Hilda: We won't talk about coding at length, but we will go through some of those acronyms that Morgan was talking about. We'll talk about billings and denial management. So, let's start walking through some of this.

When the next when it comes up, it's going to talk about appointment scheduling, and we know that scheduling appointments in advance in community-based organizations like yours, can be a challenge, even not common practice, your clients are used to coming in on a walk-in basis, as needed.

So as we talk about some of these concepts, we do recognize that you have a lot of clients that just walk in for services. But, let's talk about scheduling appointments ahead of time. As it stands today, you may not collect some of the information that you will need to be collecting for insurance billing, or to help with the revenue cycle management.

And some of this information includes insurance and payer coverage, insurance coverage. Plan IDs and other identifying information for your clients. This information may not be collected today. One, we understand you may not have contracts with payers, and you also are just not used to doing that [00:02:00].

There are reasons for not collecting it and some of those include time constraints, and just not being able to have that time with your client. So, what we'll talk about is the information that needs to be collected. How to collect it and what you couldn't be working towards.

There are systems out there that help with scheduling appointments, you may be using something like Outlook, or you might be using scheduling software. There are practice management softwares, and I'll talk a little bit about practice management softwares. Those are softwares that help with billing insurance carriers, so they help create the claim form that needs to be created to send that information, and get reimbursed by the health plan.

During the appointment scheduling process, it also helps manage the availability or the scheduling and keeps track of those appointments.

So let's move on to the next slide, and talk about appointment confirmation. So once the appointment has been scheduled for your client, assuming they've called in, or they've come in if this is a walk in, we understand that appointment confirmation isn't necessary. This is something that needs to be done within 24 hours.

So, if you have any of your clients that are calling in ahead of time, to schedule a time to received services, confirming those appointments 24 hours prior, or within 24 hours from that is best practice [00:04:00].

All clients should be asked at the time whether it's a walk in or over the phone, and ahead of time should be asked if they have insurance coverage. If they do, again, you want to enter it into the system, whether it be a practice management system, or some other manual method, so that you can bill that insurance appropriately, and check eligibility, which we'll talk about here in a minute, before the client comes in for services.

One of the items we'll cover is a financial policy. Billing for and on behalf of the client; billing that insurance is a courtesy to your clients, and regardless of whether they have insurance coverage or not, the financial responsibility and obligation for the services that you provide falls on your clients. So making sure that your clients know what your financial policies are, what your charges are is important. And during the time that the client is scheduling that appointment, it's important for you to discuss some of those financial policies.

In addition to that, some of the information you can collect from you clients when you identify that they have coverage is any co-pay amount. And that’s the amount that the client is responsible for paying at the time of service.

Let's move on to the next slide and talk about what happens once the client has checked in. And again, we are going with the scenario that the client has scheduled an appointment ahead of time and not the walk in. Some of these steps are bypassed if it's just a walk in. I want to interject this now, if you're not familiar with [00:06:00] HIPAA, you should become with it as soon as possible.

HIPAA stands for the Health Insurance Affordability and Accountability Act, which became effective in 1999, and they’ve got many different rules. One of the rules is a Privacy Rule of 2003, which regulates the use and disclosure of protected health information. Protected health information is information that has to do with your client's health status, their services that they are receiving and you as an agency are under this act.

You're required to protect your clients' information. So as you're considering the check-in process make sure that that area is secure, is private, and you can your staff can have conversations with the clients that cannot be heard by the rest of the patients that may be in the waiting room.

We talked about knowing the co-pay that the patient or your client is responsible for, the time of service so one of the things that we recommend as we've done assessments at other organizations like yours and other agencies, and Lou Ann mentioned you've been doing some work with that. One of the things that we recommend is that you have a credit card machine in that check-in area, [00:08:00] or at the front office, so that your front office staff can readily process any payments for those co-pays.

Also having a clear sign that outlines what payment methods you accept. Whether you accept checks or cash, or credit card, then what types of credit cards you accept, is also helpful. Make sure you have a centralized place where those payments are collected.

We talked about our practice management system earlier, or other methods that you may be keeping track of appointments, also consider utilizing those systems to keep track of the payments you've collected related to those appointments. So, if you have a practice management system, or some kind of a scheduling system, make sure you can notate and do so as soon as you collect that copayment against that appointment.

The slide we are on now, talks about a superbill, but I think we need to talk about what a superbill is. When you see a client, and you provide services, a superbill is the snapshot that covers all of the information related to that visit. It includes the clients' demographic information, their insurance coverage. It also should include the numeric representation of the services you provide.

So let me talk about that now. A CPT code is the numeric representation, or the numeric code for the services that you provide. So an office visit has a code assigned to it. An ICD-9 code is a diagnosis code [00:10:00]. So what that tells a commercial or a third party payer, an insurance company, is why the physical condition, the health condition, or the reason for you providing the services that you have provided.

So a CPT code is always related or associated to an ICD-9 code that is the diagnosis code. So, the superbill should be populated with the client's information. So to paint a picture, what you'll have is a notation on your practice management systems, for the sake of this example.

You have a practice management system with outlining your client's appointments. You'll have any co-pays associated to that visit in that practice management system with; just noting that you've collected co-pay, and then

you'll have a superbill that has that same information that will include the patient's demographic of course, the date of the appointment, and what services were provided to that patient.

Once that superbill is filled in, so your providers have notated what services they've provided, that information is then entered into best practice management system to send out to the insurance company in the form of a claim. And we'll talk about that, um, here in a few minutes.

It's important to note now that the term superbill and encounter form are used interchangeably throughout this webinar, and in the industry it takes the name of a charge slip [00:12:00].

