

**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)

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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

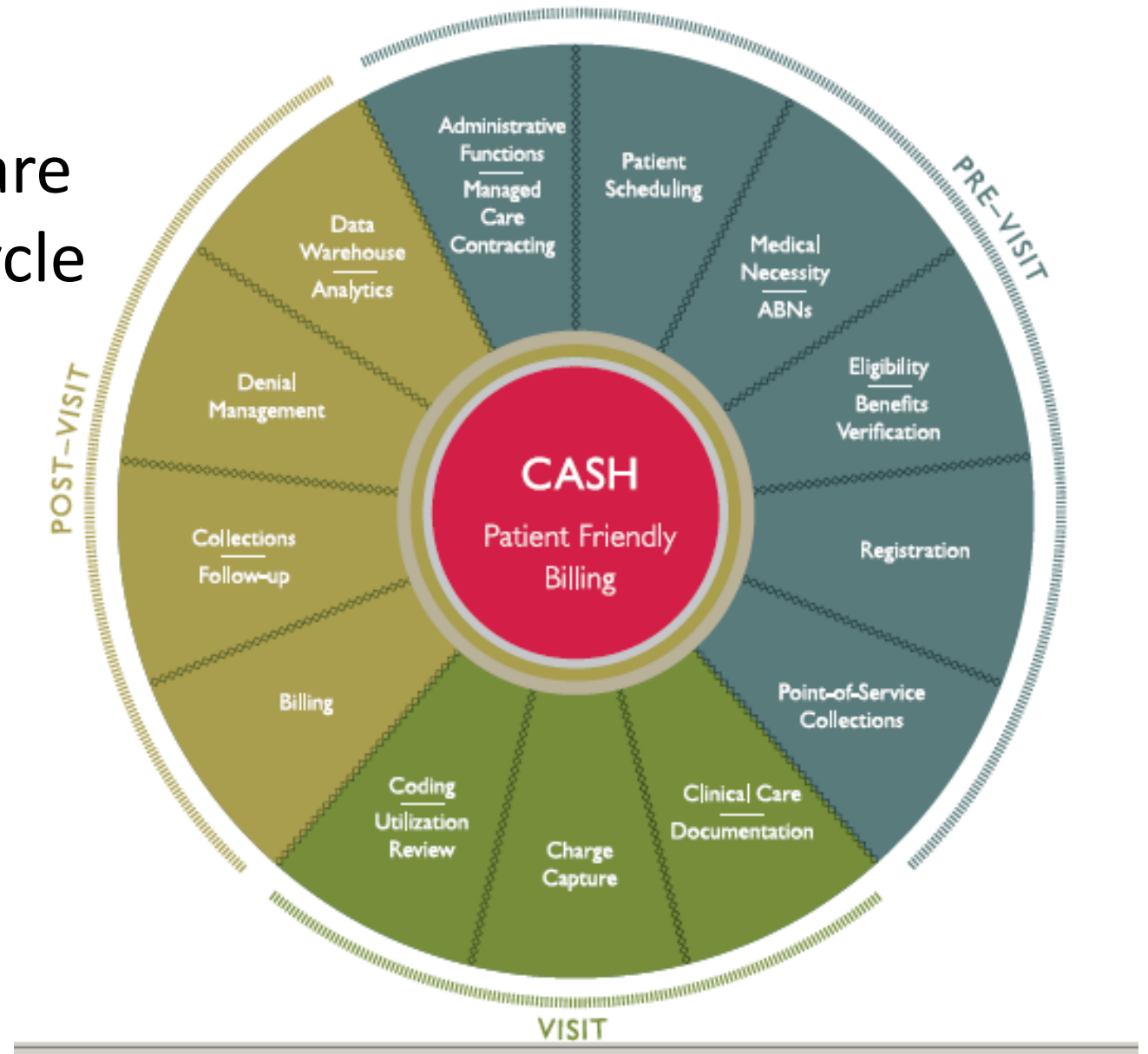
- Interactive functions
 - Polls
 - Raise/Unraise hand
 - Chat
- Chat to host technical issues
- Chat to everyone or host/presenter for questions or comments

