TRANSITIONING TO BILLING 2: BEST PRACTICES FOR SUCCESSFUL REIMBURSEMENT – *IMPLEMENTING EFFECTIVE REVENUE CYCLE MANAGEMENT PRACTICES AS A KEY ELEMENT OF AGENCY SUSTAINABILITY*

December 17, 2013

1:00 PM Eastern Standard Time (90 minutes)

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Sexual Health & Reproductive Health Training & Technical Assistance Center – Regions VII & VIII

JSI RESEARCH & TRAINING INSTITUTE, INC.

Capacity building assistance (CBA) provider

- Monitoring and evaluation
- Organizational infrastructure
- Effective Behavioral Interventions

Training and Technical Assistance (TTA) provider

Improving capacity in two areas:

- Bill and get reimbursed by Medicaid and other third-party payers
- Conduct prevalence monitoring of chlamydia and gonorrhea and use data for QI

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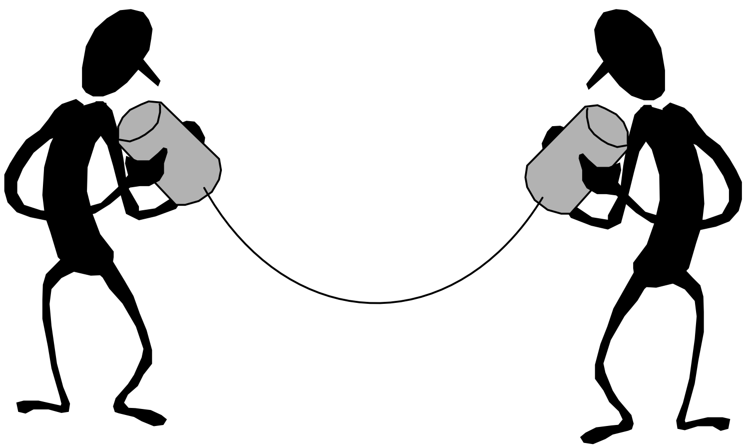
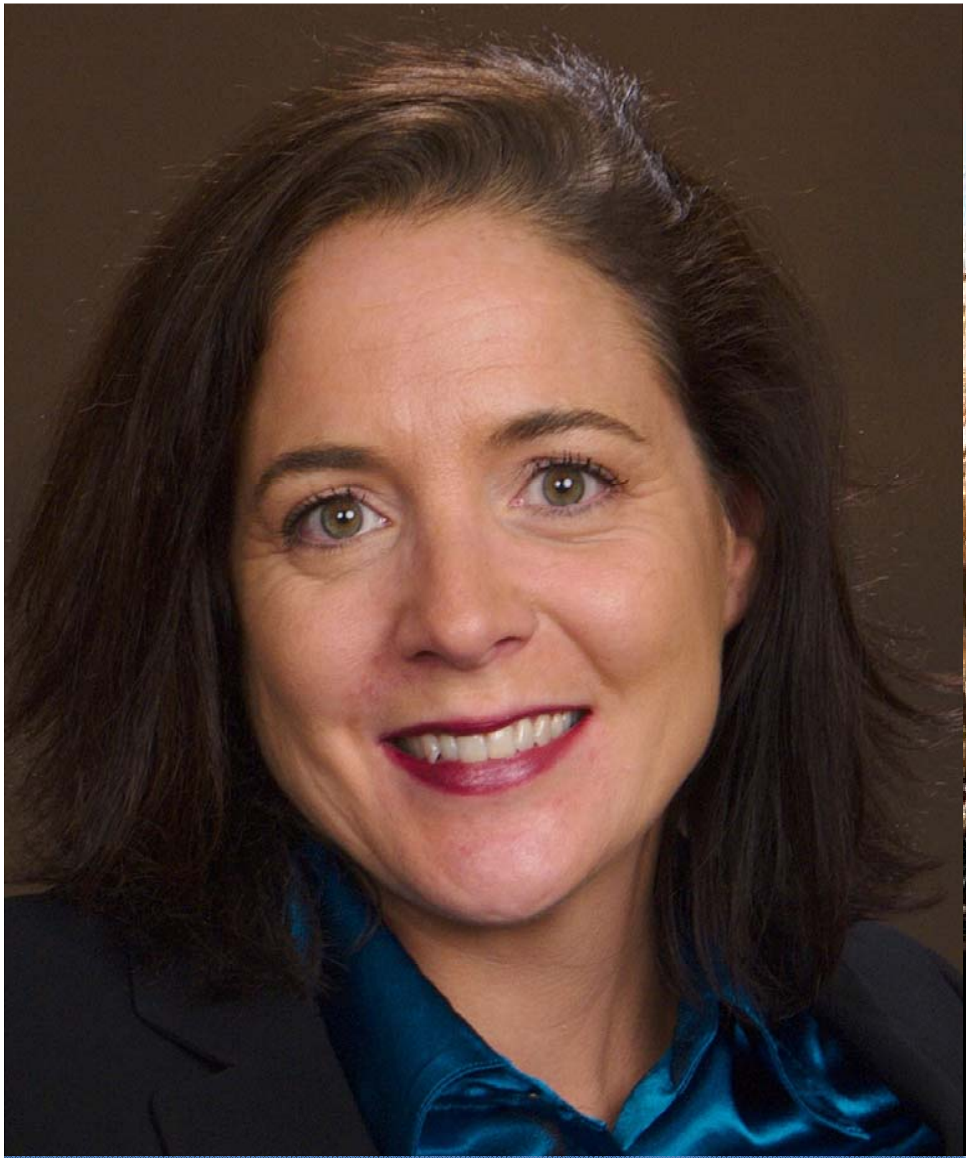
WEBINAR BASICS

