Fine print,
Health care billing may not rank as everyone’s favorite conversation topic, but understanding the billing process and its many challenges is fundamental for any medical office.

While the Affordable Care Act has reduced the number of Americans who are without health insurance, high-deductible health plans are on the rise. In fact, insured patients can face significant cost-sharing burdens, as out-of-pocket deductibles, co-pays, and coinsurance constitute significant components of the routine costs of care.

Unlike other areas of the economy, health care billing remains invariably complicated by the involvement of third-party payers. Along with cost-sharing practices, the price for medical services and procedures rarely matches what insurance carriers allow as covered payment. To cope with such billing challenges, medical offices need well-trained staff and clear, consistent billing policies and procedures.

**Contractual adjustments**

Write-offs present billing concerns for most medical offices. Generally, a write-off refers to any amount deducted from a medical bill. Offices often allow write-offs when they do not expect to collect payment. While there are several types of write-offs, including those for hardship care, bad debt, and small balances, the contractual adjustment is one of the most frequent.

The contractual adjustment essentially represents a discounted insurance rate, also referred to as the allowable. How does it work? “Contractual adjustments are based on the contract you have with the managed care provider,” says Laura Palmer, FACMPE, a senior industry analyst with the Colorado-based Medical Group Management Association (MGMA). “For example, we know that a Medicare patient who has surgery is going to be responsible for 20 percent of their bill if they don’t have secondary insurance. But that 20 percent is going to be based on a contracted amount—what the Medicare allowable is. If the charge for a procedure is $1,000 and Medicare pays $400, 80 percent of that will be paid by Medicare and 20 percent by the patient. The other $600 is a contractual adjustment. So that’s a type of write-off.”

For managers and staff, effectively managing this type of write-off begins by having familiarity with the contract rules of participating health plans. “I do recommend that managers just get out all the contracts and read them,” says Mary Pat Whaley, FACMPE, CPC, a Durham, North Carolina-based health care consultant specializing in solo and independent physician practices. Whaley urges managers to know every allowable and then enter each one into the billing system. Doing so helps prepare for situations in which payers do not pay according to established contracts.
Such advice might appear obvious, but as Whaley notes, managers often work with contracts negotiated by others. “For a lot of managers, they’ve inherited contracts. They’ve come to a practice from elsewhere or they’ve been promoted within a practice and didn’t really have anything to do with negotiating the existing contracts.”

As Whaley and many experts recommend, contract payment schedules should be kept on file in the office’s practice management software. When a payment is posted, the system will then automatically alert staff whether the payment is correct. For more frequently-used insurance carriers and procedures, another recommendation is to set up an electronic spreadsheet that allows staff to check the accuracy of a payment.¹

Managers must also keep the big picture in mind by looking for any patterns in how insurers are covering services, adds Palmer. “We want to be able to monitor any trends,” she says. “If an insurance company seems to be denying certain services, or we learn that certain payment arrangements aren’t covered, we want to understand the policy and communicate that information clearly to patients.”

Rules and silent PPOs
Unfortunately, in a volatile health care market, staying up to date on contract rules involving multiple insurance carriers can prove quite the task.

Consider silent PPOs, for example. This term refers to the practice by which insurers or third-party payers, through a preferred provider organization (PPO) or other network organization, pay a physician’s lower contracted rates through a secondary network. They do this despite a lack of direct authorization from the health care provider.

“When a practice signs a contract with a provider network, sometimes the contract will state that they can resell your contract as part of the network to other companies without your approval,” explains Whaley. “We call those silent PPOs because—as a result—a practice may unknowingly accept an allowable for a procedure or a service and thereby that write-off.”

Unfortunately, the terms of doing business with a silent PPO often come to light only after the fact. “A manager or biller might receive a reimbursement and notice there’s a discount, but it’s not with any provider group they’ve contracted with,” says Whaley. “So they get on the phone, do the research, and eventually find out the discount is covered under a particular PPO.”

