Revenue Processes in an Urban/Tribal Setting

Best Practices

Is your Accounts Receivable prehistoric and terrifying?

How did it get this way?

What are we going to do now?

How can we prevent it from continuing?

PREVENTION

The Revenue process begins before any patients are seen….

TASK	RESPONSIBLE PARTY (Whose problem is it?)
Provider Credentialing	Human Resources/Administration
Billing Systems Settings	Business Office & I T
Forms / E H R pick lists	Business Office
Training	Registration; Providers; Coders; Billers
Policies and Procedures	Management

BEST PRACTICE TIMELINE

- Verify eligibility & BENEFITS <u>before</u> the encounter
- Providers complete documentation the same day as the encounter
- Code/audit within 24-48 business hours of the encounter
- Bill within the following24-48 business hours
- Follow up on unpaid claims at 45-60 days

Before the encounter Prevention

Task	Responsible Party
Print Appointment List (Pull Charts)	Medical Records/Eligibility Specialist
Verify eligibility for insurance; Medicare; Medicaid & BENEFITS	Depends on your clinic staffing model (Best Practice: Eligibility Specialist)
Prepare any necessary forms (annual registration, GPRA, Special Program)	Depends on your clinic staffing model (Best Practice: Eligibility Specialist)
Call to remind patient of appt – this is the best time to discuss any insurance issues	Depends on your clinic staffing model (Best Practice: Eligibility Specialist)
Schedule with a provider who	Credentialing

The patients arrive…

- **Insurance Verified**
  - Update Forms
  - Collect Co-pay
- **New or Uninsured**
  - Route patient to Eligibility Specialist
  - Register patient and screen for resources

Cash Patient – Best Practice

If the patient is uninsured and will be paying cash for the services, a “Best Practice” is to have an established flat rate fee for an office visit (~$50.00).

Collect this prior to sending the patient back to see the providers. Any additional services can be priced at the sliding discount and fees may be collected after services are rendered.

Forms?

Demographic Forms	Business Forms	Visit Forms
Photo Identification	Notice of Privacy Practices	Chart note (PCC, PCC+)
Native Heritage Documentation	Insurance card	Special program forms (CDP, Family Pact, Medicare MSP/ABN)
Proof of income (if applicable)	Annual registration	Charge Sheet/Super Bill
Determine Sliding Discount eligibility (apply discount to professional services only)	Insurance eligibility confirmation	Internal and external referral forms and authorizations
	Accident details	Immunization registry printouts

Documentation

PROVIDER	NURSE/MEDICAL ASSISTANT
History of present illness	Chief Complaint
Review of systems	Vital Signs
Past, family, social history (pertinent)	New or Established (to clinic) Patient
Examination of body areas/organ systems	Procedures performed (injections, immunizations)
Diagnoses & treatment options	Supplies used or dispensed
Procedures performed	Health Factors & Screenings
Lab, Radiology, procedures ordered	Patient Education performed
Outside records requested/reviewed	Allergies, Medication list
SIGN AND DATE	Charge Sheet (Cash patients = services, procedures and labs)
	SIGN AND DATE

