5 Ways to Get Paid More in 2017

Thank you for requesting our "5 Ways to Get Paid More in 2017". At DBC, we have been serving the needs of the Chiropractic community for over 30 years and are happy to share what we have learned with you.

The 5 topics we consider important to your success in 2017 include:

- Improving Cash Collections
- Effective Use of Reminders
- Using Collection Methods such as Patient Pay
- Avoiding Meaningful Use Penalties
- Offering Cash or Budget Plans to Your Patients

At DBC, we offer:
Chiropractic Industry Specialization: We know the unique challenges that affect today's chiropractor, our primary focus for over 30 years. No other software company can make that claim.

Experienced Support Technicians: Our average support technician has over 10 years of experience providing support on our products to the chiropractic community. We know our customers well. When you purchase AS/PC Complete®, all of our technicians are adept at handling calls on any topic. And, all contacts are returned the same day in inquiry is received

A range of software products that are tailored espressly for today's chiropractor: A state-of-the-art billing and practice management system; a Stage II certified EHR and an appointment scheduler offering a broad array of reports and reminders are included in AS/PC Complete®.

A committed management team: Our owners are our employees, so we have a vested interest in seeing you succeed. We are accessable and enjoy speaking with our customers personally.

Improve Cash Collections

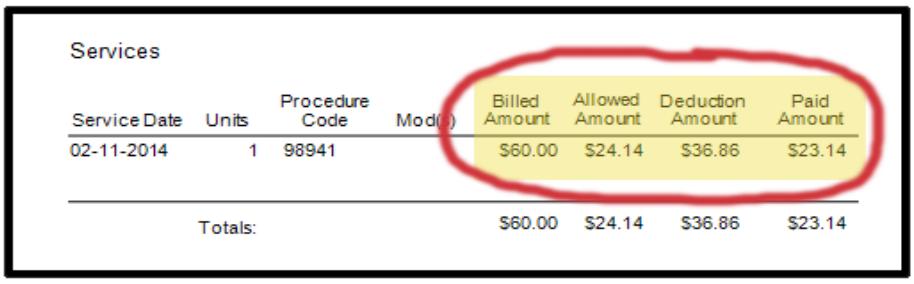
Central to the efficacy of good collection policy is eliminating confusion. Studies show that 71% of patients will pay their bill right away if the bill matches the EOB that they received from their insurance carrier. Yet many don't realize the importance. If your office engages in creating accounting methods that don't follow any generally accepted principles, you can expect to experience more problems as higher deductibles and patient copay and coinsurance payments take up a greater percentage of your collections.

Better Collections

Here are some tips to help the collection process be more successful:

1. Follow the coordination of benefits information from the carrier. Or put another way – don't take CO-45 write-offs before the carriers does. Why? Because your statement won't match the EOB and the patient will likely not pay without a lengthy phone consult.

Does your statement match the EOB?

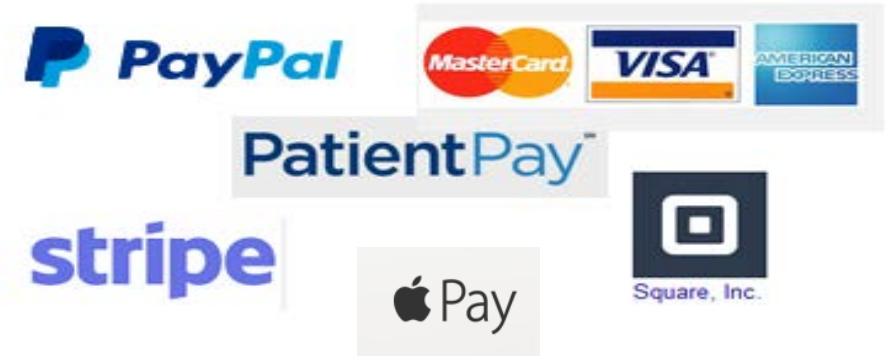


Services

Service Date	Units	Procedure Code	Mod(s)	Billed Amount	Allowed Amount	Deduction Amount	Paid Amount
02-11-2014	1	98941		$60.00	$24.14	$36.86	$23.14
Totals:				$60.00	$24.14	$36.86	$23.14

2. Provide a clear explanation of the patient responsibility on a patient's account. AS/PC Complete PM offers a one click explanation that can be emailed or traditionally mailed to the patient. This single feature eliminates a lot of confusion.

