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BUILDING HEALTHY PRACTICES

Immunization Billing Project
Webinar Session – IV

Contracting and Revenue Cycle Billing Management

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IN ASSOCIATION WITH
Maryland Partnership for Prevention
AND THE
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Course Objectives

Contracting and Credentialing:

- Understand the importance of payer contracting and credentialing.

Billing – Technical Set-up:

- Understand why it is essential to have an efficient practice management system (PM system).
- Understand the key features that should be available in your PM system and through your clearinghouse.
- Understand the necessary components of a practice management set-up, requirements of systems monitoring and updating for successful billing and reimbursement of services.

Revenue Cycle Billing Management:

- Appreciate the importance of the front-end contributions to the success of the billing process.
- Appreciate how claims submission occurs, how insurance claims are tracked and how payments are posted.
- Understand how to identify and address improperly processed claims.
- Appreciate how to process, track and collect patient accounts receivables.
- Identify and understand key terms and nomenclature associated with insurance and billing processes.

Presentation Outline

Section I

- **Payer Contracting and Credentialing**

Section II

- **Infrastructure for Medical Billing**
  - Technical Set-up
  - Practice Management System Set-up
  - Clearinghouse

Section III

- **Revenue Cycle Billing Management**
  - Front-end processes
    - Registration, data collection, insurance verification, payment collection and reconciliation
  - Clinic processes
    - Documentation, coding, charge capture
  - Billing office processes:
    - Claims, denials, payments

Section I
Contracting

Payer Contracting

All health plan contracts must be approved by the Office of the Attorney General ("OAG"), the Secretary of the Department of Health and Mental Hygiene, and the governing body of the county in which the health department is located.

MCO contracts require additional approvals.

The AG's Office is working with Health Officers and DHMH to develop approval procedures.

The AG's Office is also working with Health Officers and DHMH to negotiate contracts with several health plans.

Payer Contracting: Commercial Plan Progress

- The AG's Office is in the process of discussing contracts with United, CareFirst, Cigna, and Aetna.
- A contract with United should be in place within the next couple of months.
- Legal terms of a contract with CareFirst have been finalized, and CareFirst will be reaching out to each LHD with contracting materials.

Payer Contracting: MCO Progress

- Legal Addenda for contracts with MCOs are complete.
- DHMH regulations and MCO provider manuals require LHDs to have certain written procedures in place before they can contract as MCO service providers.
- The AG's Office is drafting policies and procedures for review by the Health Officers and DHMH.

Payer Contracting: Credentialing

Most health plans are requiring the LHDs credential providers individually (rather than credentialing the entire LHD as a whole).

Providers should be in the process of completing their CAQH applications in order to be credentialed with United.

CareFirst will use the same CAQH application when it begins credentialing.

Payer Contracting: Credentialing with United

In July, each LHD was asked to submitted a completed Data Collection Form to United. The form included information regarding the LHD, each provider that was to be credentialed, and central contact information for the LHD.

United issued CAQH numbers for each provider whose information was submitted on the data collection form.

Providers should be using those numbers to sign in to the CAQH website and complete their credentialing application.

Several health departments reporting not receiving the CAQH numbers, and the OAG and United are in the process of redistributing them.

United, the OAG, and two HO representatives are meeting bi-weekly to monitor the status of credentialing and address and problems that arise.

Payer Contracting: What you need to know

- **Information regarding health plan procedures and policies can be found in the plans' provider manuals, and those manuals must be reviewed by pertinent LHD staff.**

- **It is very important to comply with the procedures outlined in the provider manuals. If proper procedures for claim submission are not followed, claims will likely be denied, and the LHD will be prohibited from charging the patient.**

- **United will provide some training materials and webinars during contract implementation.**

Payer Contracting: What you need to know

Each LHD should have a central contact for contracting issues. Those contacts were identified on a data collection form that was submitted to United and the OAG. Information is also being provided to Health Officers.

If you have questions, you can contact Claire Pierson of the OAG at claire.pierson@maryland.gov or 410-767-6526, or you can reach out to the central point of contact in your LHD.

