

# Blue Ridge Ob/Gyn Financial Policy

Welcome to Blue Ridge Ob/Gyn Associates. We want to thank you for choosing us as your healthcare provider. In an effort to provide the best care possible, we would like to take a moment and explain a few of our policies. If you have special needs, we are here to work with you. By providing this information we hope to avoid any disagreements or misunderstandings concerning our expectations from our patients as well as payments for professional services rendered.

## Updating Information

Please be sure that we have the most current demographic and insurance information at all times. You will be asked to sign in with your name, address, phone number, and insurance company name at each visit, as well as complete a new demographic sheet on a yearly basis. You will also be asked to show your insurance card and picture ID at every visit; exceptions will be made for those patients who are being seen on a regular basis in a short period of time, for example after 28 weeks our OB patients are coming in every 2 weeks and then every week. We consider your insurance card similar to a credit card because you are asking us to bill another party for services you are being provided. This helps to ensure that your claims are being filed correctly as filing claims with the incorrect information delays processing and increases patient liability. Any time you have any changes to your demographic information (phone number, marital status, address, etc...) we will ask you to fill out an abbreviated patient registration form with the updated information for our records.

You will be asked to complete a full patient registration form once a year to keep our records updated. This form also is where you sign to give us authorization to file your claims to your insurance company on your behalf and also gives us authorization to release your medical information to the insurance company so that they can process the claim.

## Medicare

We are no longer accepting new patients who have Medicare coverage, however we are always glad to continue to see our current patients who have become eligible for Medicare. In an effort to help avoid unexpected expenses we would like to explain a little about Medicare. One, Medicare only covers certain preventative services and applies frequency limitations to those services. Medicare will cover the collection of a pap smear and the breast and pelvic exam once every 24 months. If you choose to have these services more frequently, you will be responsible for payment. Keep in mind, whatever Medicare does not approve, then any supplemental insurance will not cover either. Secondly, Medicare never covers the office visit portion of an annual well woman exam; the patient will be billed for this charge. Third, we are required by federal law and Medicare guidelines to charge all patients the same amount; therefore if you are seen for an annual well woman exam we must charge for the office visit, as well as the collection of the Pap smear and the breast and pelvic exam. Should you have concerns about payment for your services, please speak with our billing department prior to your visit.

## Appointments

We understand that your time is valuable and we do our best at keeping the schedule running smoothly and on time. Out of respect for all patients we ask that you arrive on time for each appointment and we suggest arriving 15 minutes early to allow time for any changes or updates that need to be made. Any patient who arrives greater than 15 minutes past their scheduled appointment will be asked to reschedule for a different day. Should an emergency arise, we ask that you be patient as we do our best to handle the situation and return to seeing patients as scheduled. Unfortunately, it may be necessary for us to reschedule appointments unexpectedly, should this occur we will do our best to notify you as soon as possible and reschedule you at the next earliest time.

We recently adopted a new system that automatically calls you 2 days prior to your appointment to remind you. It will ask you to confirm your appointment, but it will also give you options to select to if you would like to cancel or reschedule. If you choose the option for reschedule one of our staff members will call you to reschedule that appointment. This system also will eventually be able to call you with a reminder when it is time for you annual exam or any other appointment the provider discussed with you at your last visit for the future.

Should you need to cancel or reschedule an appointment at any other time than during your reminder call, please contact the office as soon as possible; you must call at least 24 hours prior to your appointment. Failure to notify the office prior to your scheduled appointment 3 times could result in you being dismissed from the practice. A \$25 no show/late cancellation fee will be assessed to your account for every appointment that you no show for without contacting the office.

## Insurance Information

***Notify the staff of any changes in your insurance coverage as soon as possible. It is your responsibility to provide us with your accurate information. It is fraudulent to knowingly present invalid insurance information.***

We will NOT file your insurance claims without a copy of your current ID card. If you need medical services and you do not have your insurance card, you may still keep your appointment. However, you will be asked to pay for services in full prior to being seen. We will quote you the best estimate possible based on the reason for your visit; however it is not a guarantee that there will not be additional amounts due at check-out based on what was actually done during your visit. All insurance companies have a deadline for claim filing and if you supply us with your insurance card within that time frame we will file your claim. When the claim is paid, you will be reimbursed for any overpayment you made. If we do not receive the information until after the claim filing deadline has passed, we will not submit the claim, therefore you will not be able to get any reimbursement from us for your visit.