A superbill is also a summary of the services that you provide. What it looks like is perhaps a one-page document with your most common procedures, your most common services, that is, that you provide to your clients. Along with the list of the diagnoses, the most common diagnoses that you may utilize to explain why the services are being rendered to your clients.

During the check in process, we've already talked about making sure that it's a private area where you can have conversations with your clients, about the services they're about to receive. We've talked about some of the administrative work of creating a superbill, to make sure you capture and notate what services have been provided.

Some of the other things that you need to make sure you gather, is a copy of that insurance card, the billing that needs to be sent, or the claim form that needs to be sent to the appropriate address, or the appropriate payer, and getting an copy of that insurance card will help ensure that that happens, as the back of most insurance cards indicate where these claims need to be sent.

Verifying demographic information, information that you may already have on file you certainly can verify against what the insurance company has on file. Obtain signed paperwork including your financial policies the registration forms that you may have your clients fill in; and, again, making sure that your clients understand their financial obligations for the services that they are receiving [00:14:00].

One of the things we talked about during the last webinar was whether as an agency you were considered in network or out-of-network for a specific client's insurance. If you were not a part of it, we talked about being a network means to

have a contract with your client's insurance, indicating that you have agreed to receive reimbursement a fixed reimbursement for the services that you provide to any of their members.

Being out-of-network simply means you don't have a contract, and it's important for you to remember that if you don't have a contract, some plans do not reimburse out-of-network providers. Other plans do reimburse out-of-network providers, or offer out-of-network benefits to their members.

If you are considered an out-of-network provider insurance companies oftentimes will not send you or your agency reimbursement directly, they'll send that reimbursement to their member, but you can avoid this by having your client sign an authorization form, assigning benefits to you. Meaning that the insurance can reimburse you directly, so as a part of that paperwork make sure that you have some language in your financial policies, or in your registration forms that include assignment of benefits in case you are an out-of-network provider and you would like to receive payment directly, rather than having the insurance company send it to the clients.

The next slide will take us into the check-out process, but before we start talking about the check-out process, let me just give a summary of what we've talked about thus far and then I'll briefly talk about what happens between check -in and check-out.

So, we've talked about taking on and assuming that your clients are scheduling ahead of time. You can gather the information when appointment is scheduled, information including their contact information, whether they are insured or not. You verify eligibility or benefits with that insurance, and whether you're in-network provider or out-of-network provider, so that you can then communicate to your clientswhat their benefits are, what their financial responsibilities are.

Once the client has arrived at the time of the appointment, must verify and check their demographic information and their insurance coverage, making sure that you have the appropriate information. Collect any copayment that may be due. Generating a superbill so that you can capture the services that you've provided and will provide that to the client.

And, of course, having the client sign any additional forms that may be necessary, including that assignment of benefits. Once that process is complete the clients then receive the services, and then we can start talking about the check-out process.

But before we do, I'd like to stop and see if there any questions. I think I went through these areas a little fast. So I just want to check and see if there are any questions regarding the appointment scheduling and the check-in process.

Morgan: If you have any questions feel free to send them in via the Chat, or once again, you can raise your hand. Right now we don't have any questions coming in.

Hilda: Great. So please don't hesitate to ask questions as we go, and I will stop and answer them as we are able to.

Let's start talking about the check-out process. It may not be logistically possible to provide a private section for the patient to check-out certainly it may not be logistically process or possible to provide secure or private sections for both the check-in and the check-out process. But if at all possible, it is ideal to provide that private area at check-out as well, so that you can discuss financial matters with your clients. So any additional balance, whether it's a deductible payment, or now that you know what services have been provided to the client, you can let them know if they have an additional balance, or may have an additional balance.

It's also important, if possible, to have uh another credit card machine at the check-out process. Now, oftentimes both check-in and check-out is the same area, in which case the credit card machine can be shared, but certainly for convenience and for ease of collections, having a credit card machine at that point is beneficial.

If your superbill includes your most common procedures, your most services, your most common diagnoses, it can also include your fees associated to those services. So once the client has received the services, and your clinician has filled out that superbill, or circled, or clearly marked what services have been provided, that's one way that you can communicate to your client what they will owe for that service [00:20:00].

Now if they are covered and you're going to bill the insurance company, you can let them know that that charge will be billed out to their insurance company and their insurance will process it.

Again, if you're in-network you will receive the contracted amount. If you are out-of network it really depends on whether your client has out-of network benefits or not. And again, this is a conversation that should take place with the client.

If there is an amount due that you're aware of, so a copayment or a previous balance from a previous visit, make sure you collect, if at all possible, before the client leaves. Also make sure that provide a copy of the superbill to the client whenever possible. This will, again, communicate to the client what balance might be due, what balance what charge you're going to send out to the insurance company, and also conserve as a receipt for any copayments that have been collected.

We've talked about using the practice management system to help you manage the appointment book, help you manage the copayments and capturing or recording what payments have been collected [00:22:00]. And we've also talked about superbills and how the superbill will help you capture what services have been offered. Practice management system can also help you capture those services, and actually is what can create that claim form for you to send out to an insurance company.

So, recording payments, recording charges, is something that a system, like practice management software can help you with.

Let's talk a little bit more about collections at the point of service. We understand that what we've been talking about here may be new, and certainly provides cultural changes. Collecting co-pays, for example, is not something that may be commonly done at your organization.

Yet, as you move forward and start contracting with insurance company, this is something that your organization is going to have to start doing. Relying on other grants may not be feasible anymore. In particular as the, Affordable Care Act takes effect and more, individuals have coverage; whether it be through the Medicaid expansion, or the marketplace, collecting co-pays is something that will need to become a common practice in your organization.

And failure to collect those co-pays at the time of service can be devastating and certainly provide a financial challenge. If you don't collect the co-pay at that point, it becomes increasingly more difficult, and oftentimes [00:24:00] unrealistic to collect it after the services have been provided.

