Protecting the Contract Health Service (CHS) Budget – To Pay or Not To Pay

April 2006

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I/T/U Partnership Conference

Objective – Successful CHS Payment Management

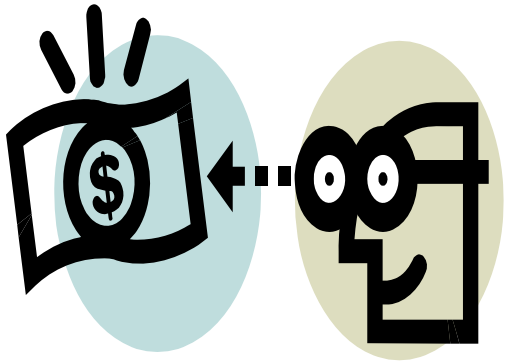
- **Tightening the purse strings – vendor education**
- **Clean claims vs. dirty**
- **Prompt Payment Act**
- **Audits – nurse auditor**
- **CHS staff development**

Your Important Role

- **CHS payment police**
- **Educator**
- **Policy analyst**
- **Educated on billing, coding, and payment requirements for all third-party payers**
- **Data quality of CHS payment information**

Vendor Education

- Billing requirements for payment
  - **Authorizations**
  - **Payor of Last Resort**
  - **Billing forms**
  - **ICD-9 Coding – diagnosis**
  - **Current Procedural Terminology (CPT) Coding – procedure**
  - **Timely filing limits**



Vendor Education (continued)

- Getting the word out
  - CHS eligibility and authorization policies
  - Letter to vendor announcing new billing requirements and payment policies
  - Schedule on-site visit with vendor
  - Schedule an informational seminar for all vendors

Billing Forms

- HCFA -1500 – Health Insurance Claim Form
  - Printed in red ink for optical scanning
  - Services from physicians and suppliers (except ambulance services)
  - Physicians' professional outpatient claims

Billing Forms (continued)

- HCFA-1450 (UB-92) Uniform Bill claim form
  - Hospital inpatient billing and payment transactions
  - Considered a summary statement compiling all charges and is accompanied by a detailed statement
  - The detailed statement lists dates of service, codes, descriptions, and fees for individual services

Diagnosis Coding – ICD-9-CM

- International Classification of Diseases (ICD), Ninth Revision, Clinical Modification
- A system for classifying diseases and operations to facilitate collection of uniform and comparable health information
- Required for CHS payment processing

ICD-9-CM (continued)

- Volumes 1 and 2 are used in physicians' offices and other outpatient settings to complete insurance claims
- Volume 3 is a Tabular List and Alphabetic Index of Procedures used primarily in the hospital setting
- Always coded to the highest degree of specificity

ICD-9-CM (continued)

- V codes are a supplementary classification of coding.
  - V codes are used when a person who is not currently sick encounters health services for some specific purpose.
    - Donor of an organ or tissue
    - To receive a vaccination
    - To discuss a problem that is not in itself a disease or injury
    - Family planning consultation

ICD-9-CM (continued)

- E codes are also supplementary classification of coding
  - The use of an E code after the primary or other acute secondary diagnosis explains the mechanism for the cause of injury or poisoning
  - Looks at **external causes** of injury and poisonings rather than disease

Procedure Coding

- CPT
- A reference procedural code book using a numerical system for procedures, established by the American Medical Association
- Required for CHS payment processing

CPT (continued)

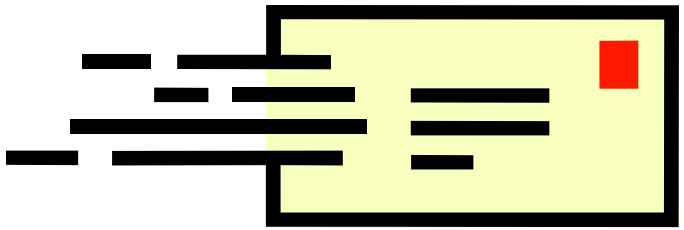
- CPT uses a basic five-digit system for coding services rendered by physicians, plus two-digit add-on modifiers to indicate complications or special circumstances
- Represents diagnostic and therapeutic services on medical billing statements and insurance claim forms

CPT (continued)

- Healthcare Common Procedure Coding System (HCPCS)
  - Pronounced “hick-picks”
  - Three levels of coding
    - Level 1: the American Medical Association (AMA) CPT codes and modifiers (national codes)
    - Level 2: CMS designated codes and alpha modifiers (national codes)
    - Level 3: Codes specific to regional fiscal intermediary or individual insurance carrier (local codes) and not found in ether Levels 1 or 2

Clean Claim Definition

- A clean claim means that the claim was submitted within the program or policy time limit and contains all necessary information so it can be processed and paid promptly.