It is your responsibility to notify us in a timely manner of any insurance changes. Ultimately you should notify us prior to checking in for your appointment, or even on the phone when scheduling so we can make a note of the change to ensure we ask you for the updated information. All insurance companies have a limit on the amount of time we have to file a claim; for example Cigna claims cannot be filed more than 90 days after the date of your visit, United Healthcare gives us 6 months, but some give us as little as 45 days. Since it is your responsibility to give us the correct information you are the one held accountable if you do not furnish us with the information to be able to file your claim within that time limit and you are responsible for the entire charged amount.

If you are covered by two plans, usually you are the subscriber for one and a dependent on the other one. The plan for which you are the subscriber is your primary carrier. By law, your claims must be filed with it, before submitting them to your secondary plan. You do not have the option of designating your secondary plan as primary and it is fraudulent to conceal the existence of a primary plan from a secondary one. We typically only file claims directly to primary insurance plans. If you have a secondary insurance, upon request, our billing office will provide you with a form of itemized charges that you can use to file to that plan. The only exception our office makes is if your secondary coverage is with Blue Cross Blue Shield, Medicare, Medicaid or Tricare we are required to file the secondary claim for you. Regardless of your secondary coverage you are responsible for any balances due after your primary insurance company pays.

If you are covered by an insurance company that we are not contracted with we will provide you with an itemized form of your charges that you can use to file a claim to your insurance company with. However, payment in full is due the day services are rendered. Also, keep in mind that if we are not contracted with your insurance company we are not held by their negotiated rates and you therefore may not be reimbursed 100% of what you paid by your insurance company.

### **Co-pays, Co-Insurance & Deductibles**

We are required by your insurance plan to collect co-pays on the date of service. This will be collected upon check-in along with any other balances owed on your account. Failure to do so will result in your appointment being rescheduled to the next available open appointment time on another day except in the case of emergent medical situations. We also reserve the right to notify your insurance company if you fail to pay your co-pay, and other “out-of-pocket” charges, such as deductibles and/or co-insurance which is a breach of your personal contract with your insurance carrier and may result in your insurance company terminating your coverage. For your convenience we accept MasterCard, Visa, American Express & Discover. We also accept Cash and Personal Checks. We do process all of our checks electronically with Telecheck. If your check payment is declined you need to be prepared to make alternative payment and contact Telecheck to find out why it was declined, we do not have access to that information.

### **Past Due Accounts**

If your account becomes past due, we will take necessary steps to collect this debt. You have 90 days to pay your balance and will receive 3 statements from our office. Each statement gives you 30 days to make a payment before your next statement will cycle out. A 4th statement will go out with giving you 10 days as a last chance to pay your balance. At that point if we have not heard anything from you or received payment on your account it will be deemed a past due account. Your account will then be referred out to a collection agency and you will be responsible for paying and collection costs that are incurred. Any patient whose account is referred out for collections will also be dismissed as a patient from our practice.

You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as Equifax, Experian or TransUnion. You understand that if this account is submitted to a collections agency and is reported to a credit reporting agency the fact that you received treatment at our office may become a matter of public record.

### **Prescriptions for UTI and/or Vaginitis**

If you think that you may have a urinary tract infection (bladder infection) and or vaginitis, you need to see a physician so that a urinalysis and/or wet mount can be performed. If you decline to schedule an appointment, and the physician elects to treat you without seeing you in the office, there is a fee of \$25 for taking your call, providing physician consultation by phone, and calling in a prescription. This applies to such consults that occur during or after regular hours. This fee is payable by you and will not be filed to your insurance company.

### **Annual Examinations vs. Problem Visits**

As a commitment to your health, our physicians recommend that every patient have an “annual exam” that enables them to evaluate your overall health and make sure you are not developing any unexpected problem or illnesses. Unless there is a major new finding, or a significant medical problem which must be addressed, we must submit the service to your insurance company as a routine, annual or preventive examination. Your “annual exam” consists of three parts; the office visit portion of the visit, the Pap smear, and the pelvic and breast exam and is billed to your insurance this way. It is your responsibility to check with your insurance carrier to check your coverage for these services. Not all insurance plans cover all three portions of the exam and therefore will be your responsibility.