3. Provide many ways to accept payment such as check, check by phone, credit cards, debit cards, Paypal etc.



How many ways can your patient pay you?

4. Send your statements right away and send them electronically
5. Use a modern service to collect patient balances like Patient Pay. http://www.patientpay.com/ (see section 3)

Appointment Reminders

The benefits of a good patient appointment reminder system are myriad. As a practitioner, you feel many of these things immediately. Reduced cancellations and no-shows, are probably the most obvious. However, when you factor in the impact that missed or late appointments have on your practice, you soon realize that your daily schedule isn't the only thing that takes a hit.

Consider the cost of labor for rescheduling appointments, disruption in the flow of patients and staff, the satisfaction of the other patients when you are able to stay on schedule, the cost of following up on missed appointments, and the ability to provide consistent care for patients without interruption. All of these things have an impact on your business and on your patient's satisfaction with coming to your practice.

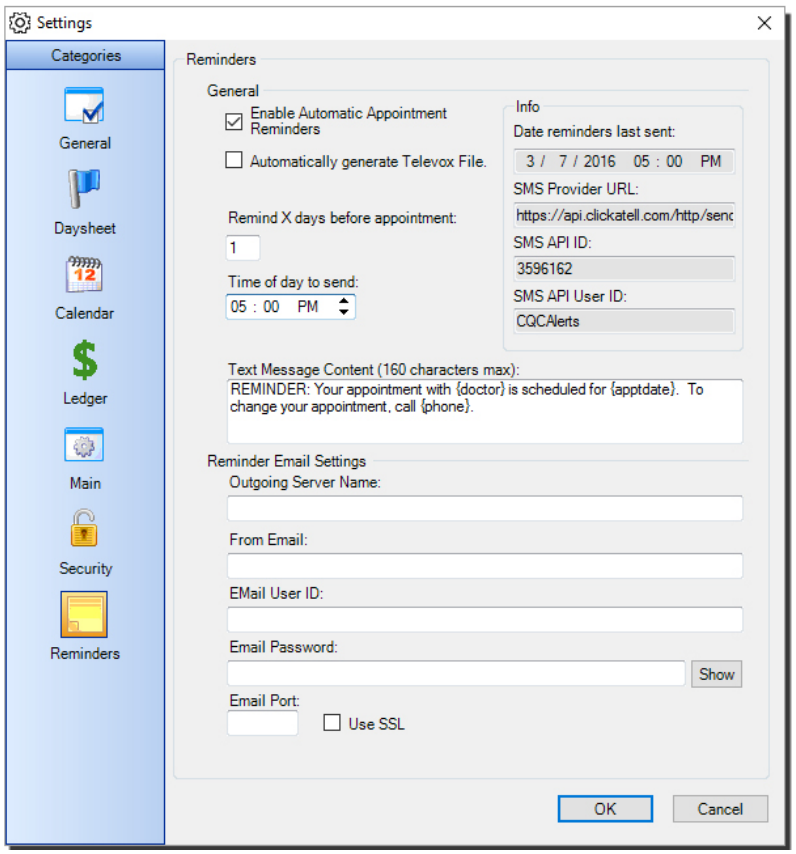
AS/PC Complete automatically reminds patients about their upcoming appointments. The reminders can be in the form of an email, or a text message that will arrive on the patient's computer or cell phone. Reminders are a set it once and forget it feature. No one has to 'remember' to send out the reminders as that would be counterintuitive. The reminders are encrypted which means that they are safe.

AS/PC Complete® offers a range of options when it comes to patient reminders. The reminders can be in the form of an email, or a text message that will arrive on the patient's computer or cell phone. Reminders are a set-it-once-and-forget-it feature. No one has to 'remember' to send out the reminders as that would be counterintuitive. The reminders are encrypted which means that they are safe.

Reminders are encrypted and safe

Reminders

In AS/PC Complete the appointment reminder screen below allows you to set up the email message and to determine how and when the reminders will be sent from your office. Again, once set, the process is fully automatic.

