



# THE HARVARD ADVISOR

THE RIGHT CHOICE FOR RESULTS

2011, Vol. 1, No.1 (Pages 1-4)

## Harvard News and Views

With this newsletter, we wanted to introduce (and in many cases, reintroduce) Harvard Collection Services to our current and future business partners. Harvard Collection Services is a full-service, nationally-licensed, results-oriented receivables management company with a long history of providing debt recovery services to the healthcare industry. Harvard was founded in August 1980 by Gloria Kaiser. Throughout its 30 year history, Harvard Collection Services has demonstrated proven success in merging leading edge technology and collection procedures in order to provide clients customized receivables management solutions that meet their individual and unique needs. In October 2010, Gloria decided to retire and sell her stake in the company to Eli Global, a holding company with over \$100M in revenue and over 700 staff in twelve offices. This partnership has enabled Harvard Collection Services to invest in talent and technology to provide an even better service and return on investment to our customers. For our existing customers, we appreciate your business and support, and look forward to serving you in 2011 and beyond. If you are not our customer, we invite you to call us to discuss your business needs.

## Collection Points

- Business write off \$152.5 billion + in bad debt. Third party debt collectors recover \$52 billion +.
- In 2009, municipal governments reported \$40 billion in uncollected debt. Third party debt collectors recovered 56 billion for taxpayers.
- In 2009, the federal government reported \$30.9 billion in uncollected debt. Third party debt collectors recovered \$788 million for taxpayers.
- At least 43 states currently employ third party debt collection to recover taxpayer dollars.

Source: ACA International


## Stop Losing Money On No-Shows With These Tips

While it is fine to have a patient not turning up for an appointment once in a while, but if no-shows are regular in your practice, it's time to act. Get the details from our experts on how to make sure your practice isn't losing money because of countless missed services.

### Examine the Patient's Insurance

Probably the best way to encourage patients to keep their appointments or call you if they need to cancel is to charge a fee when they don't show up. But when,

and if, you can charge a no-show fee depends on the insurance your patient has.

In most cases, you should be able to charge patients a fee when they miss an appointment. But check your contracts, because you may have a clause forbidding no-show charges or specifying particular cases when you can and can't bill the patient. For example, most payers will not allow you to charge a patient who cancelled her appointment more than 24 hours before the scheduled appointment time. 

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➔ “We charge everyone but WC (worker’s compensation),” says **Marilyn Glidden, CPC**, practice coding specialist for Neuroscience & Spine Associates in Naples, Fla.

**Medicare specifics:** As of 2007, Medicare allows us to bill for no show appointments,” says **Barbara Prater, CPC, CCP, CPMB, CHIS**, billing specialist for Clinical Neurosciences of Tampa Bay in Clearwater, Fla. “However, we still can’t bill Medicaid.” You’re allowed to bill a Medicare patient a no-show fee as long as you don’t discriminate and only charge your Medicare patients. Apply the same no-show policy and fee to all of your patients.

**Self-pay:** For self-pay patients and those with indemnity insurance, billing for no-shows may be perfectly legal. However, you should check first to make sure your state law permits this type of billing.

Just because your contract says you can bill for a no-show fee, don’t be tempted to bill the payer. Most likely, you’ll need to bill the patient or you’ll get a non-covered service denial. For example, if you bill a missed appointment to Medicare, your claim will be denied citing reason code 204 (*This service/equipment/drug is not covered under the patient’s current benefit plan*).

## Specify Your Policy in Detail

For payers that allow you to bill for no-show appointments, the contract will usually require you to give the patient advance notice of your no-show billing policy.

Have a financial policy that mentions the fee in writing and include that policy in the paperwork you give to every new patient. Have the patient sign two copies of the policy: one that he keeps, plus one you will keep with his chart.

In your policy, include information such as:

- The patient needs to notify you that he is not going to show Whether you’ll charge a fee
- If you are going to charge a fee, what that fee is.