Payer Contracting: Specific Questions

- **If an LHD is in network, can the LHD see patients that have plan restrictions that require them to see their PCP for all services or be referred to an in-network specialist?**
  - The answer to this question depends on the specific contract or provider manual at issue. Generally, it appears that LHDs will be required to refer to in-network specialists and to adhere to any PCP referral requirements of the plan.

- **Will there be the 24/7 call coverage requirement with the MCOs if contracted?**
  - Possibly. The answer to this question depends upon the specific contract or provider manual at issue.

Health Plan Reimbursement and Charge Setting Regulations

- Charges for LHD services are set pursuant to Title 16 of the Health-General Article of the Maryland Code and COMAR 10.02.01.
- DHMH and the LHDs are looking at a number of changes to the charge setting regulations. Those changes include altering the method for setting costs and clarification of the application of the sliding fee scale.
- Health plan reimbursement rates are set by contract and will likely be different than the charges that are set by regulation. Additionally, reimbursement may be reduced further to account for a member's co-pay or deductible.
- Until further guidance is issued, you should generally continue to apply the sliding fee scales in the manner that you have in the past.

Vaccine Purchasing:
Anti-Trust Issues and Private Purchase Vaccine

- **In some cases, LHDs may be prohibited by anti-trust law from reselling (i.e. submitting claims or charging) vaccine that was given to the LHD or purchased at a lower price by the LHD because of the LHD's status as a government entity.**
- **In those cases, LHDs will need to purchase private vaccine for resale.**
- **There may be exceptions to this prohibition, and whether or not it applies to your LHD depends upon the circumstances of your LHD.**
- **If you do not purchase private vaccine but wish to submit claims for the vaccines that you administer, please contact Claire Pierson at the OAG.**

Section II
Infrastructure for Medical Billing

- Addresses the technical functions required to generate and transmit claims for services to payers or statements to patients.

Technical Infrastructure Set-up Includes

- **Operational Functions and Modifications**
  - Data Collection and Verification
    - Front Office
  - Clinic Flow and Documentation
    - Clinical Staff
  - Billing Claim Processing, Denial Management
    - Billing Staff
- **Reporting**
- **Monitoring**

Practice Management System

- **Practice Management System set-up**
  - Payer files
  - Payer ID numbers
  - Provider NPI numbers
  - Organizational NPI number(s) for each location
  - 9 digit zip codes for each service and payment location
  - Maintain, verify and update codes
    - CPT
    - ICD 9
    - Denial codes
  - NDC numbers
  - Monitor and update data

Clearinghouse

- **Electronic Claims** - Processes and transmits electronic claims to insurance carriers and are maintained in one central place.
- **Electronic Eligibility Verification** - Verify insurance eligibility, provide benefit information before services are rendered.
- **Electronic Remittance (ERA)** - Automatically updates patient accounting.
- **Claim Status Reports** - Know the status of a claim at all times.
- **Rejection Analysis** - Have error codes displayed in plain English.
- **Online Access** - Edit and correct claims 24/7 online.

Clearinghouse

- **Printed Claims** - When necessary, have medical claims automatically dropped to paper but still be able to track them electronically.
- **Patient Statement Services** - Have your patient statements put on 'autopilot' at less cost than you can mail them out yourself.
- **Affordability** - When you take into consideration the cost of purchasing forms, printing, envelopes, and postage; a clearinghouse ends up costing about the same as processing paper statements, except you have many added benefits.

Interactive dashboards enable you to drill down, search and see claim details

Section III

Revenue Cycle Management

- Links all sequential billing processes and involved personnel to provide for optimal income generation.
- Incorporates critical elements including accurate data and ongoing communication between providers and billing-related staff.