- Interactive functions
  – Polls
  – Raise/Unraise hand
  – Chat
- Chat to host technical issues
- Chat to everyone or host/presenter for questions or comments





Lou Ann Wilroy

Partner, RT Welter

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WEBINAR OBJECTIVES

By the end of the webinar, participants will be able to:

1. Describe the function of a practice management system and electronic medical record (EMR)
2. Describe 4-6 key steps involved in the three stages of the revenue cycle
3. Identify the difference between CPT, ICD-9, and HCPCS codes

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The Health Care Revenue Cycle

Source: Health Data Management: "*Revenue Cycle Management*" June 2008

APPOINTMENT SCHEDULING

- Collect as much information as possible by phone at the time of scheduling:
- Demographics
- Insurance Information
- Reason for Visit

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APPOINTMENT CONFIRMATION & ELIGIBILITY

- E-mail or mail forms and appointment confirmation
- Call/text confirmation 24 hours prior to appointment
  - Remind client to bring insurance card
  - Verify eligibility and benefits

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CHECK IN PROCESS

- Check-in area should be inviting, accessible, and HIPAA compliant
- Credit card machine and/or scanning equipment should be within easy access of front desk
- Client information should be loaded into system and pre-populated on encounter form/superbill

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THE ENCOUNTER FORM OR SUPERBILL

Includes CPT codes for new, established, and comprehensive visits

Includes ICD-9 codes

Pre-printed with client demographics and outstanding balance (or utilize electronic version with EMR)

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CHECK IN PROCESS

- Obtain copies of insurance cards
- Verify demographics
- Obtain signed paperwork
- Review financial obligations and obtain payment (or provide estimate for collection at check-out)

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CHECK OUT PROCESS

- Provide a private area for financial conversations
- Credit card machine and check scanning equipment should be within easy reach of check-out area
- Confirm the insurance to be billed
- Confirm balance due

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CHECK OUT PROCESS

- Collect payment
- Provide copy of superbill/receipt
- Schedule next appointment
- Address questions

