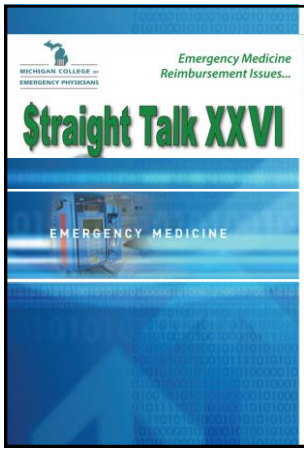


Patient/Guarantor Communication Strategies

November 2017

Ed Gaines, JD, CCP
Chief Compliance Officer
Emergency Medicine Division
Zotec Partners, LLC
egaines@zotecpartners.com
Greensboro, NC
877-271-2506

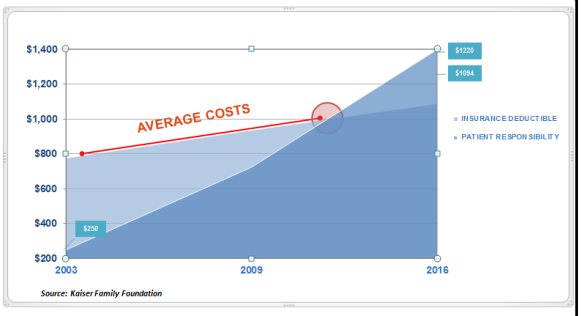
The Caveats:

- **Lightning rounds—drink from the fire hose & then Q&A if time**
- **Informational only and not legal advice;**
- **Several Federal Circuit Ct decisions will be referenced but the relevant circuit in which your clinic is located may not follow these precedents—several of these issues are not settled law across the country.**
- **Consult w/ experienced healthcare counsel in terms of specific patient financial responsibility forms and documents, specifically TCPA, FDCPA & OIG guidance, requirements and potential pitfalls.**

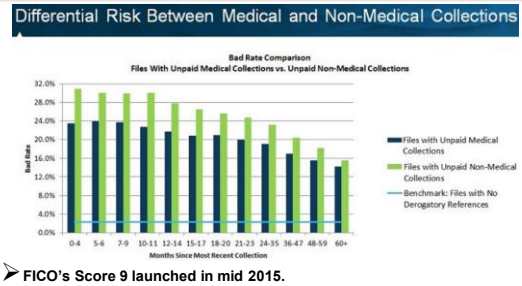
Learning Objectives

- **Define background on the TCPA and FCC's interpretations of the express consent requirements.**
- **Distinguish the healthcare treatment exception from the RCM functions**
- **Demonstrate one texting platform approach for the Pt cost sharing.**
- **Relate context for the FDCPA to RCMs and how it may impact "post billing" or back end communications with the patient**

Pt/Guarantors are underwater vs. cost sharing



FICO's changes in assessing "medical debt" vs. "non-medical debt" in Aug. 2014



- FICO's Score 9 launched in mid 2015.
- http://www.fico.com/en/blogs/risk-compliance/impact-medical-debt-fico-scores/

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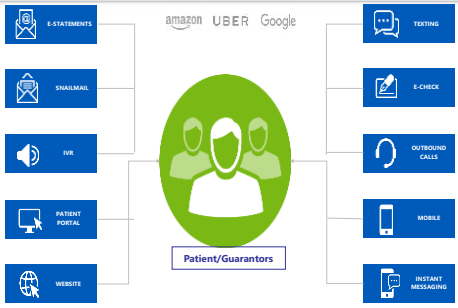
Business to Pt/Guarantor



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Regulatory Background for Patient (Pt.) Communication Strategies:

- Telephone Consumer Protection Act (TCPA) 1991.
- TCPA prohibits calls via an automatic dialing system <u>to cell phones w/out the Pt's prior express consent , absent an emergency purpose.</u> *See* FCC 2008 Order (FCC 07-232)
  - FCC noted that the legislative history of the TCPA supported that persons who knowingly release their phone numbers have given permission to be called absent instructions to the contrary.