Elements of Revenue Cycle Management

- **Revenue Cycle Management includes the following elements for the overall control of personnel and processes, generation of accurate data and optimal revenue generation:**
  - Front-end Operations
  - Documentation of Services
  - Coding
  - Charge Capture and Charge Entry
  - Claims Generation and Transmission
  - Payment and Denial Processing/Monitoring
  - Accounts Receivable Management and Key Indicator Reporting
  - The Auditing Process
  - Third Party Contracting

Front-end Operations

- **Provide staff with the training and tools include:**
  - Knowledge of insurance.
  - Obtaining accurate patient and insurance information and collecting balances due.
  - Verifying patient information for completeness and accuracy.
  - Monitoring the accuracy of the front-end data entry process.

Documentation of Services

The basic principles for documentation of services provided are:

- If it is not documented, **it did not happen**.
- If it cannot be understood, **it did not happen**.
- If it cannot be read, **it did not happen**.
- If it did not happen, **it should not have been paid**.
- If it was paid, **the money should be paid back.**

BILLING OFFICE- Charge Capture

Charge Capture

- Import codes from EHR
- Design and update super-bills that prompt accurate charge capture.

Verify the accuracy and validity of codes

Connect payable diagnosis codes to procedure codes

Audit completed super-bills and or imported codes

Charge Reconciliation

Provide continuing education and ongoing feedback to providers regarding coding accuracy and patterns

Charge Capture

Steps to strengthen the charge capture process:

- Follow the path of an encounter to identify all billable clinical services provided.
- Shadow providers to identify actual services rendered.
- Identify correct and accurate codes for services.
- Ensure that all services are billed correctly (coding and modifier rules).

Charge Reconciliation

- Use visit tracking reports to identify no-shows, missed charges.
- Reconcile posted charges to source documents, e.g., encounter forms (superbills).
- Reconcile encounters to patient sign-in sheets.
- Reconcile service volumes to external resources, e.g., lab logs.
- Reconcile to inventory control for injectables and other billable supplies.
- Post charges within 24 hours of service.

BILLING OFFICE - Claims Submission

Strategies for optimal and accurate claims processing:

- Contract with a reputable clearinghouse.
- File claims electronically.
- File claims in a timely manner at least twice weekly.
- Look for value-added functionality in the PM system:
  - Claim scrubbing
  - Denial management
  - AR monitoring
- Preview claim reports prior to submitting claims.
- Correct errors prior to submission.
- Reconcile submission reports to acceptance reports.
- Review and correction of clearinghouse denials immediately.
- Review and correct payer denials immediately and resubmit claims.

BILLING OFFICE - Payment Posting

Payment Posting:

- Payer Payments
- Patient Payments

Payment Reconciliation:

- PM system report
- EOB's
- ERA's
- Bank

BILLING OFFICE - Payment Processing and Monitoring

- Enroll in electronic fund transfers (EFT) and electronic remittance advice (ERA).
- Use software to report payment variance from contracted rates to verify that accurate payments are received.
- Reconcile all payments to source documents, e.g., EOBs, super-bills or patient receipts.
- Ensure that the fee structure is above contracted rate.
- Train staff to monitor contractual amounts and bundling edits.

Denial Management

- **Strategies for monitoring and reducing payment denials include:**
  - Monitoring specific reasons for claim denials to identify trends.
  - Analyzing reports indicating frequency of "Remark" codes.
  - Tracking and categorizing denials by payer and provider.
  - Monitor claim denials to identify trends.
  - Correct the root problems for the denials and rejections.
  - Follow-up on denials within 24 hours.
  - Develop appeal letter templates.
  - Educate staff on payer-specific policies.

Denial Management

Most common reasons for denials:

- Demographic errors
- Lack of "medical necessity"
- Delays in timely filing
- Lack of pre-authorization
- Duplication of claims
- Additional information required
- Coding errors

Denial Management

To help reduce the incidence of denials, staff should have:

- Current CPT and ICD-9 coding books
- Administrative payer manuals.
- Program manuals and policies.
- Newsletters and Provider bulletins.
- Payer fee schedules and claim management tools.
- Communication/relationships with payer Provider Representatives

Accounts Receivable Management

- **Steps to help effectively manage Accounts Receivables:**
- Develop a Key Indicator dashboard to monitor the financial health of your revenue cycle.