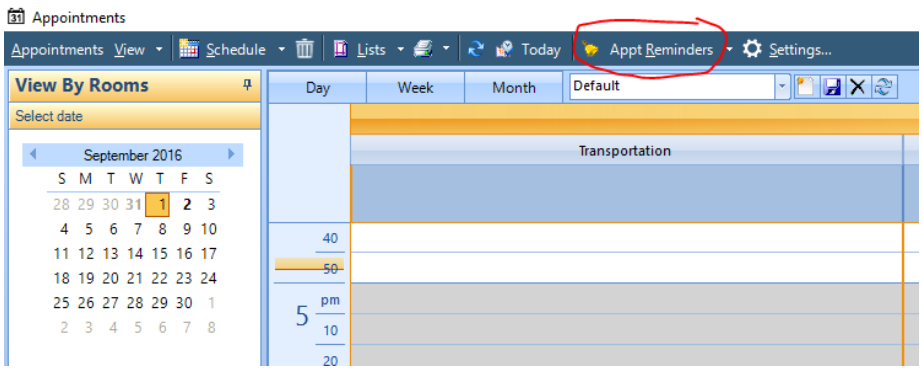


Now that the setup of reminders is compete let's tell the reminders when to be delivered…

Customize your message

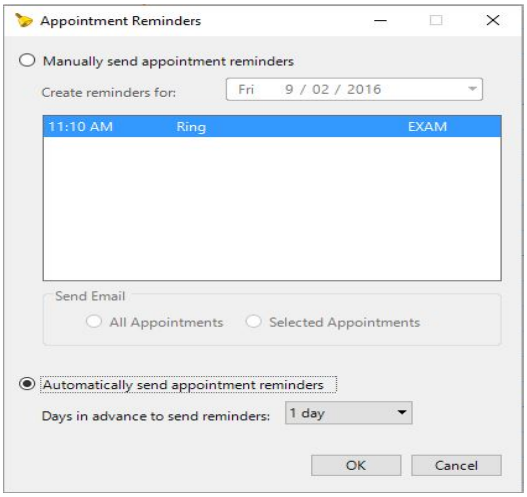
The text and email reminders are sent out of the office with the same message for all patients. You can customize the message in the Appointment Scheduler by choosing “Appt Reminders” here:

Once setup, the reminders are sent automatically.



Schedule Delivery

In the Appointment Reminders Screen choose your delivery preferences.



Patient Pay Collections

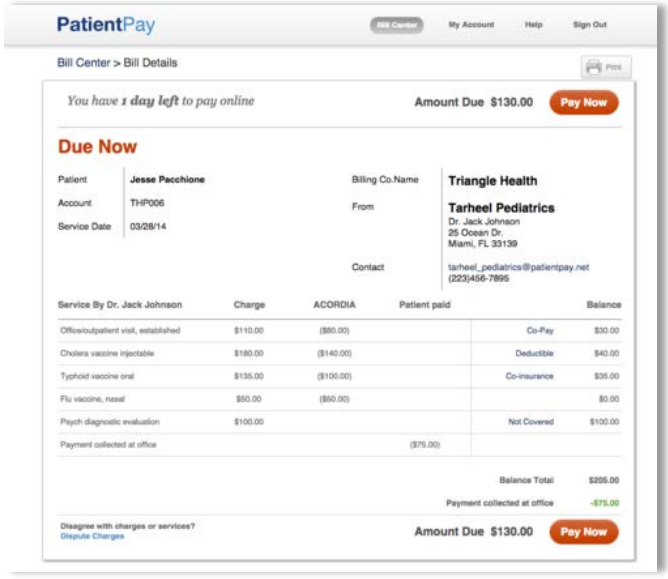
PatientPay lets you get bills out electronically so patients get them right away, and you get paid faster. Providers that use PatientPay get paid on average **in less than 14 days.** PatientPay automatically posts payments right into your software so there's no manual entry or errors. Providers **save up to $4.00 per payment** collected.