I think I've mentioned this, but I'll mention it one more time. The co-payment is the out-of-pocket portion of the visit, or of the cost of the visit, that the insurance company has determined your client will be responsible for.

Morgan: We do have one quick question. Someone wanted to know, "If no preexisting contract with insurance, then no-contract violation, correct?"

Hilda: In terms of collecting the copayment?

Morgan: I imagine so.

Hilda: If there is no contract between the organization and the plan, then you're not obligated to collect that co-pay, that is correct. However, if the client has out-of-network benefits, and you intend to bill the insurance for out of network provider there will be a co-pay, oftentimes higher than it would be in-network for the client. And, again, failure to collect that co-pay at the time of service may lead to never collecting that co-pay.

Morgan: Thank you. And we have one other quick question from Alexander on the line, so I'm going to un-mute his phone right now.

Alexander: Thank you for the time. I have one question. So what I do, we are nonprofit organization, we provide service or prevention STIs, HIV testing. So in the doctor office they don't do the chart, so how we can do it, to obtain the contract with the company or the insurance, because the doctors, they refer to us to provide this service [00:26:00].

Hila: Let me ask a clarifying question, the physicians refer to you to provide the counseling, testing?

Alexander: Counseling … Yes, counseling, testing case manager for HIV clients. So why they do that, because you know we are a small organization, we established four years ago, but now we had to be looking about the matching for the credit card, for the insurance. How is the process for us, because we continue in this business, because the doctor office, they don't do that. So they refer to us, because they don't do the case manager also the clients with HIV.

Hilda: Sure. Have you contacted any of the insurance carriers in your area pursuing a contract? Letting them know exactly what services you do provide for their members?

Alexander: Okay, not yet, this is my homework now.

Hilda: Yeah. That would be the first step; to make sure you contact … and particularly if you have a lot of clients that are coming in and they have a given insurance

company and, let's say United, contacting United locally, and their website should direct you to the provider services. Contacting them and letting them know what services you provide will get you started on that contracting process.

Alexander: Okay. Thank you, for the information.

Morgan: Thanks, Alexander. If you could un-raise your hand, we'll know that your question has been answered. Then we have one other question that's been chatted in; Marty wants to know if it's standard to deny service if the client does not bring a co-pay [00:28:00].

Hilda: Is it standard to deny service if the patient does not bring a co-pay? It is not standard. That is an organization's financial policy, or an issue of the financial policy. You can decide to not treat, and some medical practices do this if you don't bring your co-pay at the time of service they won't see you. But it certainly isn't standard. That was really a strategic decision that needs to be made by each organization.

Morgan: Okay. He had a quick follow-up. Marty asks, "Will insurers generally reimburse at a lower level if the nurse practitioners or physician's assistants provide service, rather than a physician?"

Hilda: Each health plan is different as to how they handle contracting with different types of providers. Some health plans will actually only contract with a licensed profitability, and don't really have any type of contract provision in place, to contract with non-physician providers.

And so that's one of the things that when you're starting this process and you're learning about the insurance companies that are in your area, and in your market that you might want to contract with, it's very important to find out from each insurance plan what types of providers they will reimburse directly.

We do see health insurance plans that reimburse on a different fee schedule, for PAs and nurse practitioner … practitioners and non-physician providers in some cases. It varies greatly by health plan. So it's important, before you sign a contract with an insurance company, to find out what their requirements are as far as the providers that are covered under the plan, and who are allowed to be reimbursed, and make sure that you can meet those requirements [00:30:00], because we actually have worked with some agencies that contracted with health plans who did not have the licensed providers in place, on staff, and they couldn't paid.

So, the answer to that question is that it varies greatly by health plan, and it's important for you to become familiar with health plan's policies, as far as which types of providers can be reimbursed and at what the fee schedule is for each.

Morgan: The next question is, "If you are contracted with an insurance company, is it a violation not to collect copayments across the board? In other words, if a co-pay is not collected during the service, but an invoice is provided for the patient to mail payment; is that sufficient?"

Hilda: Yes. Actually, it is. It's ideal and, of course, it's preferable for you to collect the co-pay. Always collect the co-pay upfront, and usually when you sign a contract with a health plan, you are obligated to collect that co-pay from the patient upfront when the patient presents in your facility.

If, however, you're unable to collect that co-pay upfront, you certainly can go back, on the backend, and try to collect the payment, retrospectively, from the client. It is, as Hilda mentioned, often very difficult to collect those funds after the client visit, and in many cases you will be in breach of contract with the insurance company if you don't collect the co-pay upfront.

And you should be aware, that if you don't collect the co-pay, and you submit the claim to the insurance company, the insurance company is always going to subtract the amount of that co-pay from your payment. So that's a loss for your organization that you most likely will not be able to collect because the insurance company is not going to cover that dollar amount. It's the patient's responsibility.

Morgan: Thank you. We've had a few more questions come in, but we are going to move on right now for the sake of time [00:32:00]. We'll try to get to them at the end of the webinar, or we'll give you options on how to contact us and we'll get those questions answered.

Lou Ann: Thanks, Morgan. I'm going to move on to the next slide. This is Lou-Ann, and I'm going spend a little bit of time talking to you about tips for requesting payment form clients. Hilda has talked about collecting payment from client upfront at the time of the visit, as a co-pay, these next couple of slides will apply to collecting of co-pays, but also will apply to outstanding balances that your clients might have.

If you know upfront that the services that your client is receiving in your facility are not going to be covered by their insurance, whether they have Medicaid or private insurance, or if they don't have insurance at all, and you know that that

client is going to have an outstanding balance that's not going to be covered. We would encourage you to put a collection process in place, and start to transition into learning how to collect from your clients.