- **Track monthly and regularly monitor key statistics, including:**
  - Charges and payments
  - Days in Accounts Receivable
  - A/R Aging - Current, 31-60 days, 61-90 days, 91-120, Over 120
  - Collection ratios and Aging by payer
  - Denials

Accounts Receivable Management

To strengthen the Accounts Receivable Management process:

- Implement a written Self-pay Financial policy, including payment plans and monitoring.
- Implement written procedures for tracking and working outstanding insurance claims.
- Build relationships with third party Provider Representatives for outreach and education.

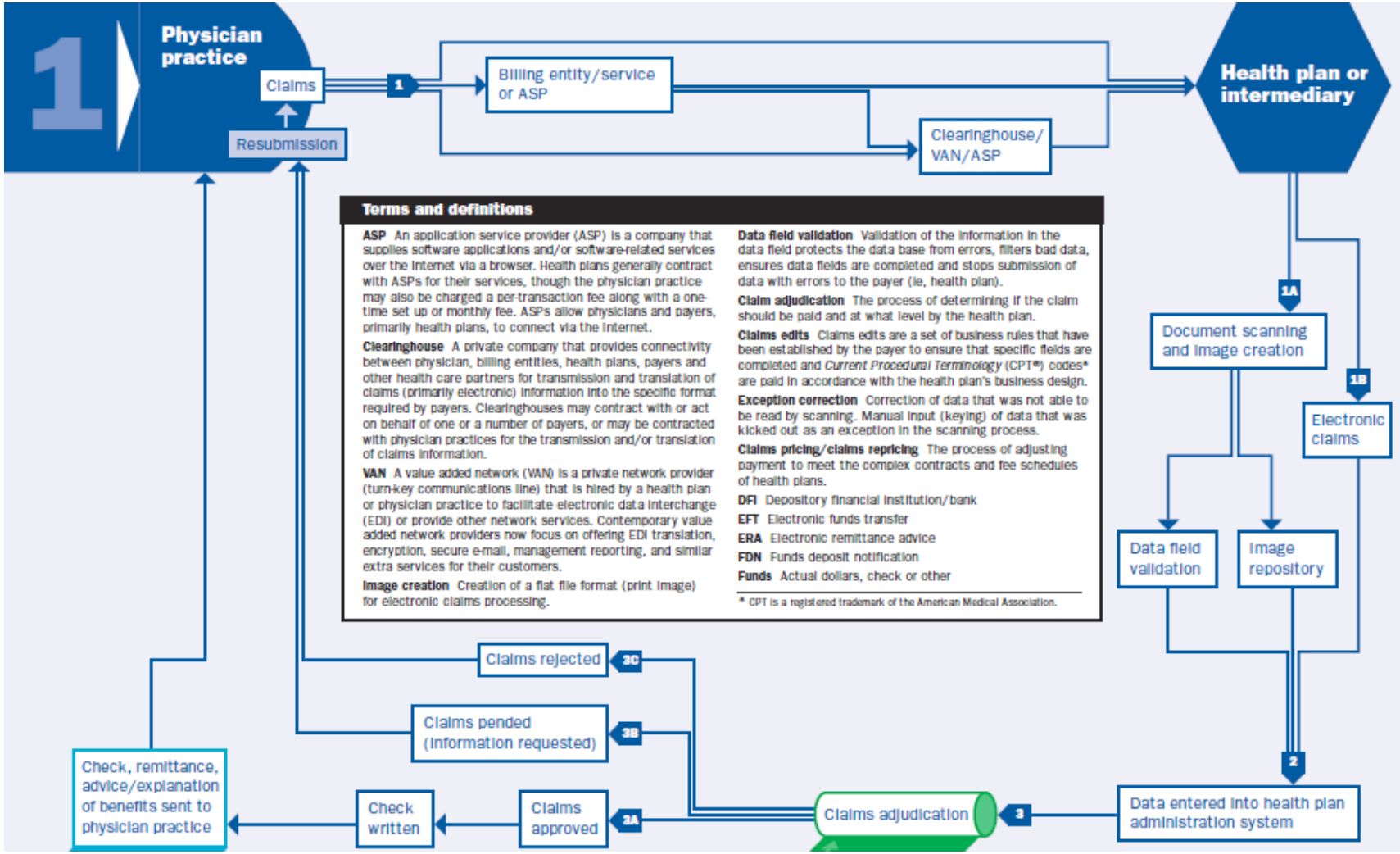
Payer & Patient Account Receivables

- Review overdue payment reports
- Track and follow-up on denials and appeals
- Account follow-up
- Have established financial policy and procedures in place
- Send statements out at least bi-weekly for easier A/R management and cash flow
- Collections