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



APPROVED OMB-0833-0105

CARRIER

HEALTH INSURANCE CLAIM FORM

PDA PCA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GRO UP HEALTH PLAN (SSW or IP) <input type="checkbox"/> FECA (SSW or IP) <input type="checkbox"/> OTHER <input type="checkbox"/>		10. INSURED'S ID. NUMBER (FOR PROGRAM IN ITEM 1)			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
3. PATIENT'S BIRTH DATE MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)			
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			
CITY STATE		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)		11. INSURED'S POLICY OR UPOR FECA NUMBER			
10. OTHER INSURED'S POLICY OR GRO UP NUMBER		12. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> d. RESERVED FOR LOCAL USE		13. INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>	
11. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>		14. EMPLOYER'S NAME OR SCHOOL NAME			
12. EMPLOYER'S NAME OR SCHOOL NAME		15. INSURANCE PLAN NAME OR PROGRAM NAME			
13. INSURANCE PLAN NAME OR PROGRAM NAME		16. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes return board complete Item 5and.			
READ BACK OF FORM BEFORE COMPLETING & SENDING THIS FORM.					
14. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (authorize the release of any medical or other information necessary to process this claim. Also request payment of government benefit if other to myself or if the party who accepts assignment below.) SIGNED _____ DATE _____		15. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (authorize the payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED _____			
16. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (UMP) MM DD YY		17. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. ID. NUMBER OF REFERRING PHYSICIAN			
19. RESERVED FOR LOCAL USE		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE FROM MM DD YY TO MM DD YY			
20. DO NOT WRITE OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24 BY LING)		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO # CHARGES			
21. 1. _____ 3. _____ 2. _____ 4. _____		21. MEDICARE RESUBMISSION CODE ORIGINAL REF. NO.			
22. PRO AUTHORIZATION NUMBER		22. PRO AUTHORIZATION NUMBER			
23. DATES OF SERVICE From MM DD YY To MM DD YY		23. DATES OF SERVICE From MM DD YY To MM DD YY			
24. PLACE OF SERVICE A. _____ B. _____ C. _____		24. PLACE OF SERVICE A. _____ B. _____ C. _____			
25. PROCEDURES, SERVICES, OR SUPPLIES (Specify unusual circumstances) CPT/HCPCS MODIFIER		25. PROCEDURES, SERVICES, OR SUPPLIES (Specify unusual circumstances) CPT/HCPCS MODIFIER			
26. DIAGNOSIS CODE		26. DIAGNOSIS CODE			
27. # CHARGES		27. # CHARGES			
28. DAYS OF SERVICE OR Family Plan		28. DAYS OF SERVICE OR Family Plan			
29. EMO CO B		29. EMO CO B			
30. RESERVED FOR LOCAL USE		30. RESERVED FOR LOCAL USE			
25. FEDERAL TAX ID. NUMBER SSW EIN <input type="checkbox"/> <input type="checkbox"/>		25. FEDERAL TAX ID. NUMBER SSW EIN <input type="checkbox"/> <input type="checkbox"/>			
26. PATIENT'S ACCOUNT NO.		26. PATIENT'S ACCOUNT NO.			
27. ACCEPT ASSIGNMENT? (or pmt. assign. see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. ACCEPT ASSIGNMENT? (or pmt. assign. see back) YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. TOTAL CHARGE \$		28. TOTAL CHARGE \$			
29. AMOUNT PAID \$		29. AMOUNT PAID \$			
30. BALANCE DUE \$		30. BALANCE DUE \$			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEDUCTIBLES OR COINSURANCE (I certify that the statement on the reverse apply to this bill and are made a part thereof) SIGNED _____ DATE _____		31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEDUCTIBLES OR COINSURANCE (I certify that the statement on the reverse apply to this bill and are made a part thereof) SIGNED _____ DATE _____			
32. NAME AND ADDRESS OF FACILITY WHERE SERVICE WAS RENDERED (Other than home or office)		32. NAME AND ADDRESS OF FACILITY WHERE SERVICE WAS RENDERED (Other than home or office)			
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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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