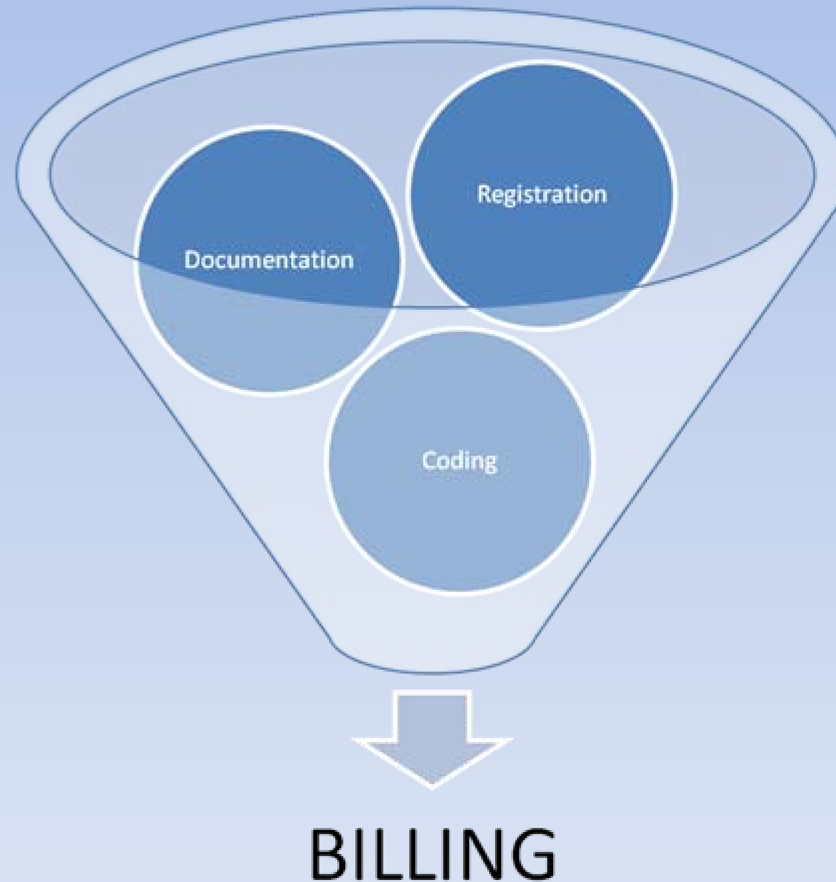
Inadequate Preparation
Incomplete Registration
Incomplete Forms
Incomplete Documentation
= uncollectible events/ the emergence of dinosaurs

Check Out

Medical Assistant	Front Desk
Schedule Follow Up Appointment(s)	Collect any balance due
Provide internal or external referrals; orders for lab or radiology	Verify all forms have been completed and signed by patient and provider(s)
Process any pre-authorizations	Assemble end of visit forms and chart for coder/medical records
Return patient to front (with completed charge sheet for cash patient)	

Uncollected patient balances
and
co-pays will become …

Billing is the outcome of the encounter



Coding & Billing

CODING	BILLING
Verify all encounters are collected for the Date of Service (check appt list)	Verify service is billable, per payer guidelines
Verify forms are complete &signed &coding is complete and accurate	Review progress note to ensure coding is complete and accurate
Verify an ICD-9 is documented for all procedures and products	Translate code for payer guidelines (Medicare G-Codes) …Prepare claim
Verify &enter the procedure, product and diagnoses codes, additional data	Assign modifiers and Link services to diagnoses as applicable
Prepare Date of Service packet : Proof of insurance eligibility Receipt for payment collected (?) Chart Note (Non-E H R) Charge Sheet (Non-E H R)	Approve claims Submit electronic batches or Print Check for unbilled encounters Process problem encounters (signature, documentation, etc…)