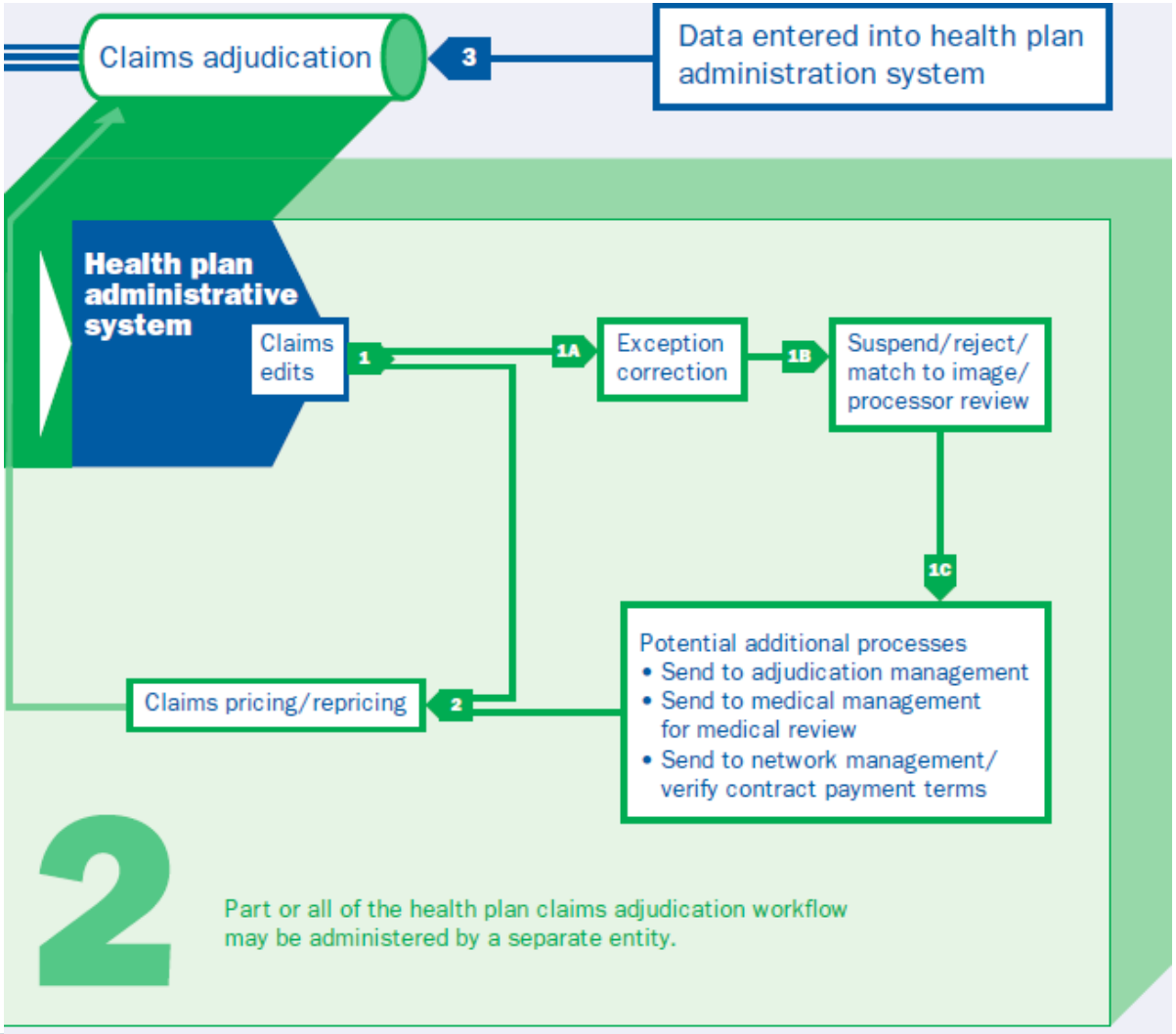
Reporting

- Use reports to:
  Provide continuing education and ongoing feedback to providers regarding coding accuracy and patterns.
  Educate staff and reduce errors.
- Types of reports:
  - Account Receivables Reports
    - Payer Reports
    - Patient Reports
  - Payer Analysis Reports
  - Payer Mix Reports
  - Service Analysis Report