This can be a very difficult transition, and some of the things that we would suggest, and how you handle this, is at the time of the visit, when the patient is checking out, if you're attempting to collect a payment from them, ask them, very politely, how they would like to pay the amount due. Decide if you're going to accept credit cards or debit cards. If you're going to accept checks, if you're going accept cash only. And if you have some different options in place, provide those options to the client at this time and give them the option.

Ask them, "How would you like to pay your balance today?" Also keep it very personal, make sure you address the client by name that really help to make the process go smoothly, and has sort of a friendly tone to it.

But on the other hand, you'll want to be professional when you're asking your clients for cash, for funding. You don't want to try to use humor; because this can often be offensive to clients as this is a very sensitive issue. And one of the things that you might start to hear as you move into this realm of collecting payment from your client, maybe you've been known all these years, as a free clinic, and you've never collected from your clients [00:34:00].

You're going to hear things from your clients like, "Well, I've never had to pay before when I've come here, why do I have to pay now?" And so you want to be prepared to explain to them that because of healthcare reform, that your agency is now collecting insurance, and that you have to follow those guidelines, and that you're just like any other medical facility. The healthcare services that they're receiving are not free, and that they are responsible for paying their part.

So you want to be very professional and stay calm and polite, and in control. And inevitably there are going to be those occasions where things get a little bit stressful, and maybe your client might be irate or upset that you're asking them for money. The best thing to do in those situations, we would suggest is just to go and grab another colleague, and pass that client on to someone else. If necessary, just to change the tone and try to address the issue with someone with the client and see if that helps.

A couple of other things that you can keep in mind, if the client tells you, at the time of the visit that they don't have the money and they can't pay the amount

that's owed to you, get them to commit to a date that they will be able to pay the amount due.

Ask them, "Okay, so you can't this balance today, when can you pay the amount due?" And let them commit to a timeframe, 30 days, that they will pay you, and then you document that carefully, and make sure that you invoice accordingly.

Also, try not to go beyond 30 days. After 30 days, if you don't collect a payment, it makes it more and more difficult to collect as time goes by. You want to make sure that you document everything and follow-up accordingly with the client.

Without a firm commitment in this follow-up process, once the client walks out of your clinic, your chances of getting paid are actually reduced by 50 percent. And then after the 60-day mark, if you've invoiced the client and not received payment, your chances decrease drastically again [00:36:00].

Hilda: So the recap of what we've talked about, these three items on this slide are some of the most common missteps during this process. Not obtaining the client's current information including their insurance, their demographic, and even their coverage, what their insurance company will pay for, failure to collect previous balances, and also not collecting those copayments at the time of service.

These are some of the most challenging items to do consistently, but they are also some of the most important ones.

The next slide is a graph that will help you visualize the end-of-day reconciliation process, or charge capturing process. The superbill, those charge sheets that were filled out by the clinician, indicating what the services provided to client were, should be matched up to the schedule. So even if your client came in for a walk-in, those clients should be tracked on your appointment book, so that you can reconcile those superbills to the schedule.

Those, combined, will produce the end-of-day reports. Those reports should also include any payment collected for the services, or for the clients that came in for services on that day.

A deposit slip ought to be generated from that, and that should be linked. That deposit slip should match all of the cash, the checks, or credit card receipts that you may have. And of course, make sure you keep that cash and those checks in a secure location until they are deposited in to your bank [00:38:00].

We are going to move on and talk about the revenue cycle, management process after the visit, so we've talked about everything prior to the visit; the scheduling of the appointment, everything that happens during the visit. Now, let's talk about what happens after the visit. We are going to talk a little more about practice management system and the EMR system.

Lou Ann will cover some of the coding and documentation issues, and let's talk about claim submission and collections of claims and follow-up of claims. A practice management system, as I've mentioned before, helps generate that claim. Most claims are sent to payers electronically, although some insurance companies still accept claims that are faxed to them, or even mailed.

Sending a claim now includes the information that you've already gathered from a client, that is the insurance ID, their demographic information, and a list of those CPT and ICD-9 codes, and again, Lou Ann will talk more about that coding and documentation piece.

But a practice management system really helps automate some of those processes. Once you send that claim to an insurance company, you've billed an insurance company. I'll say it differently, once the insurance company has a certain period of time to process that claim and, again, if you have a contract you'll reimbursed for the amount that is outlined in your contract. If you don't have a contract you'll get reimburses out-of-net as an out-of-network provider if that client has have network services.

Oftentimes though, you have claims or visits that go without being paid for a period of time, in excess of 45 days [00:40:00], and for those claims that are outstanding you should try and collect on them or follow-up on a claim.

Oftentimes an insurance company will receive your charges, and something will be wrong. Some diagnoses won't be appropriate, or a CPT code will have an extra digit, or not enough digits, or something will go wrong, and they will deny that claim. They won't pay on it, and what you receive is an explanation of benefits or a payment notification with a zero pay, or no cash or no check attached to that.

And oftentimes a denial reason will be included in that explanation. Denial management is crucial for the revenue cycle management process, for making sure that you collect on all of those services. Anytime you receive a denial you want to respond and make any changes or modifications, or adjustments to those claims as soon as possible.

Denial reasons, like I said, could be as simple as a missing diagnosis code, incorrect client demographic information, or even as simple as coverage, so that the client's benefits did not cover those services.

Accounts receivable is like in other businesses, what is still outstanding, accounts, or claims, or visits that you're still expecting to reimbursement for. Accounts receivable is often divided into sections based on how long it's been since you've provided those services and you've been paid. Accounts receivable is often referred to as an aging as well [00:42:00].