Posting - Best Practice: 835 files

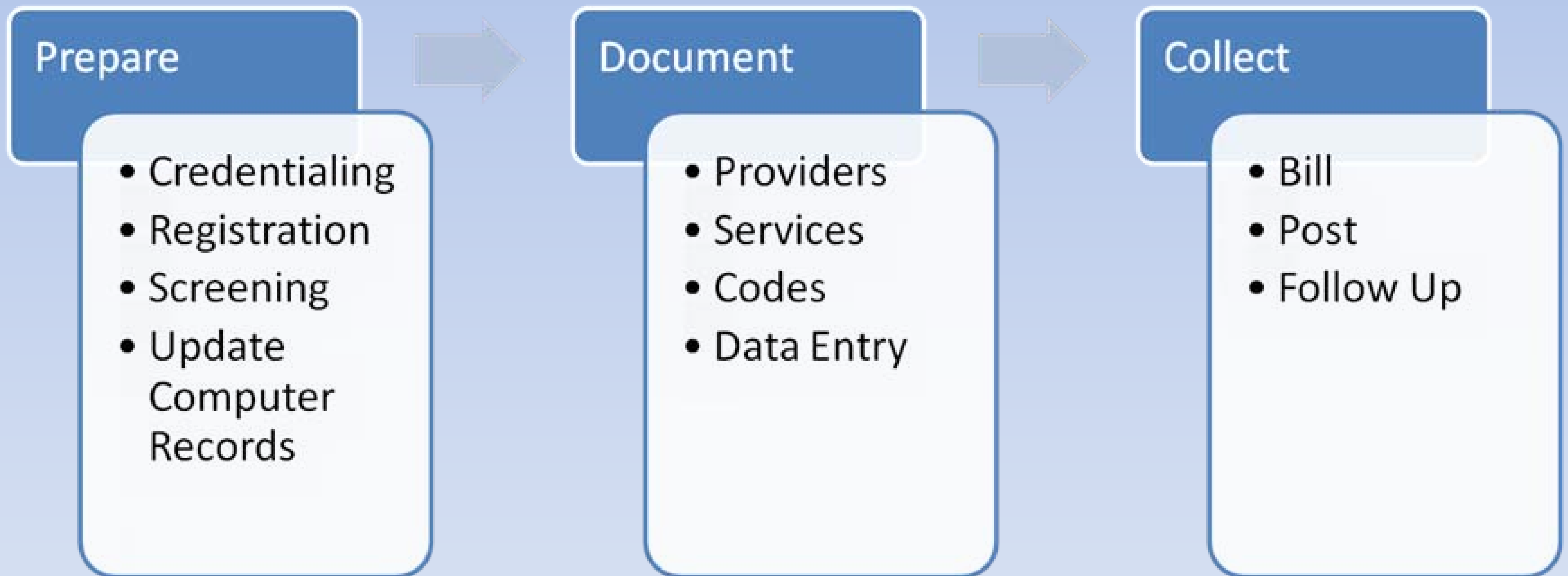
PAYMENTS & DENIALS	WORK THE UNPAID BALANCES
Create payment batches &post insurance payments **the day they are received**. Post PT pmts **within the month** of the payment	Review denials and adjustments – they may be wrong
Roll claims to secondary payers and bill the **same day**	Discuss denials with registration, providers, coders, billers (as appropriate)
Prepare letters for balances due – attach a copy of the EOB (same day)	Appeal invalid adjustments and denials
Work the denials the **same day**. You will not have more time tomorrow.	Send statements for unpaid patient balances
File payments, adjustments and denials by date of transaction	For unpaid insurance claims, call or research claim status on website

Dollars or Dinosaurs
Follow up makes the difference

Accounts Receivable Management

Monthly Activities	
Balance Accounts Receivable ASM – Current Balance (caution) TAR Report – Paid/Adjusted BLS Report – Billed Spreadsheet for finance, Board and Executive Management	**Work the problem payers** 0-60 = Billers Own this timeframe 61-90 = Alert BO Manager 91-120 = Alert Finance 120+ = Alert Executive Mgmt
Balance bank deposits to business office payments. Identify any missed payments or non-AR items.	

Process



Collections

The medical practice should establish an internal collection time frame in which the account will be worked internally before the account is written off and/or turned over to an external collection agency.

A policy should be developed that provides guidance regarding which accounts will be turned over to an external collection agency. The policy should be followed consistently.

The internal collection period is generally 90 or 120 days in best practice examples.

The medical practice should consider using two external collection agencies so that results of the two can be compared. A method of tracking the success of the external collection agency should be implemented in the medical practice. If the external collection agencies are collecting 40 % or more of the accounts, this may be a sign that the internal collection efforts are lacking.

Medicare Timely Filing Limits

Claims with Dates of Service*	Must be Submitted By
October 1, 2005 – September 30, 2006	December 31, 2007
October 1, 2006 – September 30, 2007	December 31, 2008
October 1, 2007 – September 30, 2008	December 31, 2009
October 1, 2008 – September 30, 2009	**December 31, 2010**
October 1, 2009 – September 30, 2010	December 31, 2011
October 1, 2010 – September 30, 2011	December 31, 2012
October 1, 2011 – September 30, 2012	December 31, 2013

5 levels of Medicare Appeal

Appeals Request Process
The following information must be included with your request for all appeal levels.