“The first time we see a patient we have them sign a ‘No Show and Cancellation Form,’” Glidden says. “It tells them that if they do not show up or cancel within 24hours of their appointment, they will be charged.”

If your practice calls patients to remind them of their appointments, consider mentioning the no-show fee during those reminder calls as well. You can also post the information about your fees in the registration area and in the waiting room.

**Set your fee:** Your no-show policy should spell out exactly what fee you will charge for a missed appointment. Many practices set one fee for an office visit and another, higher fee for procedures. “The going rate around here is \$50 charge for office visits and \$100 if they had a procedure scheduled,” Glidden explains.

One way to lower your no-show rate, especially for procedures, is to collect a deposit when the patient schedules the appointment. For example, many urology practices see a high rate of no-show patients for elective vasectomy procedures. As a result, several practices now collect a \$100 or more deposit for those appointments.

## Consider Discharge For Repeat Offenders

Most practices allow patients one or two “freebies,” meaning that they excuse the first missed appointment and do not charge a fee. You should send a letter to the patient, however, reminding him of your practice’s policy on no shows.

Once you’ve sent a letter reminding the patient of the policy, you should consider charging a fee for additional missed appointments. Then, if the patient begins to consistently schedule and no-show, you have the right to discharge him as a patient after a few offenses.

“We send reminder letters for the first two no show appointments,” says **Angie Noetzelmann**, billing representative at the Windsor Family Clinic in Colo. “The third one gets a \$50 fee since that is to cover that appointment time. The fourth no show, we discharge [the patient] from the practice.”

You can even include the exact fees you’ll charge in the letter you send for the “freebie” no shows so that your patients cannot say they didn’t know about the fee.

“The no show letter we send shows all four offenses and we circle which number it is, so they are well informed of the \$50 dollars before they get to that third no show,” Noetzelmann adds.

**Important:** When a patient does miss an appointment without notifying the office in advance, you should note it in the patient’s file. This will give you an accurate count of how many times a patient has been a no-show. Accurate documentation can help with any legal issues that arise if you end up discharging a patient from your practice.

Become a member of SuperCoder.com to stay in line with billing updates. ■ ■ ■



## Provider Update: Some 2011 Preventive Services Deductibles Waived

If your practice performs certain screening tests for Medicare beneficiaries, such as Pap tests or some colorectal cancer fecal assays, changes in the 2011 Physician Fee Schedule (PFS) Final Rule might boost demand for your work.

The 2011 PFS will “eliminate out-of-pocket costs for most preventive services beginning January 1, 2011, reducing barriers to access for many beneficiaries,” according to CMS administrator **Donald Berwick, MD**.

The 2011 PFS expands Medicare coverage to encourage the use of “preventive services,” in accordance with Congressional mandate. Among other things, “Congress removes some of the Part B cost-sharing obligations to encourage patients to obtain certain of these services,” the PFS states.

**For example:** For certain lab services, that means patients will no longer be required to pay any deductible amount, beginning Jan. 1. The following lab tests move from 2010 payment status of “coinsurance applies and deductible is waived,” to 2011 payment status of “waived:”

- P3001 — *Screening papanicolaou smear; cervical or vaginal, up to three smears, requiring interpretation by physician*
- G0328 — *Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous.*

For a complete list of covered preventive medicine codes, see the 2011 PFS in the Nov. 29 Federal Register at [edocket.access.gpo.gov/2010/pdf/2010-27969.pdf](http://edocket.access.gpo.gov/2010/pdf/2010-27969.pdf). ■ ■ ■



## CMS Releases 2011 Conversion Factor Rate

Despite adjusted rate of 33.9764, overall change is zero.

The President locked in a zero percent adjustment to your Medicare Part B payments but that doesn't mean you've got the same rate.