- <u>Prohibition applies to text messaging.</u>
- Purpose: to regulate telemarketing/automated "robo-calls" & protect against invasions of privacy.

- Private right of action for the greater of actual $ loss or $500 per violation, which can be trebled to $1500 for willful violations. 47 USC Section 227.

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FCC's Regulatory Rulings & Guidance:

- Federal Communications Commission (FCC) was given regulatory authority by Congress.
- Today: 400+ hospital group said that over 80% of the Pt phone numbers were mobile phones in 2016.
- 2008: Consumers may provide express consent to be called on mobile phone if he/she knowingly releases his/her number during the transaction that resulted in the debt owed.

- Consumers may revoke prior express consent "through any reasonable means" and "any manner that clearly expresses a desire not to receive further messages." FCC 15-72 (7/10/2015).
  - http://apps.americanbar.org/buslaw/committees/CL230000pub/newsletter/201509/feature_2.pdf

  - "Health treatment exemption" to prior express consent does not apply to "pre-collect" calls for revenue cycle mgmt. (RCM)

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FCC's Regulatory Rulings & Guidance:

- Express consent is when the called party provides his/her cell phone number to 3d party, e.g. a creditor, 1992 FCC Ruling, 2008 FCC Order and 2015 FCC Order, FCC 15-72, Paragraph 52 (7/10/15).
  - Prior express consent is not limited to consent between the parties.
  - Consent may be obtained through an intermediary for non-telemarketing voice calls or SMS messages. FCC 2014 *In re GroupMe* Declaratory Ruling.
- Also two important federal circuit court of appeals cases in healthcare:
  - ***Mais v. Gulf Coast Collection Bureau, Inc.,*** 768 F. 3d 1110, 1123 (11th Cir. 2014) (patient's spouse provided his cell phone during hospital registration for radiology services and express consent upheld & medical creditors were w/in the FCC's 2008 Ruling)
  - ***Baisden v. Credit Adjustments, Inc.,*** 813 F. 3d 338, 346 (6th Cir. 2016) (cell phone provided to hospital in registration and consent upheld)

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Examples of phrasing the SMS/text messages

- Practice name and reminder that the Guarantor/Pt. provided their mobile phone #.
- Option to link to their patient statement or call the Pt. services dept., once the account is verified.
- The option to reply STOP to stop receiving text communications.
- Recall the FCC statement that consumers can revoke prior express consent "through any reasonable means". 2015 FCC order.
- Keys to the initial text:
  - No PHI
  - Clear opt out
  - Training of the RCM staff when there is an opt out.
  - Method of validation if the guarantor/Pt. does not opt out.

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Texting metrics to capture in client reporting: % response by age bucket

- Cumulative response rate.
- Text message opt out %.
- Payments made via web portal.
- Payments made via non-web portal, e.g. e-check, hard copy or IVR.
- Which Guarantors/Pts. update their profile or insurance information?
- % of Guarantors/Pts. who accessed the web portal or made an in bound call.

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FDCPA's "Traps": Be Careful with Pt. Statements, "Pre-Collect Letters" & Phone Calls:

- Fair Debt Collection Practices Act (FDCPA) strictly regulates collection agencies when/where/how Pts are contacted
  - Intent: prohibit abusive or harassing debt collection practices, and false, deceptive or misleading representations to collect a debt
  - Mandatory notification statements to debtors (known as the "mini-Miranda" statements).
- Largely a strict liability statute w/ Attorney Fees and Class Action potential: per violation penalties of actual damages + $1K or class action penalties of lesser of $500K or 1% of the net worth of the debt collector
- Federal Trade Commission (FTC) is the relevant regulator.
- Ties to TCPA: 2008 FCC order stated that debt collection calls were not subject to TCPA's separate restrictions on "telephone solicitations".