But let's move on to the next slide and talk a little bit about practice management softwares and the technology, but we do have a poll before we start talking about that, and I'll pass it back to Morgan.

Morgan: Yeah, thank you. Before we get to the poll, we just had a couple of questions that came in, and since we are transitioning to a new topic it we are going to ask the questions now.

Linda asks, "If your provider is contracted with insurance but he's not on site when services are rendered, can we bill for the nurse who provided the service?"

Hilda: Um, that does depend on your service, and it also depends on the type of contract that you have with the insurance. We talked about the contracts where they are grouped based on an entity, so the contract is with the organization, and all of the providers are covered or listed on the contract. So it really depends on the services that are provided, whether a nurse is qualified to provide those services, or not, and also what type of contract you have with that insurance company.

Morgan: Okay. We have one other question come in. It is, "Will most insurers agree to suppress EOBs to patients? I'm concerned about the protection of confidentiality for minors, covered by parents' insurance for STDs?"

Yvonne: That's a great question. And currently across the country we really don't have a solution to this issue [00:44:00]. A couple of things you can negotiate with an insurance company when you're contracted with them, or even after you've already contracted them to talk to them about suppressing EOBs for your clients. Some insurance companies will agree to suppress the EOBs, especially for minors, however suppressing the EOB and stopping the insurance company from actually mailing an EOB to the client's address, doesn't really solve the confidentiality issue.

If the client is a minor, and is covered under their parents' insurance policy, or even if the client is an adult and is under a spouse or another family member's insurance policy, whoever is the holder of that insurance policy, or the beneficiary that's covered, usually have access to claims information. So even if the EOB is suppressed that individual that holds that policy, that policyholder can usually log on to the insurance company's website, or contact the insurance company. And they can get comprehensive information about any claims that have been filed under their plan.

So, unfortunately, at this point in time, we really don't have a viable solution for confidentiality for insured clients. So, the most important thing here is to make sure that you are addressing this issue with all of your clients when you see them, and ask them proactively if they need to request confidential services or not. And technically if they do need to request confidential services, you have to make that decision, most likely you probably don't want to file their insurance, because at this point we can't really guarantee that their confidentiality will be protected.

Morgan: All right, thank you. All right, now we are going to move on to the poll.

As we are waiting for the poll to come up, I'll just go ahead and read the question and answers, and then you'll have a minute or so to put in your answers. So it's asking, "What types of technology does your agency have in place currently? Paper-tracking system, electronic computerized scheduling software, practice management system, electronic medical record, or other type of system?"

Yvonne: Thank you, everybody, for participating in the poll. It looks like 11 percent of you currently have an electronic medical record in place, so that's great, because I think that really helps makes the process of transitioning to billing an easier process.

Then it looks like we have 8 percent that have a practice management system. Then 6 percent have an electronic computerized scheduling system. And then, the remainder is using a paper-tracking system. [00:50:00].

So now we are going transition over to really talking about technology implementation and how it can assist you as you work for possibly implementing a billing, um, and reimbursement system. So we'll hand it over to you, Hilda, to kind of start talking about technology implementation.

Lou Ann: All right. Thank you, Yvonne, and Morgan. This is Lou Ann, actually. I'm going to take it from here.

So, for medical practices of all types, transitioning to new technology can be a really daunting task, especially if you have an incorporated technology into your practice before. However, in today's environment, it's really imperative to become automated in response to the healthcare industries' development. Like the Medicare and Medicaid Electronic Health Record Incentive Program, the Meaningful Use Program, and ongoing transitions to ICD-10 and the 5010 version of HIPAA, electronic standard transactions.

And this all might sound a little bit foreign to you, but it's important to understand what your agency's needs are, and the many options that are available. So we are just going to talk basically about the differences between practice management systems and electronic health record, or electronic medical record systems, the practice management system, is the business side of the technology [00:52:00].

That's basically the non-clinical components of the technology that help you with your scheduling your billing, collecting patient information, the demographics; it checks all of those things for you. And you can certainly purchase the practice management system itself, at a minimum, to help you get your practice automated and get things rolling. You can collect enough information through a basic practice management system to be able to bill insurance and track your collections.

The electronic medical records is the more comprehensive version of the technology which usually includes the practice management system module, then also includes the clinical component, which is where you have your electronic medical record, and all of your clinical documentation about the patient. You can document what happened during the patient's visit. You usually have your code, your ICD-9 and CPT codes are attached, and that’s where you start to move away from paper to a fully automated system with an electronic health record system.

There are lots of different types of systems out there, a lot of vendors, a lot of variations in pricing. And so, if you're moving in this direction you definitely want to do your homework, and do some research to learn about what's available in the market.

And now we are going to talk a little bit about coding and documentation. We are not going to spend a lot of time during today's webinar, on coding, as the purpose of this webinar is not to provide extensive coding training, but it's important for us to cover the basics of medical coding, because medical coding is the core, um, basis upon which you're going to be paid by insurance companies.

Coding is the transformation of the services you provide, the diagnoses and the supplies, um, that are provided to your clients into alphanumeric codes. There are basically three primary code sets.

CPT codes report the medical services and procedures that will provide it to the patient. Such as, diagnostic, radiology, laboratory, surgery, many others. CPT codes identify the type of visit [00:54:00], or the encounter that the patient had when they were visiting your clinic. So it could an office visit, whether or not it was an emergency department visit, a surgical procedure. CPT codes basically describe what you did.

ICD-9 codes identify the particular diagnosis. So, ICD-9 codes basically describe why you did it. These codes describe the disease or condition. Now, in the United States, we currently use the ninth revision of ICD-9, um, but in many countries, ICD-10 is already in place. The United States will transition to ICD-10 on October 1st, 2014. So we have less than a year to transition to ICD-10.