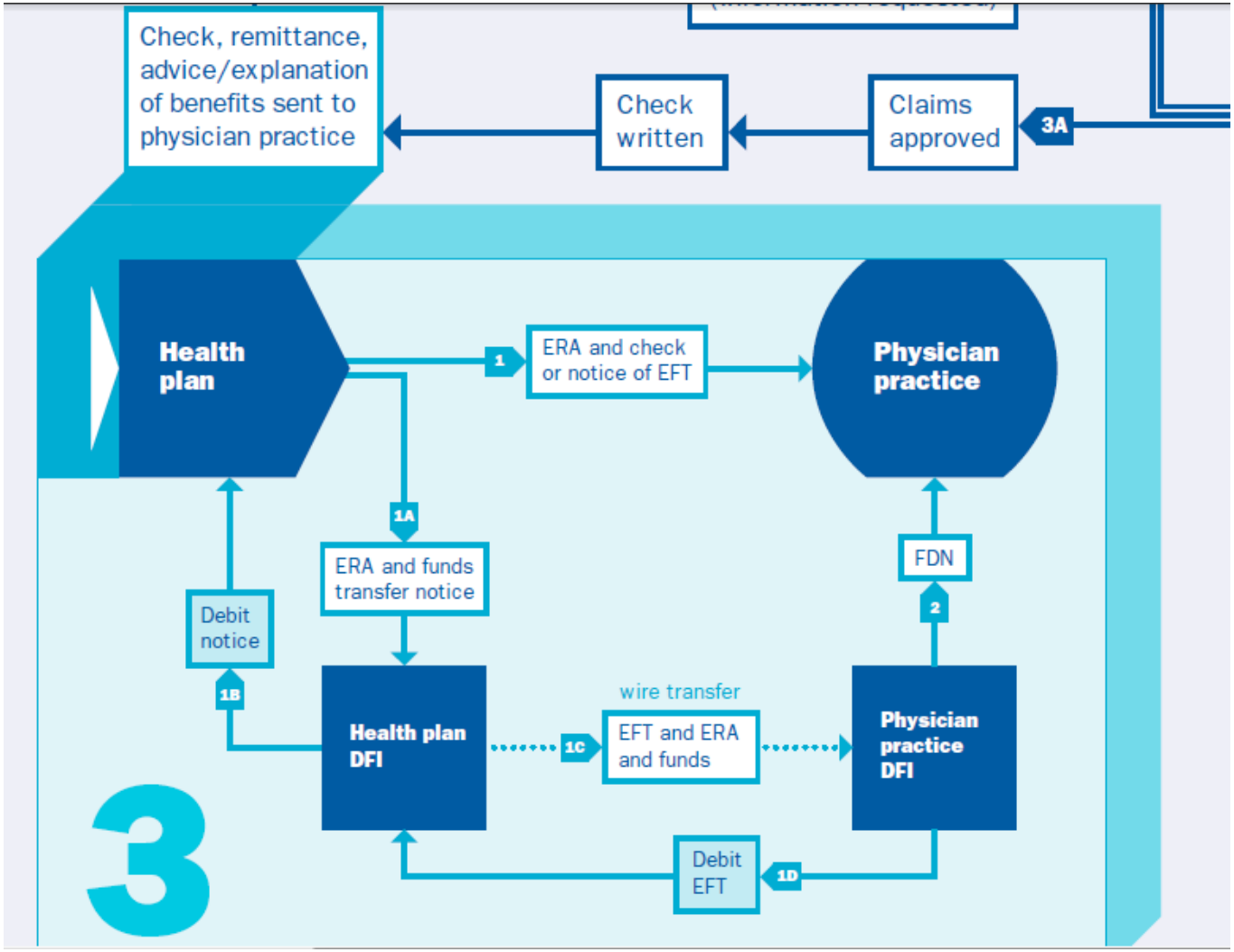
AMA Guide – Follow That Claim