- Name
- Health Insurance Claim number (HICN)
- Dates of service
- Item/service at issue
- Signature

First Level—Redetermination (issued on or after May 1, 2005)
The first level of appeal is carried out by the fiscal intermediary/carrier.
Time limit to initiate = 120 days from the date of the initial determination
Time limit to complete the review = 60 days
Amount in controversy—no minimum amount

Send the completed CMS-20027 form—Medicare Redetermination Request—to the appropriate contact.

Medicare 2nd Level

Second Level—Reconsideration

- Please use the form included with the redetermination decision when sending the reconsideration appeal request.
- The second level of appeal is carried out by the qualified independent contractor (QIC).
- Time limit to initiate = 180 days from the date of the redetermination decision
- Time limit to complete the review = 60 days
- Amount in controversy—no minimum amount
- Send the completed CMS-20033 form—Medicare Reconsideration Request—to the appropriate contact.
- Go to the Centers for Medicare & Medicaid Services (CMS) Web site for additional information regarding reconsiderations and QICs.

5 levels of Medicare Appeal continued

Third Level—Administrative Law Judge Hearing

- The third level of appeal is an administrative law judge (ALJ) hearing.
- Time limit to initiate = 60 days from the date of the QIC decision
- Time limit to complete the review = 90 days
- Amount in controversy = $120 (on or after January 1, 2008)
- Amount in controversy = $110 (Prior to January 1, 2008)
- Send the completed CMS-20034A/B form—Request for Medicare Hearing by an ALJ—to the local Office of Medicare Hearings and Appeals field office specified in your reconsideration determination.
- Office of Medicare Hearings and Appeals field office addresses.

Medicare 4th Level

Fourth Level—Medicare Appeals Council

- The fourth level of appeal is carried out by the Medicare appeals council (MAC).
- Time limit to initiate = 60 days from the ALJ decision
- Time limit to complete the review = 90 days
- Amount in controversy—no minimum amount

Send requests for a MAC review to:
Department of Health and Human Services
Departmental Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

Medicare 5th Level

Fifth Level—Federal Court Review

- The fifth level of appeal is carried out by the Federal District Court.
- Time limit to initiate = 60 days from the Medicare appeals council decision
- Amount in controversy = $1,180 (on or after January 1, 2008)
- Amount in controversy = $1,130 (Prior to January 1, 2008)

Send requests for a judicial review to:

Department of Health and Human Services
General Counsel
200 Independence Avenue, SW
Washington, DC 20201

HMO and PPO Complaints

WHO REGULATES WHAT TYPE OF HEALTH PLAN?

- The majority of California's health plans are regulated by either the California Department of Insurance (CDI) or the California Department of Managed Health Care. The CDI regulates point-of-service health plans and certain Preferred Provider Organization (PPO) health plans underwritten by health insurance companies authorized by the CDI.

DMHC

The CDI does not regulate Health Maintenance Organizations (HMOs) or certain PPOs, which fall under the Knox-Keene Act (i.e., Blue Cross of California or Blue Shield of California).

Complaints against these types of health plans should be submitted to:

- Department of Managed Health Care (DMHC)
  980 Ninth Street #500
  Sacramento, CA 95814-2725
  Web site: http://www.dmhc.ca.gov
  Provider Complaints (877) 525-1295

CA Dept Insurance

For a list of health insurance companies regulated by the Department of Insurance, visit our website at: http://ww.insurance.ca.gov

For a list of the HMOs and other health care service plans regulated by the Department of Managed Health Care, please visit the DMHC website, as shown above.

Examples of the Types of Problems That You Can Submit to the CDI

- Improper denial or delay in payment of a claim
- Other claims handling issues
- Dispute Resolution Mechanism difficulties
- Misconduct of the health insurer

HMO Prompt Pay

Existing law requires HMOs to pay claims within 45 days. If they don't, interest accrues at 10 % a year on the late payments.

Provider Complaint Unit

The prompt and fair payment of health care providers is crucial to California's health care delivery system, as they are the one true link to the patient. To honor that link, in 2004 the DMHC established the Provider Complaint Unit (PCU) to ensure the prompt and accurate payment of provider claims. The PCU provides an easy and free method for healthcare providers, including doctors and hospitals, to get help with claims payment problems. As of February 2010, the PCU has recovered nearly $19 million for California doctors and hospitals as a result of submitted complaints.