The CPT Manual is published by the American Medical Association, while the ICD-9 book is published by the World Health Organization. However, both manuals may be purchased directly from the American Medical Association's website.

When you are coding a patient visit, the ICD-9 code must match the CPT codes. In other words, the diagnosis for the patient must justify the procedure or the services that you provide. More than one ICD-9 code may be listed per CPT code. The CPT code, again, identifies the type of visit or encounter.

Yvonne mentioned HCPCS codes earlier. These are a subset of CPT codes, that basically were created by the Centers for Medicare and Medicaid Services many years ago, and we'll talk a little bit more about the HCPCS codes later.

So, we'll talk a little bit about ICD-10 briefly. Why are we changing to ICD-10? We talked about, a few minutes ago, how ICD-10 is being used internationally at this point. Change can be really difficult and the transition to ICD-10 will certainly be

challenging or payers and for providers [00:56:00]. However, there are definitely some benefits and improvements with ICD-10.

ICD-9 is 30 years old, and is based on medical knowledge from the late 1970s. Think about how much our healthcare environment has changed since then. ICD-9 consists of some outdated and obsolete terminology, and is really inconsistent with current medical practices. ICD-9 also hampers our ability to compare costs and outcomes for different medical technologies, and really can't support the U.S. as we transition into an interoperable health data exchange.

ICD-10 which is much more detailed, and there are a lot more codes involved with ICD-10, it helps you to describe better what services you provided. It significantly allows providers to better describe the care through the coding process. It allows us to better be able to collect data, measure outcomes. It helps us to process claims more accurately, make clinical decisions. Actually helps track public health outcomes. Identify fraud and abuse, and also helps with conducting research.

A little bit about coding and documentation basics. If it isn't documented in the medical record, whether your medical record is a chart on paper, or whether your medical record is electronic, in an electronic medical record system, if it isn't documented it didn’t happen; which means, that you need to be really careful, and make sure that your providers are thoroughly documenting the services that were provided to the patients that you see. Your documentation must be clear, concise and substantiate medical necessity for the procedures that you're providing, or procedures and services that you're providing to your clients.

Coding or services not provided is fraud. Keep this in mind. If you code for something that you actually didn’t do, that’s considered fraud. The medical record actually provides documentation of the assessments, the decision-making, and the general management of the patient [00:58:00]. You will want to make sure that your medical records are accurate and concise.

Now we have another poll for you to participate in.

Yvonne: While we are waiting for that poll to come up I'll read the questions and answers. "So, does your organization currently code services that you provide? Yes. No. Not sure and not applicable."

Yvonne: Thank you, everybody. It looks like about 50 percent of you who answered the question, do currently code for your services. So that's great. And then it looks like we have about 17 percent who have not started coding for services, and 11 percent indicating that it is not applicable to their organization to code for services.

So, thank you for participating; that gives us a nice sense of where people are as we move forward with the rest of the information.

Yvonne: And I'll pass this back to you, Lou Ann and Hilda.

Lou Ann: All right. Thank you, Yvonne and Morgan. So it's great to hear so many of you already implement coding practices, and for those of you haven't, even if you're not sending in claims to insurance right now, you want to make sure that you learn how to code for the services that you provide. Because even if you're not submitting insurance, coding for services is the accepted way to document the services that you're providing to your clients.

We are going to talk a little bit about billing and claims submissions. Claims are submitted on the CMS 1500 form. Most payers actually require electronic claim submission today [01:02:00]. This means that the 1500 form is transmitted electronically via a HIPAA compliant, secure, encrypted data submission.

Hilda talked about HIPAA a little bit earlier, the Health Insurance Affordability and Accountability Act. HIPAA was actually initially created to protect this type of information submitted by electronic claims. Faxing a claim form from your office to an insurance company is not electronic claim submission.

Your clinics should have an appropriate mechanism in place to complete claim forms electronically. Manually completing a claim form on paper is not really cost-effective, and is really not an efficient use of your personnel time. There are so many solutions to this, there are a myriad of systems and software programs available to enable any size of clinic today, to implement electronic claims submission, and many of these are available at a reasonable cost.

Most facilities would greatly benefit also from using a clearinghouse for the claim submission process. Most electronic medical record vendors require the use of a preferred clearinghouse, but there are many effective, reputable clearinghouses out there on the market, and we'll talk a little bit about what that means.

This slide shows you what the 1500 claim form looks like. Those of you who are coding and billing, you certainly are familiar with this form. Those of you who haven't seen this before, you'll want to start to get familiar with this. This is the CMS 1500 claim form, this is the universal claim form used by all payers, including Medicare and Medicaid.

The claims clearinghouse is a great resource for you. Claims clearinghouses were actually created years ago by the health insurance companies across the country to try to make things, um, more streamlined when it comes to claims submission, rather than receiving individual claims from individual providers, and receiving thousands and thousands of pieces of data daily, the large health insurance companies in the United States, created claims clearinghouse, sort of [01:04:00], as a liaison between the providers and the insurance companies.

Claims clearinghouses standardize your claim information and submits that information, on your behalf, to payers. Claims clearinghouses help to prevent errors and allow you to catch and correct errors within minutes, rather it taking days or weeks for you to go back and forth with the insurance company to get those things corrected.

Fewer of your claims will be delayed or rejected if you use the clearinghouse. The clearinghouse basically scrubs your claim and cleans them, making sure that your Ts are crossed and your I's are dotted before the claims go to the payer. They reduce your reimbursement time to about 10 days or less form getting payment from the payers, and they submit your electronic claims in a batch, all at once, rather than having you submit each claim separately to each individual payer.

The clearinghouse provides a single location to manage all of your claims. It's highly recommended that any healthcare facility that's submitting claims to payers, to consider using a clearinghouse.