The Medicare and Medicaid Extenders Act of 2010, which was signed into law on Dec. 15, established a payment update for 2011 of zero percent. To cover the cost of the legislation, Medicare had to modify provisions in the proposed 2011 Medicare Physician Fee Schedule final rule, which altered some of the RVUs, as well as the conversion factor. However, as the conversion factor went down, most of the RVUs went up, ensuring that you shouldn't notice any payment woes over the changes.

For instance, the RVUs for outpatient E/M visit code 99212 will change from the 2010 rate of 1.08 to a higher rate of 1.22 in 2011. Multiplied by the conversion factors for their respective years, the payment for 99212 this year will still be higher than it was last year, despite this year's lower conversion factor (2010 payment was approximately \$39.82 compared to the 2011 payment of approximately \$41.45).

The emergency update also changes other factors in the fee schedule. For instance, it notes that the bilateral surgery indicator for code 27685 (*Revision of lower leg tendon*) is now 1, meaning that you can collect

additional fees when the procedure is performed bilaterally, whereas it used to be 0, which meant that no payment adjustments were made if the procedure was performed bilaterally.

To read CMS's transmittal regarding the emergency update, visit <http://www.cms.gov/transmittals/downloads/R828OTN.pdf>.

Get 2011 accurate payment rates at SuperCoder.com or download the files from the CMS Website.

### Payment Challenge: Issue a refund on Overpayment

**Question:** *We've discovered that a patient overpaid us on her copay. We collected \$50, which was the last copay we had on record. It turns out that the patient's plan changed but is still under the same payer. Her copay is now only \$25 for an office visit, however. Can we just credit her account or do we need to issue a refund?*

**Answer:** You do need to issue a refund to the patient, but how you do that is up to the patient. As soon as you discover that a patient has overpaid you, your practice should notify the patient. You cannot hold onto the money indefinitely. ■■▶

- ➔ You can credit the patient's account, but only if the patient agrees to that. If the patient will be returning your office you can suggest that you apply the overpayment as a credit toward the patient's co-payment for the next visit.

If the patient doesn't want to apply it toward a future visit, however, you must return the overpayment. You should offer two options:

- A credit on the patient's account that you will apply to future services
- A refund of the overpayment.

**Tip:** You may find it easier to just send the overpayment amount back to the patient with a letter explaining the situation, rather than notifying the patient and discussing

options. Follow whichever process works best for your practice.

**Bottom line:** You cannot and should not keep an overpayment -- from a patient or a payer. That practice may get your provider into big trouble. The agreement to return any overpayments is fundamental to a provider's eligibility to participate in the Medicare program. Section 1866(a)(1)(C) of the Social Security Act (42 U.S.C. § 1395cc) requires participating providers to furnish information about payments made to them and to refund any monies incorrectly paid. The 2010 Patient Protection and Affordable Care Act creates new obligations under the False Claims Act whereby a Medicare provider who fails to timely report and refund an overpayment may be subject to substantial damages and penalties. ■ ■ ■

## Get To Know Us

### Meet Bonnie Lee

Bonnie Lee has joined Harvard Collection Services, as the Vice President of Sales and Marketing. Bonnie has over 35 years of management experience developing and executing integrated sales and marketing plans for clients through credit and cash management services, collections, credit, EBO and consulting.

Married to John, she has 2 children-Richard who is a teacher at St. Catherine's High School and Raechel who is a producer with Digital Domain. Her other babies are Lilly, Lucky, Major and Lady-her 4 Collies. Bonnie is passionate about her volunteer work and serving on several non profit boards. She believes it is important to give back to the community and pay it forward. Her hobbies are gardening, travel and being involved with her local corvette club...you most likely will see her visiting clients in her red corvette.

Bonnie is looking forward to meeting you and assisting you with your business reviews of cash flow, collection procedures, credit policies and any of your revenue needs.



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The Harvard Advisor is published to provide current and future business partners with information that may be useful to their businesses. It should never be considered legal advice.

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