Functions / Summary

• The PCU has an online Provider Complaint System to evaluate claim reimbursement disputes such as timely submission and payment of claims, failure to pay according to contracts, coding disputes, enforcement of the provider bill of rights, and problems with post-emergency stabilization care.

Provider Complaint Unit

In addition to resolving individual complaints, the PCU looks for systemic or recurring types of payment, payer or contract problems within health plans in order to target appropriate follow-up or enforcement activity. In 2008, the DMHC fined PacifiCare of California $3.5 million for not paying provider claims on time.

The PCU has also established an Independent Dispute Resolution Process (IDRP) to give non-contracted providers of EMTALA-required emergency hospital and physician services a fast, fair and cost effective way to resolve claim payment disputes with health care service plans and their capitated provider groups. The IDRP is voluntary for both non-contracted providers and payers. Disputes are decided by an independent third-party review organization.

- If you are a provider and would like to report a problem regarding claims payment or learn more about the Independent Dispute Resolution Process, please contact us at 1-877-525-1295, or go to http://www.healthhelp.ca.gov

Related Content
How to submit a provider complaint:
http://healthhelp.ca.gov/providers/clm/clm_comp.aspx

Collection Calls

Phrases to Avoid When Collecting

These phrases are all demand phrases.

- You need to….
- I need…..
- You must…..
- We require…..
- I want you to….
- You have to…..
- I expect……
- Our policy states……

  No one likes to be told what to do, so the remainder of the sentence will not be received well by the patient or insurer.

For a better response, try one of the following:

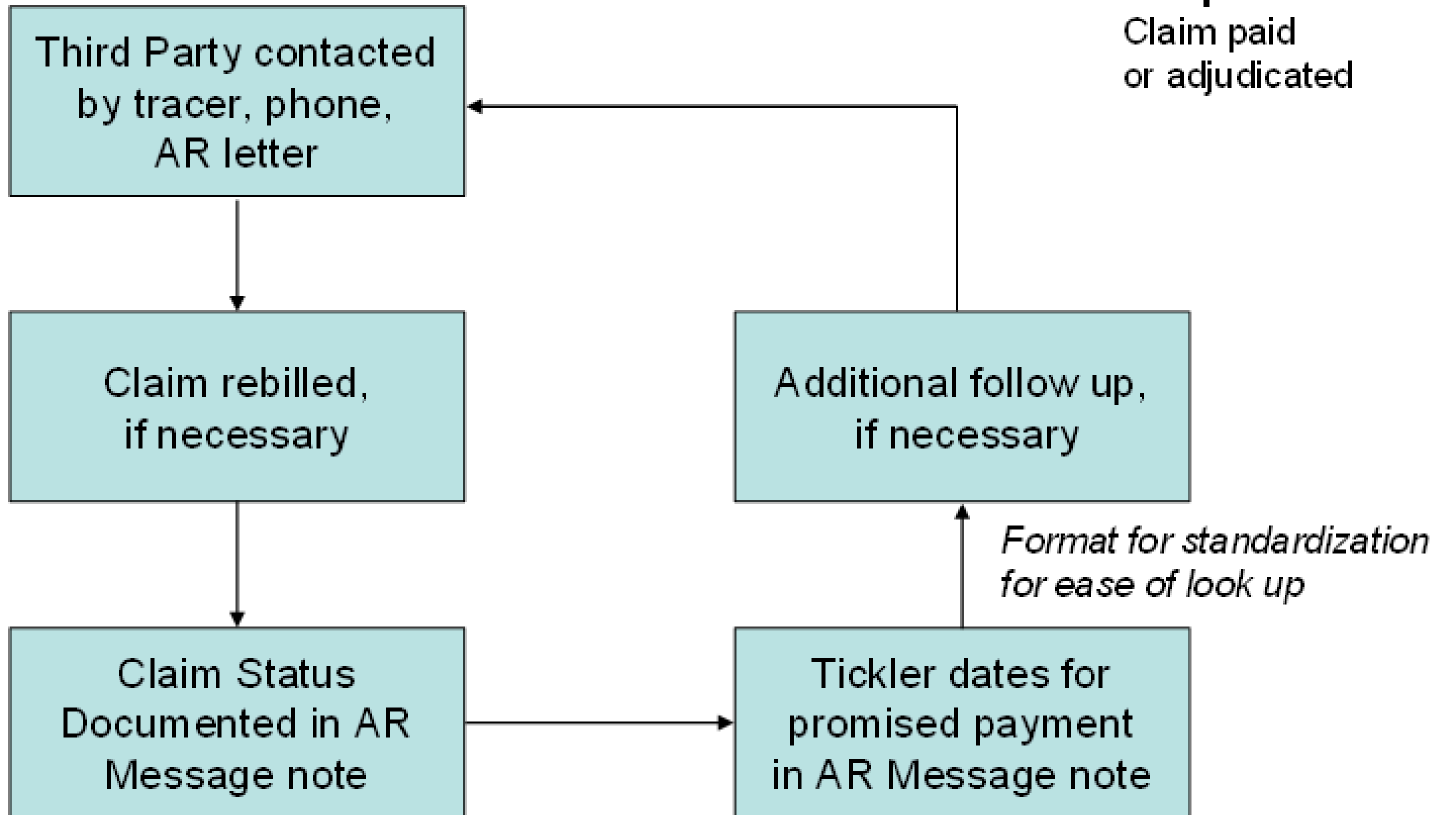
- Here are some options for you…..
- What can you do?
- May I suggest…..
- You might want to try…..
- Did you know you can