Regardless how your claims are submitted, whether it's through the clearinghouse, or electronically in-house in your clinic, or even if you're still using paper claims, it is imperative that you follow up with payers to obtain claim status. Once you confirm that the claim has been received by the insurance company, you actually don't have to sit and wait, and be patient, and be at the mercy of the payer, you can actually be proactive and make sure that you get paid in a timely manner.

You can, and should do this. You should be proactive. So depending on your billing method, you should actually expect to receive payment from insurance company within 10 to 15 days. For those claims that are not paid within this timeframe, you should implement a process for claims follow-up. This is also known as working a claim. That's a common term in billing.

The most common reasons that claims may be delayed would be that, one, the claim was never received [01:06:00]. This mainly happens if you're still using paper claims, they seem to mysteriously get lost by the insurance companies. This is another reason that you'll want to get up and running with sending electronic claims. It's easier to track.

If the claim hasn't been followed up in a timely manner by your staff, it could be a month or longer before you even realize that the payer hasn't received your claim. For paper claims, you want to allow at least 10 business days before you contact the payer, to follow up and confirm that the claims have been received.

For electronic claims, if you use a clearinghouse, you will receive confirmation quickly that that claim was received by the payer. If you've filed a claim yourself, from your own clinic, you should call within five business days to confirm with the insurance company. The sooner you find out if your claim has not been received, the sooner you can resubmit it, and the sooner you'll be paid.

The second most common reason for delay is that the claim has been denied. If you find out that the insurance company has denied your claim, you need to correct the issue if it's correctable and resubmit that claim as soon as possible.

And then finally, sometimes a claim will be pending for additional information. Maybe, um, some information was missing. The insurance company might go directly to the covered individual, or the member to request that information. Or, they might come back to you, as the provider, to get the information that's missing. No matter what, you'll want to make sure that you're following up, that you know what the issue is, and that you're helping to make sure that this process takes place as expediently as possible, even if you have to contact your client or patient, to get their cooperation.

When claims are denied and the issue is not something that you can correct in order to resubmit the claim, you might want to consider appealing the claim denial. However, it's really important that you determine whether or not it's worth the time and effort to file an appeal [01:08:00].

How this works, is you review the denial reasons why the payer denied your claim, and then you might make an attempt to appeal it. A common reason for denial is that insurance companies will come back and say that there was no prior authorization received for the services that you provide.

Maybe that authorization actually was received but it just wasn't documented correctly. The insurance company never received the appropriate documentation to show that the authorization was received. You can easily resolve that with the insurance company by just providing that documentation, and then they'll have a record of it, and the claim can be paid.

Remember to file appeals quickly. You should submit an appeal within seven days of receiving a denial notice. The longer you take to resolve a denial, the lower your chances of getting approval of the appeal. You want to ask your client, and as mentioned on the last slide, for assistance. If there's something that the patient needs to help provide, to get this, um, claim paid, and to get this appeal processed, don't hesitate to contact that client and get their help.

They might even be willing to call the insurance company on your behalf to pursue the appeal, because this means, in many cases, less out-of-pocket costs for that. And you want to go back and look at the terms of your contract with the payer, some denials might be against the conditions of your contract. If so, then this can be useful in helping you to appeal the insurance company's vision.

And then finally, that first bullet point at the top of that slide; set a minimum dollar amount. Some providers might choose to only appeal claim denials if the amount is higher than a certain figure. Say, higher than $100 you might want to file an appeal. If the amount is less than $99.99, you may want to write that off, without taking the time to go through the appeal process.

Morgan: We have a couple quick questions come up, if that's okay [01:10:00].

Lou Ann: Sure.

Morgan: Marty wants to know about retroactive billing, "How far back can they do this, and also, how long do prior authorizations usually take?"

Hilda: Retroactive billing … and this is Hilda. Thank you for the question. Retroactive billing depends on what the insurance company outlines in their contract. Some insurance companies allow, say, 90 days to submit a claim, and that's referred to as timely filing, you have 90 days to submit a claim. If you do it at the 91st day,

it's out of timely filing, and they won't process the claim, or pay for it. They are the payers that have up to 365 days to submit a claim. So that really depends on the plan. With regard to a preauthorization, is the question, how long it takes to obtain preauthorization, how long is it good until?

Maybe I can answer both. If the question is how long it takes, most companies have online systems that will allow you to request preauthorization through their website, and it's secure, and that could take us as little as 15 minutes. Other companies required a telephone call which could take at least 30 minutes to get through and get that preauthorization.

How long it's good for? They typically ask for the date of service during the preauthorization process, so it will be good for that date of service, and you can provide a range of date of services. So you could say, sometime in the week of, say, January 1st.

Lou Ann: And I think with both parts of that question, it's very important to review the insurance company's policies and procedures in the contract and billing manual that you'll receive from the insurance company, very carefully [01:12:00], because your want to be familiar with all the payers you're working with. What their timely filing deadlines are and what their requirements are for prior authorization, because they all vary greatly.

Morgan: Excellent. You just had one quick follow up. "Do they retroactively approve preauthorization?"

Lou Ann: Unfortunately the answer is that it depends on the insurance company. Some insurance companies allow for that, and others do not. And it really depends on their contract and their billing manual will be very clear about what they allow and do not.

Morgan: All right. Thank you. That's all the questions for now. We'll keep moving on for the sake of time.

Lou Ann: Okay. Thanks Morgan. So accounts receivable, what is accounts receivable? You've probably heard the term AR before, that's sort of the short term for accounts receivable. This actually means the money that is owed to your clinic. In general, account aging can be broken down as demonstrated on this slide. So these are different buckets, if you will, for accounts receivable.

