fiduciary terms in detail, including the practice's policy on charges for missed appointments and copayment collection (see Chapter 13 for advice on managing missed appointments). Whenever possible, copayments should be collected at the time of service delivery, and it may be helpful to post this policy in an obvious place in the office. All financial arrangements should be documented in writing for future reference, and the patient (or his guardian) should sign and receive a copy.

For patients covered by an insurance plan whose network you're part of, you must monitor treatment authorizations carefully. If you exceed the authorized number of sessions or bill for services beyond those authorized, your practice will probably have to absorb the costs, since payers are typically inflexible when network providers do not follow their administrative protocols. To improve collections, claims submitted to managed care organizations and other payers must also be "clean" (i.e., must contain sufficient information for expeditious processing). While there is some variability in what is required, most payers look for the diagnosis, procedure, place, date, and type of service. Using a form like

the CMS 1500 should meet most insurers' needs. Please see Chapter 30 for additional information on billing issues.

Although most practices bill their patients monthly, we recommend billing every two weeks to keep patients up-to-date with their balances. Practices should also review their collections and deposits at least once a month. An automated system greatly simplifies this .

TIPS FOR HANDLING DIFFICULT BILLING SITUATIONS

- When patients claim they have paid, but there is no record of funds having been deposited, ask them to mail or fax a copy of the canceled check or show you the credit card statement that documents the payment. If they say they paid in cash, ask for a copy of the receipt (be sure to give receipts for all cash payments).

- When patients say they cannot afford the balance due, develop a payment plan with a minimum of $20 per month or allow them to give you postdated checks.

- If a patient dies owing money, first exhaust all third-party resources. Check your state's laws about further avenues of collection. Depending upon the state, payment may or may not be the responsibility of a spouse, parents, and/or children. If applicable, it may be advisable to submit the bill to the estate attorney or the executor of the will. We recommend that no collection calls be made to the patient's family for at least thirty days.

- If you are planning to charge interest or finance charges, or to allow installments over four or more payments, you must notify patients of this policy when they begin treatment, and be aware that federal and/or state truth-in-lending laws may apply to these activities.

- When a patient's check is returned due to insufficient funds, add an insufficient funds charge of $15 to $25 to the bill (this policy should be posted prominently in the office and given to the patient in writing at the beginning of treatment). Inform the patient in writing or by telephone that payment is expected within a week or two weeks (at your discretion).

- As an avenue of last resort, warn the patient that if you do not receive payment by a certain date, the account will be forwarded to a collection agency -- and stick to that promise. (**Note:** This option is typically not worth the effort unless the bill is over $100. Furthermore, be aware that collection efforts sometimes lead to counterclaims of malpractice.) Be aware that a collection agency will keep or bill you a percentage of the amount collected. Percentages can be extremely variable, and it is wise to comparison shop.

- We recommend against paying more than one-third of the collected amount and against paying this fee up-front.

Ideally, if patients know the payment rules from the outset, you will not have problems with collecting their share of any fees you are due.