45-60 days

As illustrated in the following figure, claims are reviewed, check the Message field for last FU date and action.

- The payer is contacted by tracer, phone, and/or AR letter.
- The claim is re-billed, if appropriate.
- The claim status is documented in **AR Message note**.
- Tickler dates are set for promised payment in AR Message note.
- Additional follow-up is performed, if necessary.

The cycle stops when the claim is paid or adjudicated.


Start:
Claim reviewed by AR; Checks Message field for last FU date and action
Third Party contacted by tracer, phone, AR letter
Stop:
Claim paid or adjudicated
Claim rebilled, if necessary
Additional follow up, if necessary
Format for standardization for ease of look up
Claim Status Documented in AR Message note
Tickler dates for promised payment in AR Message note

…looking for the dinosaurs

The longer receivables go uncollected the greater the chance they won't be collected.

The key is not always the percentages themselves but the change in percentages month to month that is important.

% - Collection percentage also referred to as Realization Percentage. It represents the net amount collected (realized) divided by the gross charge. Management should calculate its realization percentage, then compare this percentage over time or to similar operations.

Days Out

Days out - The billing staff should also calculate and track the average number of days it takes to collect its receivables. The collection period is calculated as follows: (Average Accounts Receivable for 12 months times 365 days) divided by (Billings for the same 12 month Period).

The number itself is not necessarily the key, but the change in the number is what management should be concerned with. Anything over 60 days for a practice should be studied for possible problems.

Moving %

Moving % - The third indicator that should be reviewed monthly is the collection percentage. This measures the ability to collect what is billed.

The collection percentage is calculated as follows: (Net collections for the month plus net collections for prior 11 months) divided by (Gross charges for the month less contractual adjustments plus Gross Charges for the prior 11 months less contractual adjustments).

Contractual adjustments are just that, contractual in nature. They do not include bad debts.

The formula to calculate a 12-month moving average realization percentage is as follows: (net collections for the month plus net collections for prior 11 months) divided by (gross charges for the month plus gross charges for the prior eleven months).

Buckets

Buckets - Finally, the last calculation that is recommend takes the data from the accounts receivable aging report and calculates the percentage of receivable in each of aged columns.

Most billing systems will produce this report, but by putting it into the spreadsheet software and the histories can be maintained for long periods of time. This allows management to watch for trends, and catch possible problems that he/she might not see if the software only produces limited history. This can also be prepared by payor.