Dirty Claim Definition

A dirty claim is a claim submitted with errors or is missing required information.

Denied or Delayed Payment

Top Ten Billing Errors

The TrailBlazer Provider Communication department has identified the "Top 10 Billing Errors" through a data analysis program. This error listing will be published on a quaterly basis.

Top 10 Billing Errors	Occurences
1. Duplicates	1,246,686
2. Medical Necessity	761,979
3. Beneficiary Eligibility	248,317
4. Bundled Services	242,259
5. Medicare Secondary Payer (MSP)	127,217
6. Non-covered services	117,295
7. Unique Provider Identification Number (UPIN)	115,404
8. CLIA	65,862
9. Modifiers	62,862
10. Provider Number Missing	54,769

Timely Filing Limits

- Notice of claim within a certain number of days
- Limits are determined by payor
- Varies from payor to payor

Prompt Payment Act

- **Prompt Payment Final Rule (5 CFR Part 1315)** requires Executive departments and agencies to pay commercial obligations within certain time periods and to pay interest penalties when payments are late
- Applies to Indian Health Service CHS
- No mention of Tribal responsibility

Link to Your State Insurance Department Site - Microsoft Internet Explorer

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Prompt Payment Act

Example:

- California Payment Timeframes
  - Non-HMOs: 30 working days
  - HMOs: 45 working days
- Penalties
  - 15% annually; $10 additional noninclusion of interest with payment

Audit by Request

Audits and verifies the doctor's health record documentation and orders against each charge item on the bill

- Vendor submits photocopies of health record for review
- Nurse auditor or a credentialed coder
  - Onsite employee or hired consultant
  - Nurse must have clinical and financial expertise

Audits (continued)

Quality Assurance

- Random audits – preliminary
  - Inpatient
  - Outpatient
- Comprehensive Audit
  - Triggered by preliminary
  - Office of Inspector General
  - More in-depth
- Recovery

Employer Contact Information

Meridian Health Care Management

Phone:	N/A	Contact Name:	Human Resources Team
Fax:	(818)673-1914	Mailing Address:	6200 Canoga Ave Woodland Hills, CA 91367
Website:	http://www.mhcm.com/careeropps.htm		

Job Posting Information

Job Title:	Claims -- Examiners, Auditors, Supervisor	Category:	Medical Billing/Coding/Records
Job Type:	Full Time	Salary:	Competitive salaries, based upon experience. Per Year

City: Woodland Hills
State/Providence: CA

Description:

For two decades, Meridian Health Care Management, Inc. has created practical solutions to all types of managed care infrastructure/systems. We specialize in designing services that meet the unique needs of each client and our dedication has led to an unmatched reputation for excellence in our industry. Now our success has created new opportunities for dedicated individuals like you to join our **Claims Operations Team**.

Are you ready to become a part of the Meridian success? For consideration and detailed position descriptions, please submit your resume via our website: http://www.mhcm.com/careeropps.htm>

We're seeking experienced:
CLAIMS EXAMINERS, CLAIMS AUDITORS, CLAIMS SUPERVISOR

Requirements:

iF you have at least 3+ years of relative healthcare industry experience and expertise, you are encourage to apply:

Claims Examiners (temporary and full-time) -- who have expertise in analyzing, processing, researching, adjusting and adjudicating claims with the use of accurate procedure/revenue and ICD-9 codes.

Staff Development

Where to begin…

- ICD and CPT coding training
  - Current code books available
- Medical and dental billing training
  - Private insurance, Medicare and Medicaid seminars
  - Self-training
  - IHS sponsored training
- Medical terminology
  - Medical dictionary

California Area Indian Health Service

Training Announcement

California
National

~~ California ~~

October 2005

Oct 12-13: CHS Meeting/Training
Oct 17-20: Annual California Area Indian Health Service RPMS Site Manager Training

November 2005

Nov 01-03: Patient Accounts Management Workshop
Nov 14-18: Medical Coding Update and Review (4 days)

December 2005

Dec 13: Dental Billing and Coding Workshop

Questions

Charlie