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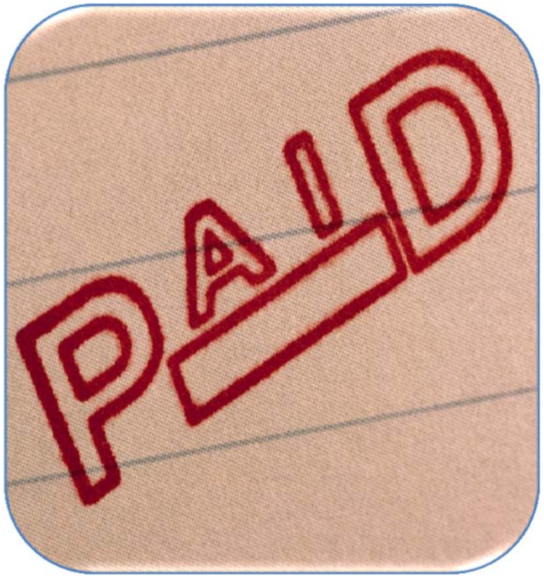
CHECK OUT PROCESS

- Upon Receipt of Payment:
  - Record payment in system IMMEDIATELY
  - Provide receipt to client



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POINT OF SERVICE COLLECTIONS

- Billing for co-payments is costly and seldom results in collection
- Failure to collect co-payments required by payers is an insurance contract violation
- Collection of co-payments is standard business practice (most services are paid for at time-of-service)

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TIPS FOR REQUESTING PAYMENT FROM CLIENTS

- Ask how they wish to pay the amount due
- Keep it personal, address client by name
- Be professional, do not try to use humor
- Stay calm, polite, and in control
- Pass the client to a colleague if necessary to change the tone

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TIPS FOR REQUESTING PAYMENT FROM CLIENTS

- Get the client to commit to a date to pay the amount due
- Try not to go beyond 30 days
- Document and follow-up
- Without a firm commitment and follow-up, once the client leaves the clinic, chances of getting paid are reduced by 50%
- After the 60-day mark the chances decrease drastically

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COMMON MISSTEPS RESULTING IN REVENUE LOSS

- Not obtaining current client information
- Failure to collect previous balances
- Inconsistency or failure in collecting co-payments

END OF DAY CHARGE CAPTURE

Reconcile Superbills with schedule

Reconcile End of Day reports

Complete deposit ticket

Keep cash and checks in a secure location until deposited

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REVENUE CYCLE MANAGEMENT: AFTER THE CLIENT VISIT

- Practice Management and EMR system
- Coding and Documentation
- Billing/Claims Submission
- Collections and Claims Follow-Up (Denial Management)
- Accounts Receivable

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ANSWER THE POLL

What types of technology does your agency have in place?

- Paper Tracking System
- Electronic (computerized) scheduling software
- Practice management system
- Electronic Medical Record
- Other

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TECHNOLOGY IMPLEMENTATION

Options for automating your clinic:

- Practice Management Systems
- Electronic Medical Record Systems

CODING & DOCUMENTATION

What is medical coding?

- ***The transformation of services, diagnoses, and supplies into alphanumeric codes***

Three primary code sets:

- **CPT®**
- **ICD-9 (ICD-10 in 2014)**
- **HCPCS**

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THE TRANSITION TO ICD-10

- Replaces ICD-9 effective October 1, 2014
- Improves ability to:
  - Measure health care services
  - Increase sensitivity when refining grouping and reimbursement methodologies
  - Conduct public health surveillance

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CODING & DOCUMENTATION BASICS

- If it isn't documented, it didn't happen
- Documentation must be clear, concise, and substantiate medical necessity
- Coding for services not provided is fraud
- The medical record provides documentation of assessment, decision-making, and general management of the patient

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ANSWER THE POLL

Does your organization currently code services you provide?