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Critical Concepts & Definitions:

- The term debt collector does not include "any officer or employee of a creditor while, in the name of the creditor, collecting debts for such creditor." §803(6)(A)
  - So Medical groups to whom reimbursements are due and owing are generally exempt unless they act in ways that bring them w/in the definitions of FDCPA.
- "Debt collector" does not include "any person collecting or attempting to collect any debt owed or due another to the extent that such activity concerns a debt which was not in default at the time it was obtained by such person." §803(6)(F)(iii) (emphasis added)
  - Revenue cycle management (RCM) (3d party billing companies) are also generally exempt unless they too act in ways to bring them within the FDCPA.
  - Two well respected attorneys argue that SCOTUS buffered the concept of RCMs being exempt under the FDCPA by stating—"the statute surely excludes from the debt collector definition certain persons who acquire a debt before default."
  - *http://www.jdsupra.com/legalnews/good-news-for-revenue-cycle-management-94866/*
  - *Henson v. Santander Consumer USA, Inc.* (June 12, 2017) (16-349)
- See also 15 USC Section 1692a

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To avoid the hidden traps--be careful in patient statement language & phone calls

- Patient statements that state or suggest that the account is subject to control of a 3d party that is not the medical group creditor can be an issue:
  - Example: outside attorneys claiming the debt on behalf of the group practice, e.g. the practice of lawyers "selling dunning letters"
- Also, language in the billing statement that states or strongly implies that the account is "in default" or "default status" can remove the RCM exemptions.
  - Examples: "Pre-collect" letters that state that they are "collection letters"
  - "Bona fide" error defense—error not intentional & a bona fide error. 15 USC 1692, Section 813.
  - Strategies: "Lawyer up" on FDCPA billing statements & Pt communication language
  - Example: charging an add'l fee if the account rolls to collections
  - if fee is not expressly authorized by the agreement.

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Covering Your Bases on Assignment of Benefits (AOB) and Financial Responsibility Registration Documents… Not to Mention ERISA:

- Employee Retirement Income Security Act of 1974 (ERISA)
- ERISA plans: larger private employer sponsored plans
- Federal pre-emption of state law—29 USC Section 1144
- Tip: obtain the SPD from ERISA plans and follow AOB strictly
- Clinicians may enforce Pt rights against the payors— "standing in the shoes" after an assignment by the Pt.

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ERISA claims:

- Consult with counsel re: ERISA and summary plan description (SPD) specific provisions for:
  - Patient financial responsibility, e.g. patient assignment of any rights against their self insured employer's health plan
  - Understanding whether you must exhaust administrative/claims appeals process first prior to litigation
  - How "adverse benefit determinations" are defined & determined by your major ERISA plans
  - Tip: obtain the SPD from ERISA plans and follow AOB strictly
  - Statute of limitations

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Summary:

- Patients are among the largest non-gov't payors in healthcare & the $ consequences of their failure to reimburse clinicians are less today.
- More Pts. have HSA cards & accounts and with health reform those accounts may be increased—this will be an ever important source of $.
- Current technology platforms/apps have impacted the Pt expectations for healthcare RCM—we must meet the Pts where they are via communications and RCM strategies.
- Experienced healthcare counsel can guide both clinicians and their RCM functions/partners to mitigate non-compliance and litigation risks.
- "What's old is new again" with traditional compliance risks around waiving or discounting the Pt cost sharing outside of established parameters.

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Emergency Medicine Reimbursement Issues...
$traight Talk XXVI

Contact information:

Ed Gaines, JD, CCP

Chief Compliance Officer,

Emergency Medicine Div.