The lack of transparency regarding silent PPOs remains controversial, and the practice has faced legal challenges in some states.² In California, the law now requires PPOs to respond to a physician’s written request for a summary of all eligible payers within 30 days in order to claim that physician’s contracted rate.³

As a consultant, Whaley recommends medical practices avoid signing contracts that allow this practice. However, she acknowledges this may not always be possible in every market. If such is the case, practices should make every effort to identify any companies that may be “silently” contracted with their networks.

“It’s important to know the names of all the products attached to a contract,” Whaley cautions.

To address these and other issues, medical offices may want to keep a ready list of key contract information available to billing staff, such as the following:
- List of PPO networks
- Contact information for contracted health plan reps
- Contract renewal dates
- Billing or credentialing rules for nurse practitioners and physician assistants
- Useful references

Issues can also arise when other noncontracted payers offer discounted reimbursement rates, claiming the office charges are above “usual and customary” rates for a particular market. As a result, patients will sometimes have concerns that their health care provider has overcharged them, leaving the patients responsible for a larger portion of the bill than expected. In these cases, Whaley suggests office staff use a phone script or prewritten letter to clearly explain billing policies and what “usual and customary” fees mean.

Deductibles, co-pays, hardship
Another billing concern questions whether it is ever appropriate to write off the patient portion of a bill. In years past, it actually was not unusual for physicians to occasionally ask the front desk to mark a bill as “insurance only.” For various reasons, including professional courtesy, the physician would decide to write off the patient’s co-pay or some other portion of the bill.

Today, it is a largely different story. A provider that frequently or routinely waives Medicare or private insurance co-pays, deductibles, or other charges may be considered to be acting in violation of federal guidelines. In fact, such practices can put a medical office at risk of having its contracts terminated or even of facing fraud charges. Professional courtesy fee discounts to staff or other health care professionals can pose yet another risk. While such discounts are generally legal, they should not be offered in exchange for business referrals, which can create kickback concerns.⁴

One situation that would call for a waiving of the patient’s portion of the bill is financial hardship. In order to do so, staff must document the reason financial hardship was determined, advises Whaley. This is accomplished through an established policy that asks the patient to meet certain requirements and, through collected backup
Writing a wrong

Common errors mean increased write-offs. Know what they are and what to do next:

- **Registration errors.** Denials often occur because of an error in the patient registration process, usually from outdated demographic or insurance information.

- **Diagnosis coding issues.** A claim may be denied because the provider’s diagnosis was not coded to the highest level of specificity.

- **Incorrect or missing patient subscriber number.** Staff should enter complete registration information into a practice management system, and confirm that information with the patient.

- **Illegible claims.** If a payer requires providers to submit claims on paper instead of electronically, issues with legibility can arise.

- **Payer changes.** A payer may make changes to its system without alerting a practice. For example, a practice may be unaware that a payer requires more detailed demographic information as of a certain date.

What should practices do when claims are denied? Appeal, and keep appealing. Staff may be tempted to write off denied claims and do away with them, but the potential reimbursement increases with each appeal.

Accurate records, clear policies

Even well-run offices occasionally experience billing mistakes. When they do, such errors can lead to otherwise avoidable write-offs and financial losses. For example, filing a claim past an insurer’s deadline or incorrectly informing a patient that the practice participates in the patient’s in-network health plan can result in write-offs of the patient’s portion of the bill. While Medicare claims need to be filed within a year, private insurers usually impose much shorter time limits (e.g., three months) that can sometimes lead to late filings.

Accurate billing and diagnostic coding for services and procedures remains one key to avoiding unnecessary write-offs. Some software vendors offer audit services that can be run on office charges, reports Carter. “If our software vendor at some point finds discrepancies with our fee schedule, we will e-mail them the fee schedules with the companies we work with and they will audit the charges for us. The clinic pays the vendor a percentage of a fee if they find a discrepancy, but otherwise there’s no fee involved. We also do our own periodic audits, pulling a day’s worth of charges for certain days and verifying to make sure contracts are being paid correctly.”