- Yes
- No
- Not Sure
- Not Applicable

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BILLING & CLAIMS SUBMISSION

- Claims are submitted on the CMS 1500 form
- Make sure all required information is complete
- Technology should be in place to pre-populate claim forms
- Consider submitting claims through a clearinghouse via secure, encrypted data transmission

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PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________ DATE ______________

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______________

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE* FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

THE CLAIMS CLEARINGHOUSE

- Standardizes claim information and submits to payers
- Prevents errors and allows you to catch and correct errors within minutes rather than days or weeks
- Fewer claims are delayed or rejected
- Reduces reimbursement time to under ten days
- Submits electronic claims in batch all at once, rather than submitting separately to each individual payer
- Provides a single location to manage all claims

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CLAIMS FOLLOW UP

- Payment should be received within 10-15 days
- Reasons for delay
  - Never received
  - Denied
  - Pending additional information

DENIAL MANAGEMENT & APPEALS

Set a dollar amount for claims to be appealed

Review the denial reason

Submit the appeal within 7 days of receiving the denial notice

Ask the client for assistance

Review the conditions of your contract with the payer

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ACCOUNTS RECEIVABLE

- Accounts Receivable = money owed to the clinic
- Account Aging:
  - 0-30 days
  - 31-60 days: greater chance of receiving payment
  - 61 – 90 days: top priority
  - Over 90 days: chance of receiving payment decreases significantly

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COLLECTIONS FROM CLIENTS

- Monthly billing: send statements to all clients at the same time each month
- Cycle billing: send groups of statements every few days or weekly
- Generate statements from practice management software or outsource
- “1, 2, 3 strikes, you’re out”
- Follow debt collection laws and observe professional guidelines

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TIPS FOR COLLECTING PAYMENT FROM CLIENTS

- Communicate the Expectations in Advance
- Examples:
  - Display prominent but tasteful signage in the clinic, i.e. *“Your insurance company requires that we collect your co-payment."*
  - Send a letter outlining your financial policy to each client.
  - Create a brochure or flyer outlining the financial policy and display in waiting room and check out area.

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TIPS FOR COLLECTING PAYMENT FROM CLIENTS

- *Examples (continued):*
  - Post the financial policy on the website
  - Include an announcement about the financial policy on recorded telephone message
  - Upon check-in, have clients read and sign a financial agreement
  - Remind clients of the policy when they call to make appointments, and provide estimates of what they will owe, if feasible

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WRAP-UP

- Your observations

- Questions

  Throughout December and January you can submit your questions to: http://cba.jsi.com/events and click on *Transitioning to Billing: Webinar Q&A*

- Evaluation

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RESOURCES

- JSI CBA: cba.jsi.com or e-mail cba@jsi.com
- JSI SHRPTTAC: http://shrpttac.jsi.com/
- Coding for STI Services: Region I STD TAC-- http://stdtac.org/files/2013/08/STDTAC_Coding_Webinar_Slides2.pdf
- Shifting to Third-Party Billing Practices for Public Health STD Services: Policy Context and Case Studies: National Coalition of STD Directors http://www.ncsddc.org/sites/default/files/media/finalbillingguide.pdf
- Issue Brief: Billing and Reimbursement: National Alliance of State & Territorial AIDS Directors -- http://nastad.org/docs/NASTAD-Report-HD-Billing-Survey-April-2013.pdf

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THANK YOU FOR YOUR TIME & PARTICIPATION!

CBA@JSI | CAPACITY BUILDING ASSISTANCE

High-quality, cutting-edge services to help community-based organizations in the U.S. deliver effective HIV prevention services.

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CBA@JSI is implemented by JSI Research & Training Institute, Inc. and is funded by the Centers for Disease Control and Prevention (CDC) to provide capacity building assistance to community-based organizations serving high-risk and/or racial/ethnic minority populations (PS09-906). Financial support for this website was provided by the Centers for Disease Control and Prevention (CDC) under the terms of Cooperative Agreement No. PS09-906. The views expressed herein do not necessarily reflect those of the Department of Health and Human Services (DHHS).

SHRPTTAC@JSI is funded by the Centers for Disease Control and Prevention (CDC) Division of STD Prevention (DSTDP) under the terms of a Cooperative Agreement with JSI Research & Training Institute, Inc. The views expressed herein do not necessarily reflect those of the Department of Health and Human Services (DHHS).