Zotec Partners

Greensboro, NC

egaines@zotecpartners.com

919-641-4927

Follow me on Twitter: @EdGainesIII

http://twitter.com/EdGainesIII

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Example: Gaining Consent for TCPA (used with permission)

"[I/patient/other identifier] acknowledge and agree that [insert company name], or any of [your/its] affiliates, including any medical billing or debt collection companies may contact me by telephone or by text message to any telephone number I provide to you, or at any other telephone number associated with my account, including wireless telephone numbers, which I understand could result in charges. I further agree that you may use any method of contact to any of these telephone numbers, including prerecorded or artificial voice messages, text messages and automatic dialing devices. You may also contact me via electronic mail using any email address I have provided to you for use. I acknowledge the contact information provided to you is private to me and I take sole responsibility for maintaining the privacy of any of the information I provide to you. I further understand that in order to revoke my consent to be contacted, I must send a written revocation of my consent to [insert company name] or to the affiliate contacting me on behalf of [insert company name]." (emphasis added)

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Appendix: AOB and Medigap provisions

- Form AOB language: *"I hereby authorize payment of any insurance or other benefits that be made on my behalf by any third-party payor including the Medicare, Medicaid and any other federal or state health care programs or plans directly to Provider [or assignee of Provider]. I understand that my assignment of any benefits that I may be due does not relieve me of any obligations to pay the Provider for any charges not covered by this assignment."*
- Form Medigap Benefits language: *"I request that payment of authorized Medigap benefits be made on my behalf to the Provider or Provider's assignee for any medical services furnished to me by that Provider; I authorize any holder of medical records or other information about me to release to the Provider, the Medigap insurance carrier and/or their designated agents any information needed to determine these benefit or benefits for related services."*

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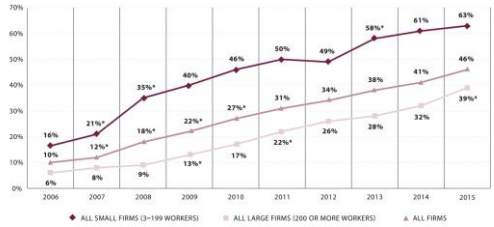
Kaiser survey on deductible growth for workers in small & large firms

EXHIBIT G

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $1,000 or More for Single Coverage, by Firm Size, 2006–2015



* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2015.

www.edpma.org

MORE EFFECTIVE BILLING: Collecting the Hard Dollars from Third Party and Individual Debtors

Providers Must Routinely Review and Analyze their AOBs to Protect their Right to Payment from ERISA Plans

This area of the law is evolving. The current cases provide some guidance to consider:

Does the provider have the right to collect payment and/or benefits from the insurance company?

Providers must ensure that the AOB clearly assigns the right to payment to the provider and the right of the provider to receive the payment. Furthermore, providers must ensure that the AOBs are properly executed by the patient or the plan participant. If the AOB purports to assign the right of payment to more than one provider, then all of the providers should be listed clearly in the AOB to ensure that each provider preserves its right to pursue and receive payment.

If the provider has the right to collect payment, does the AOB contain the necessary language to confer standing on the provider to pursue administrative appeals and file suit? Does the AOB include the right to file suit for payment alone or does it confer greater rights?

At a minimum, the AOB must assign the provider the right to pursue and receive payment. Assuming that a claim will be denied, the AOB should include an assignment of the right to pursue all administrative appeals and litigation as necessary to pursue payment. If a provider is interested in possibly making claims other than for payment under ERISA, it is imperative that a provider include broader language that includes the right to pursue all causes of action, including, but not limited to the right to pursue payment and other ERISA claims.

Moreover, in order for providers to ensure that they have the best chance at receiving payment for services rendered to ERISA plan beneficiaries, it is imperative that providers routinely review and revise their AOBs. Although PPACA gave providers additional protections by including a claimant's authorized representative in the definition of claimant in 29 C.F.R. 2590.715-2719, as it relates to internal claims and appeals processes, this protection likely will not extend to the right to file suit.

In order to avoid future problems, providers must include the right to receive benefits directly, as well as an assignment of the right to pursue payment, other alleged ERISA violations, and other causes of action against a payor. Failure to include these specific assignments could limit a provider's ability to recover and, ultimately, hurt the provider's bottom line.

*The information in this article is not intended as legal advice. By reading this article, no attorney/client relationship is formed.

https://www.americanbar.org/publications/aba_health_esource/2015-2016/july/undererisa.html