From her own experience, Carter recommends cultivating a relationship with the contact person assigned by a health plan. “If an insurance company has assigned a representative to your office, it’s definitely a good idea to get to know them,” she says. “You want to be able to work with the insurer’s representative to get the patient the best care with the best rates. It can make a difference.”

documentation, explains why the patient’s co-pays have been waived.

As it is, Medicare and private insurers require providers to make a “reasonable attempt” to collect payments. “That reasonable attempt could be one statement sent to a patient with a balance, or a request to set up a payment plan,” says Palmer, who emphasizes timeliness in making a hardship determination. “You don’t want to make that determination 90 days after the insurance is paid and you’ve already sent multiple statements. If there’s a true financial need or if the patient says flat out, ‘I can’t pay and don’t intend to pay,’ then write it off at that point.”

Notably, if a physician wants to provide a discount to a patient, one legal way to do so is to simply not charge at all. “You can certainly do pro bono work,” says Palmer. “But you [do not] want to make that determination … after you’ve seen the patient three times. You want to follow your charity or hardship care policy.”

Of course, there may be circumstances in which a physician or manager will approve a write-off due to a bad or unsatisfactory experience the patient had with the care provided. There also may be policies allowing for discounts to those who pay in full at the time of service, or remain uninsured. As with hardship care, there should be a written office policy for managing such write-offs.

Then there is also the matter of unpaid small balances to consider. Practices often will not send out statements on small balances, such as those under $10 or $15, but they will still try to collect on those balances should the patient return to the clinic, as often happens in family or primary care settings. Otherwise, small balances considered uncollectible are usually written off. If the unpaid balance is above $100 or so, says Whaley, it will eventually be sent to a collection agency.

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Accurate billing and diagnostic coding for services and procedures remains one key to avoiding unnecessary write-offs for Barb Carter, CMA (AAMA), who is responsible for insurance billing at the Grand Island Clinic in Grand Island, Nebraska.

“An insurer may have a policy that they will only allow a patient to have one routine ultrasound during pregnancy, for example,” says Carter. “But the clinic may perform more ultrasounds as the doctor feels necessary. The challenge for us is to correctly verify in the chart what the ultrasound was for. If the doctor did it not as a routine procedure but for a problem, we will code it as such and verify that the insurer’s policy will allow for that second procedure.”

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The write stuff

Approved write-offs are those that have been agreed to within a contract or in accordance with a practice's philosophy. Here are some commonly approved write-offs:

- **Contractual write-offs** involve the differences between the practice fee schedule and the allowable fee schedule a medical practice has agreed to accept.

- **Charity (hardship) write-offs** take place when a patient is in financial need and thereby incapable of paying. Such write-offs may be in accordance with a community indigent care effort, a policy adhered to in a faith-led health care system, or a financial assistance program.

- **Small balance write-offs** occur when amounts left on a patient's account may not warrant the cost of sending a bill. Many practices write off the small balance (usually $15 or less) and collect it when the patient returns. Others run a special small balance statement, usually once a quarter.

- **Prompt payment discounts** and self-pay (no insurance) discounts are write-offs for patients who receive discounts for paying in full at the time of service or because they do not have insurance coverage.

Communication pays

Every medical office has an interest in preventing patients’ medical bills from becoming overdue. Success in meeting this challenge involves both knowledge of insurance practices and an office culture that values interactive communication with patients.

“The communication challenge is one that begins when that first patient appointment is made,” remarks Palmer. “We have to be good communicators with patients so we can help them anticipate what they’re going to owe and what their insurance might or might not cover. From there it’s about making decisions along the way so that all of the steps in the billing process happen in an orderly, consistent manner.”

Certainly much of what goes into making a medical practice a viable, financially successful operation is the ability to anticipate every patient’s payment arrangements. “Whether … the patient has primary insurance or secondary, or [is] self-pay, we want to make sure that there’s good communication and an understanding from … the patient, the provider, and the office staff of what the billing expectations are at every step,” concludes Palmer.

The ability to do so can considerably minimize those circumstances that leave patients with bills they cannot pay and practices with charges they have to write off.

**References**