Your physician may recommend that screening tests are performed during your annual exam. Despite being recommended by your physician, it is possible your insurance will not consider them medically necessary, even if a positive family history for a condition exists. Most insurance plans have specific guidelines for coverage of screening tests and if your insurance determines the tests to be non-covered, you will be responsible for paying for them. The tests cannot be submitted as anything other than screening, unless you have specific, documented symptoms on the date of service that warrant the test. Even if the results of these screening tests show some problem, if they were done for screening purposes they must be submitted that way to your insurance company, and we cannot change the information on the claim for payment purposes.

If there is a new problem discovered during the exam that requires attention, or a significant medical problem requiring additional time and/or decision making on the part of the physician, there will be an additional charge for addressing the problem. You have the option to tell the provider that you do not wish to address any issues outside of the wellness exam. If you choose to combine your annual wellness exam with a problem visit to discuss any issues found during the exam, any pre-existing medical problems or any non-gyn related health problem that you choose to have us manage for you instead of an outside primary care physician there will be an additional charge for those services rendered.

The annual exam itself cannot be filed as problem related and will be filed as routine. The additional charge will be filed as problem related, with the appropriate diagnosis for the problem. It is extremely likely that your insurance company will determine that you are responsible for two co-payments in this situation; one for the annual exam and one for the problem. You are responsible for payment of any portion of your charges not paid by your insurance (excluding contractual write offs) including, but not limited to, two co-payments, if applicable. We have no control over how your individual insurance company and chosen policy choose to process your claim and assign patient responsibility.

We understand that sometimes it is not possible or convenient to return for a separate visit to discuss these additional issues and our providers are concerned about your health care above anything else. Therefore they are more than willing to take care of all of you needs during you wellness exam instead of causing an inconvenience by asking you to return for a separate visit for your problems. However, we must file those diagnosis to your insurance company along with your wellness visit.

**We understand that many insurance companies are now offering 100% coverage for wellness visits and you may have only intended to come in for a routine wellness visit because of this coverage; however if you choose to have any additional problems addressed you may be responsible for a portion. These charges are not considered part of your wellness visit, even though it was handled during your wellness visit.**

## Insurance Claims, Coding and the Law

Recent Federal laws addressing all insurance companies require that we submit claims to an insurance company accurately, reporting the exact services performed and the reason for performing them. The claim submitted must be supported by documentation in the chart for the exact date of service. Neither the chart documentation nor the claim itself may be amended or altered solely for claim payment purposes. Our practice is committed to obeying the law and will not alter records to have a claim paid. If your insurance company fails to pay your balance in full, or there is no insurance payment made within 45 days, it is YOUR responsibility to pay the doctor's bill, to the extent consistent with any payer contractual agreements.

When you are seen in our office the provider documents the details of your visit in your medical record. We are required to accurately report this information to your insurance company with your claim. We must follow the guidelines, rules and regulations given to us by the governing bodies of the healthcare industry. We cannot guarantee coverage of any services we provide, diagnoses you may be given or tests we may feel are medically necessary.

It is considered fraud for us to knowingly report incorrect or altered information on your claim just to assure coverage by your plan or policy. North Carolina has enacted The False Claims Act, which are statues against medical claims fraud. Each violation is one criminal act and is a Class I Felony if found guilty. Any and all persons involved in the act of fraud will be prosecuted and found guilty of the same crime. This includes providers, nurses, medical assistants, certified coders. If you are the one who requested the claim be altered with the false information you will also be charged the same as all parties involved.

## The False Claims Act

(A very brief summary)

Violations of the false claims act can include "knowingly"

- Submitting a false claim for payment;
- Making or using a false record or statement to obtain payment;
- Conspiring to make a false claim or get one paid;
- Making or using a false record to avoid payment to the US Government.

Defining "knowingly" - A person who:

- Has actual knowledge that the information is false;
- Acts in deliberate ignorance of the truth or false information;
- Acts in reckless disregard of the truth or false information.

Your insurance carrier is on the opposite side of these regulations. They are the ones responsible for reporting instances of suspected fraud or abuse. Therefore when you call and speak to a representative regarding denied claims and they give you suggestions on how to get your services covered and things you should ask your provider to change on your claim so that they will be covered you need to determine if what they are telling you to do would in any way constitute a violation of the false claims act. If you agree to do these things and take their advice you are immediately in violation of the act because one violation in the act is "Knowingly conspiring to make a false claim or get one paid". Keep in mind that your insurance company customer service representative is able to report suspected fraud and abuse. When you called into that representative the phone conversation you had with the representative was recorded and can be used as evidence against you in a trial.