Transitioning to Billing 2: Best Practices for Successful Reimbursement – *Implementing Effective Revenue Cycle Management Practices as a Key Element of Agency Sustainability*

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1:00 PM Eastern Standard Time (90 minutes)

Yvonne Hamby, JSI Research & Training Institute, Inc.

Hilda Delgado and Lou Ann Wilroy, RT Welter and Associates

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

Webinar Basics

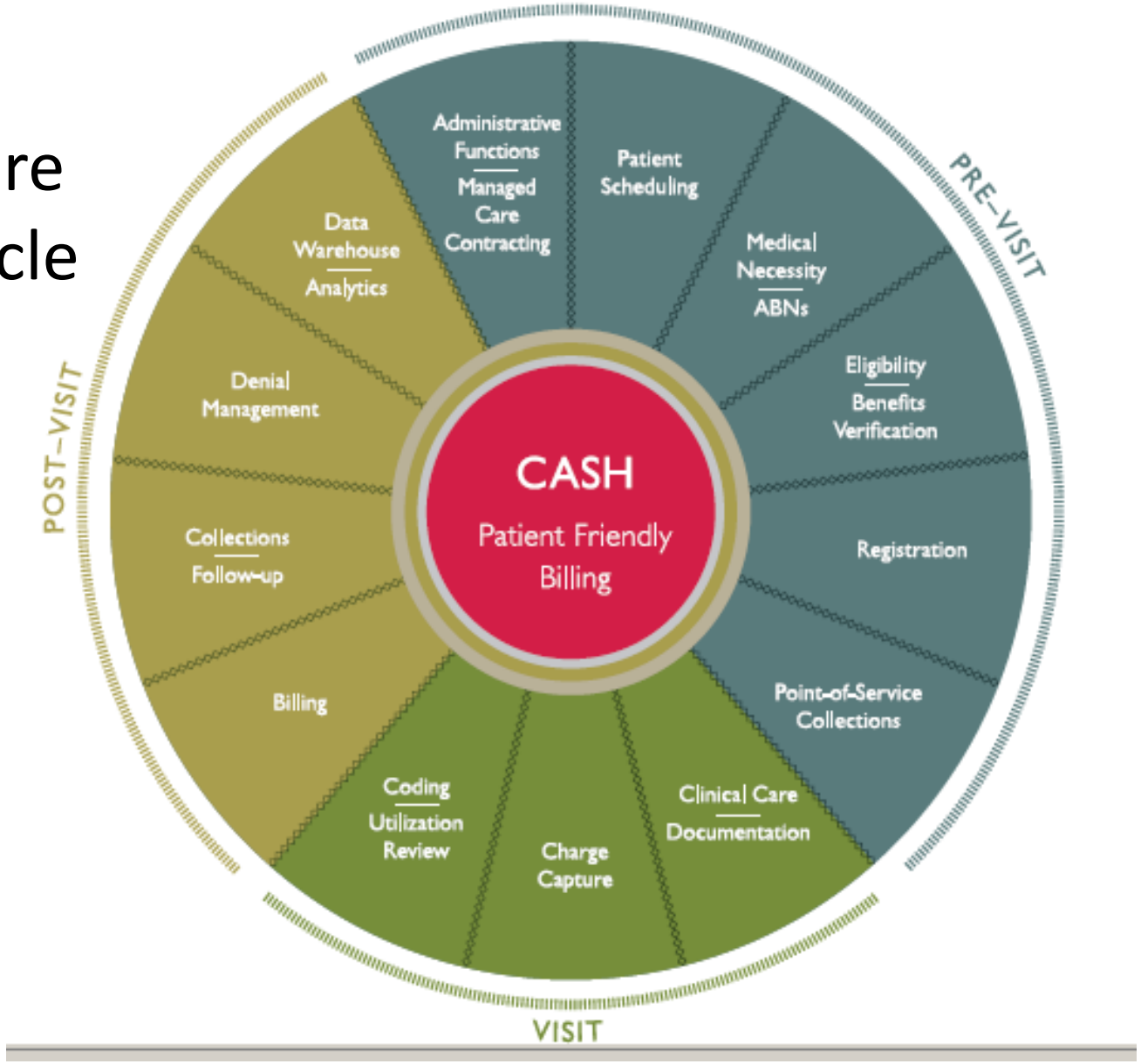
- Interactive functions
  - Polls
  - Raise/Unraise hand
  - Chat
- Chat to host technical issues
- Chat to everyone or host/presenter for questions or comments

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

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

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

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

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)

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)

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

Check-out Process

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

Check-out Process

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

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)

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

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

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

1. Reconcile Superbills with schedule
2. Reconcile End of Day reports
3. Complete deposit ticket
4. Keep cash and checks in a secure location until deposited

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

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

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

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

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.

Answer the Poll

Does your organization currently code services you provide?

- Yes
- No
- Not Sure
- Not Applicable

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

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

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 ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )		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 MM DD YY FROM / 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 MM DD YY FROM / 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 SERVICES 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

Claims Follow-up

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

Denial Management & Appeals

1. Set a dollar amount for claims to be appealed
2. Review the denial reason
3. Submit the appeal within 7 days of receiving the denial notice
4. Ask the client for assistance
5. Review the conditions of your contract with the payer

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

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

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.

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

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

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

THANK YOU FOR YOUR TIME & PARTICIPATION!

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