You'll have your zero to 30 days, that's your newest bucket of account aging, and then the next level or bucket is 31 to 60 days. This is the component of accounts receivable that you have the greater chance of receiving payment for. These are your newest claims; this is the timeframe that you really want to be paying attention to those claims, working those claims, making sure that you're receiving payment.

Sixty-one to 90 days claims that remain unpaid within this period, actually also have a very percentage of a chance of getting paid. They should be your number one priority, because they are at the point where they're at the risk of becoming uncollectible, so this is a critical time for your billing staff, to make sure that unbilled claims are being filed or resubmitted if necessary, in order to meet your timely filing deadlines [01:14:00].

And then over 90 days, Hilda talked about this a little bit when she answered the question about timely filing. Once claims have remained unpaid for over 90 days, you're chances of collecting payment decrease dramatically.

So, if the claim has been identified as uncollectible, it should be written off to prevent valuable time from being spent to collect those claims. Sometimes you'll go into a clinic or an agency that has claims that are outstanding over 120 days, and they'll be spending a lot of time and energy in trying to collect those dollars, and sometimes it's really, actually, more financially-effective just to write those off.

Collecting from clients and some community-based organizations might not have experience with invoicing clients to collect unpaid balances. It's a common practice for others in particular those of you that provide a wide range of services, in addition to HIV prevention and testing, you might be accustomed to processing collections.

You want to keep in mind that the collections process applies to clients with outstanding balances after payment has been in process and received from the insurance company, and after you have already determined the client's income level, if you use the sliding fee scale, and they've applied that amount to the sliding fee scale.

So this is the outstanding balance that's left after insurance has paid what's it's going to pay, and after you've adopted the practice of sliding the amount on the sliding scale, and offering any discount that the client is eligible for.

So you can engage in monthly billing, which means you send a statement out to all of your clients, at the same time every month, or you can also engage in cycle-billing which means that you send a group of statements out, every few days or weekly.

You can generate statements automatically, electronically from your practice management system, if you have a practice management system, or you can actually outsource the patient statement process to a billing company [01:16:00].

Something that's common in the medical field is the one, two, three strikes, you're out practice. This means that you send out three statements over a 90-day period, one a month, and if payment is not received after the third statement then the account is written off, or turned over to collection agency if that's what you choose to do.

You want to make sure, if you are implementing the collections process, that you're following debt collection laws, and that you're observing professional guidelines in your state.

We have covered a lot of information during this webinar, and we do hope that it has been helpful. So let me highlight some things that are important, and we'd like for you to keep in mind, changing your agency's financial policies to constantly obtain insurance information, file claims with an insurance, or send bills out to an insurance, require copayment at the time of the visit, collecting balances due from previous visits or current visits, is a lot of change. It's a cultural change and it's a lot of work.

So, be sure that as you make these changes, and as you update your financial policies, you communicate clearly your new expectations or your new financial policies to your client. So some examples or some tips would be start displaying in the prominent location in your waiting room, or in your organization, this new financial policy, or simple statements, like your copayment is due at the time of service.

Sending a letter out to your clients, with the new financial policy, handing that financial policy out before you give it an effective date, is also an effective way to communicate that information [01:18:00].

If you have a website, you can post that financial policy on your website. If you send regular newsletters or announcements, make sure to include a copy of any changes, whether you're making incremental changes or changing all at once.

And again, at check-in and at check-out, that's another opportunity to communicate those changes. Make sure your staff is well informed, you have all of their own questions answered about these new policies, and just communicate as clearly as you can to your clients.

So we are going to go ahead and open it now for some additional questions for the remainder of our time together.

Morgan: Okay. Right now we don't have any questions at the moment, but if you do either chat them to me, or to raise your hand, and we'll we will get to them.

Yvonne: Thank you, everybody. It may turn out, after careful consideration, some CBOs and STD clinics may decide it really isn't viable to move forward with establish third party billings, and that's okay. That's really what we were wanting this two-part webinar series to really help you think through and really do an assessment of your organization [01:20:00], and see if, you know, changing to this more business-centric model would work for your philosophy.

So, we hope that we've imparted some questions and tools that will help you through sorting through this, and throughout December and January, you can continue to submit questions to the site that's listed on the slide; which is: http://cba.jst.com/events and click on Transitioning to Billing Webinar Q&A. We've recorded both of the webinars and we'll be posting those to both the CBA site as well as the SHRPTTAC site.

For those of you on the line that are with the STD programs, and then you can go to the CBA site if you're an HIV community-based organization.

And then, Morgan has just sent out a link to the evaluations. And we'll also follow-up with an e-mail that has the evaluation in it as well, and we really would like your feedback to know how we can improve this in the event that we provide this information to future audiences or as we plan additional webinars to help with the transition towards billing.

And as the very last slide, there's a list of resources that you might find helpful for helping you continue to look at the feasibility of moving to billing. And I'm just going to stop for a moment and see if there's anyone that has any last,

[01:22:00] lingering questions before we sign-off of the webinar, or have any observations that they would like to share.

Morgan: No questions at the moment. But keep in mind those links that are posted right there. They are also going to be in the slides that will be sent out.

We did have one question. Jessica wants to know, "As an out-of-network provider, should we all be collecting co-pays in providing USPSFT-approved rated services?"

Yvonne: You know, that is a great question and we actually have to get back with an answer, I think I need to research that; in general, you should be collecting co-pays specific to the services, let us do research and get back.

Morgan: All right. At this moment there are no other questions, but like we said there are ways to contact us. I want to just thank everyone for participating in the webinar.

Yvonne: Thank you all for taking some time to be on the webinar with us. Hopefully it was helpful and we'll look forward to sending you all the materials, and having future webinars around this topic to help you move through this transition. Thank you.