Improve Collections

Get Paid Faster-

We know that getting paid by your patients is taking longer than ever, especially as more of your revenue comes from them. It can really put you into a financial bind. Groups that use PatientPay are seeing payments on average in under 14 days. This keeps less of your revenue in accounts receivables and collections, and more in your bank account.

Easy to Understand Bills



PatientPay Paperless provides patient statements that are easy to read and understand, written in language that makes sense to them. The bill clearly shows line-by-line, what the patient is being charged and what has already been paid such as co-pays, co-insurance or deductibles at the office or over the phone. Payments made by the patient are always up-to-date, reducing confusion when the bill arrives.

Better Patient Experience

PatientPay reconciles patient charges with the insurer's explanation of benefits eliminating confusion. More than 75% of patients who use PatientPay pay their bills after viewing them, which means your organization gets paid faster.

> "PatientPay is easy and convenient for me. I liked the ease of not having to create an extensive account entering tons of unnecessary information just to make a payment.
>
> Libbie Hudson, Patient"

Once your patient's claim is adjudicated by their insurance company, payments are received on average in less than 14 days. Further evidence shows patients happy with their financial experience pay sooner.

Greater Patient Loyalty

More than ever before, your patients are customers. Today the patient experience goes beyond time in the waiting and exam rooms. They evaluate every interaction with your group. When your bills are easy to understand and have the clarity patients look for, they will stay with your group and, more importantly, refer others

Tips for Avoiding a Meaningful Use Penalty in 2017

Just as most providers are getting use to the current Meaningful Use requirements, CMS announced their final rule on the Quality Payment Program (QPP) which includes the Merit-Based Incentive Payment System (MIPS) and the Alternative Payment System on Friday, October 14, 2016. There are a plethora of options and their requirements for providers beginning in 2017 and it will take a while to determine what best fits your practice.

Perhaps the more relevant and immediate discussion is what you can do NOW to avoid a Meaningful Use penalty when you attest for 2016. If any of your measures fall short of targets, there may still be time to take corrective action. Below are the major reasons that providers fail a Meaningful Use audit. Hopefully, a word of caution will prevent this from happening to your practice.

Why providers fail meaningful use

Perform a security risk analysis.

By far, the most common reason that providers fail attestation for Meaningful Use relates to holes in performing security risk analysis. Estimates run as high as 70% of audits result in a failing grade for that reason alone.

A security risk analysis is all about protecting your patients' sensitive health information. They've shared that information with you and entrust you to protect it. An analysis takes into account all potential risks to the patient information. This review includes physical safeguards of your facility and computer equipment (including portable devices); administrative oversight including designation of your practice's security office and controlling the flow of information in your office; organizational requirements in executing business associate agreements; maintaining updated policies & procedures for security guidelines; and finally, technical controls to prevent the unauthorized access to your electronic patient information.

There are no shortcuts

Unfortunately, there is no one-size-fits-all checklist of what needs to be covered. Your EHR software vendor or practice management systems can't possibly include all topics that need to be addressed. Most of the onus for this responsibility lies outside of the software itself.

Issues such as making sure monitors are turned away from unauthorized personnel and patients, security of backups, and physical location of printed patient records all are items that must be addressed by an office seeking meaningful use approval.

Government agencies such as the OCR (Office of Civil Rights), CMS, the Office of the National Coordinator for Health Information Technology all offer suggestions on what to include in your analysis. In some cases, the checklist of items can take a week or longer of full time effort to review.

We have compiled a list of most of the major items required in a security risk analysis and will be happy to share it with you upon request.

Requirements to educate your patient

Providers are required to provide their patients with specific education materials to their patients. For 2016, the current threshold is set fairly low at only 10% of your patients seen requiring this information. This material may be provided by printing and handing a copy of the information at the end of the visit or emailing information with links to appropriate sites. Remember that this is based upon the number of patients, and not upon the number of visits.

Clinical Summaries

A clinical summary is intended to provide a patient with details of their visit: what their complaints were, actions or procedures that were performed during the visit, results of any tests conducted, and any actionable items that the patient is likely to forget. These are minimal guideline and not an all-inclusive list. In repetitive office visits, it's easy for the office staff to fail to provide the patient with an after visit summary or to record that they provided it. Failure to do so, can have disastrous results on your ability to qualify for Meaningful Use. Like the

educational materials, providers can supply the clinical summary by printing and handing it to the patient or emailing it.