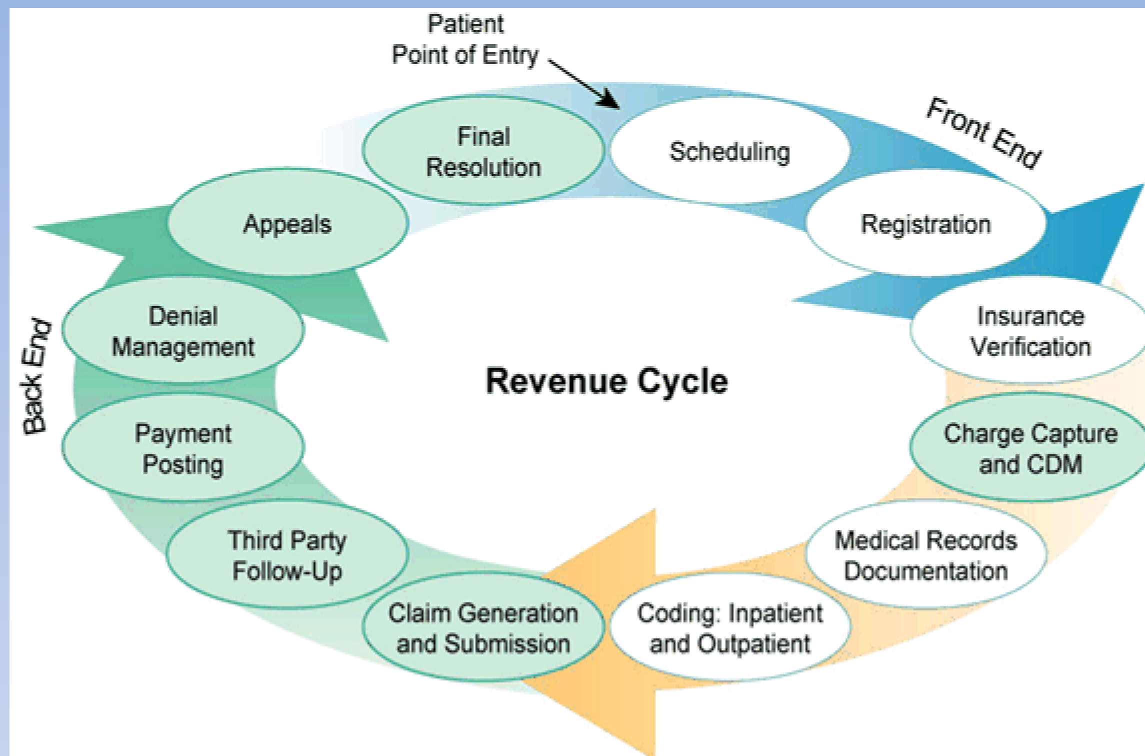
Tools

Handouts
Sample Deductible/Co-Insurance letter for patients
Sample Daily Receipts Log
Sample Monthly Accounts Receivable spreadsheet
Sample Policy/Procedure statement for claims follow up
Sample worksheet for reconciling deposits with Finance Department
Prompt Payment Laws by State
https://mymedicaredata.com - for verifying Medicare Advantage and MSP
http://www.wpc-edi.com/content/view/711/401/ - Claim adjustment codes
http://www.dca.ca.gov/publications/legal_guides/dc_2.pdf - Fair Debt Collections

Regularly (..1st Monday of the month) Review 45-60 day old claims

Complete claim reprocessing activities on the same day. Enter your notes on claim message.

Follow up on promises, appeals and “ticklers” promptly



To prevent claims from being rejected, the business process needs to review such areas as:

ELIG & BENEFITS

- Inaccurate or lack of coding
- Incomplete claims
- Lack of supporting documentation
- Poor communication with the payer
- Not billing for services rendered

Questions

Are there dinosaurs in your A/R?

What has been most helpful in managing your A/R?

Does your site employ an eligibility specialist?

Does your site verify eligibility before every visit?

Does your management review the AR?

What was the most important step to you?

10 Questions in 10 Minutes

April 1st 2010

National Census Day

Use this day as a point of reference for sending your completed forms back in the mail

MEDICAL BUSINESS ADVOCATES

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