Upload Clincal Summaries to eHealth Hubs

Your staff will find this faster and easier than printing a summary and tracking the patient down in a busy office. As of this writing, the requirement is that more than half of the patients seen must have their summaries uploaded. Remember that this is not based upon patient visits. It is based on patient count alone.

Time is of the essence in uploading your summaries. In addition to the percentage of patients seen, the upload must be done within 4 days of the date of service. Because of the time limitation, this is not something that providers will be able to easily catch up on if they let it slide. We encourage all to monitor their statistics on this measure frequently.

After a provider uploads a clinical summary, the patient will receive an email on behalf of the provider or clinic letting them know that there is new information available to them along with an appropriate access code.

Secure Messaging

In 2016, CMS is requiring only a single secured email transmission by either the provider or the patient. Services such as EMR Direct provide the necessary provider/practice verifications and encryption necessary to meet the definition of “secure messaging”. If you have not yet established this service, then you are urged not to delay. As the year end approaches, we expect that there will be a flurry of activity in getting secure messaging enabled and tested. Typically, lead times for identity verification can take 2-3 weeks even without any mistakes by the applicant.

Help is Available

The software technicians at DB Consultants have been involved with Meaningful Use since its inception. We understand the requirements and are glad to help you have a successful outcome.

Offer Cash or Budget Plans to Your Patients

Why providers are offering cash plans

Many providers have expressed an interest in offering their patients monthly cash plans instead of insurance. There are many reasons for this shift to "direct pay models" or "direct primary care". Keeping up with reporting requirements, being able to use an EMR software to serve patients instead of insurance companies, escaping industry bureaucracy and avoiding the assembly line volume approach that participation sometimes requires are common themes among those migrating to "direct care".

Unheard of just 10 years ago, some providers are now charging up-front memberships for monthly or annual service, and even posting their prices on-line.

Some of the more common monthly subscription plans include offering:

- A limited number of visits for a fixed monthly price and billing for any overages
- Unlimited monthly visits for a fixed monthly price.
- Offering discounts for pre-payment of service.

First, define what it is that you are going to be offering. Think in terms of the following limitations:

- **Service limitations** – Are you setting a maximum service based upon the number of visits or the dollar value of the services. Or is it an unlimited number of visits? Examples would include 3 visits per month or $200 worth of services per month.
- **How does your system keep track of patient visits**? Is it smart enough to know NOT to charge extra each time the patient walks in the door?
- **What happens when your patient visits or allowable service charges is reached**? Do you bill

at normal rates? Do you offer visits to be borrowed from or rolled over to future periods?

- **Can your system like your plan fees with purchased items**? Are supplements and orthotics billed at regular costs without being counted as a visit?
- **Billing frequency** – How often will you be billing the plan? Although most plans are billed monthly, we have run into a number of providers who prefer to offer quarterly or annual plans particularly as year-end specials beginning with the New Year. Alternatively, some providers offer weekly plans for patients that are undergoing short-term yet intensive therapies.
- **Term of the plan** – How long does the plan run? Your software should let you customize whether you want the plan to run for 5 weeks, 7 months, or even 3 years.
- **Renewals** – Do you want the plan to automatically renew or do you want it to expire after it has run its course?

Define your offering

Keep your patients informed.

Now that you've got your budget or cash plans in place, you'll need to establish a way of keeping your patient informed. If your plan covers a maximum number of visits/ month, be sure to inform them on them that they've reached the last covered visit and that any further visits in the period will be billable.

Is the current plan coming to a close? If so, be sure to offer your patient the opportunity to renew. They'll appreciate your anticipation of their needs and keeping them informed.

As with any service contract, make sure that you always have up to date written service agreements so that your terms and prices are clearly identified. No one likes a surprise statement for extra charges in the mail.

Interested in Learning More?

Thank you for requesting the “5 Ways to Get Paid More in 2017” guide. We draw from decades of experiences with thousands of Chiropractors when we share and publish a guide like this. If you have any questions or comments about our suggestions, or would like to learn more about the services and products we offer, please contact our experts at DBC.

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