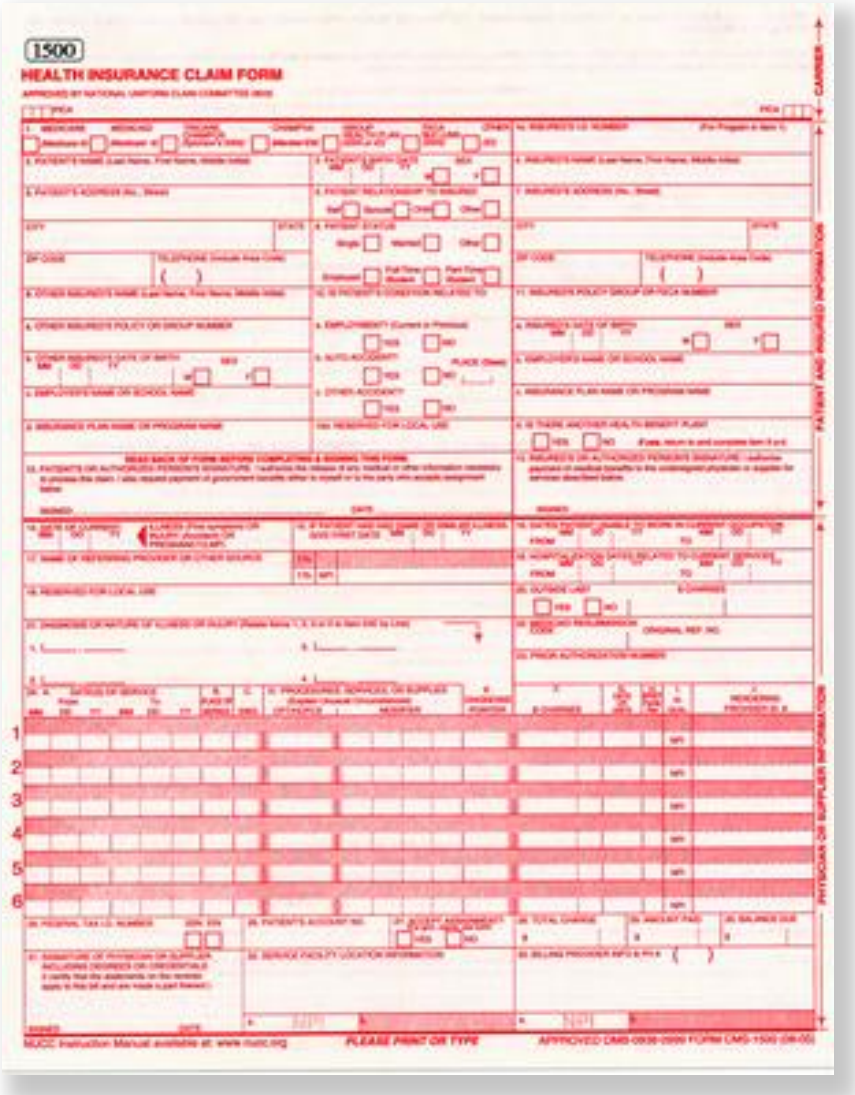
AMA Guide – Follow That Claim



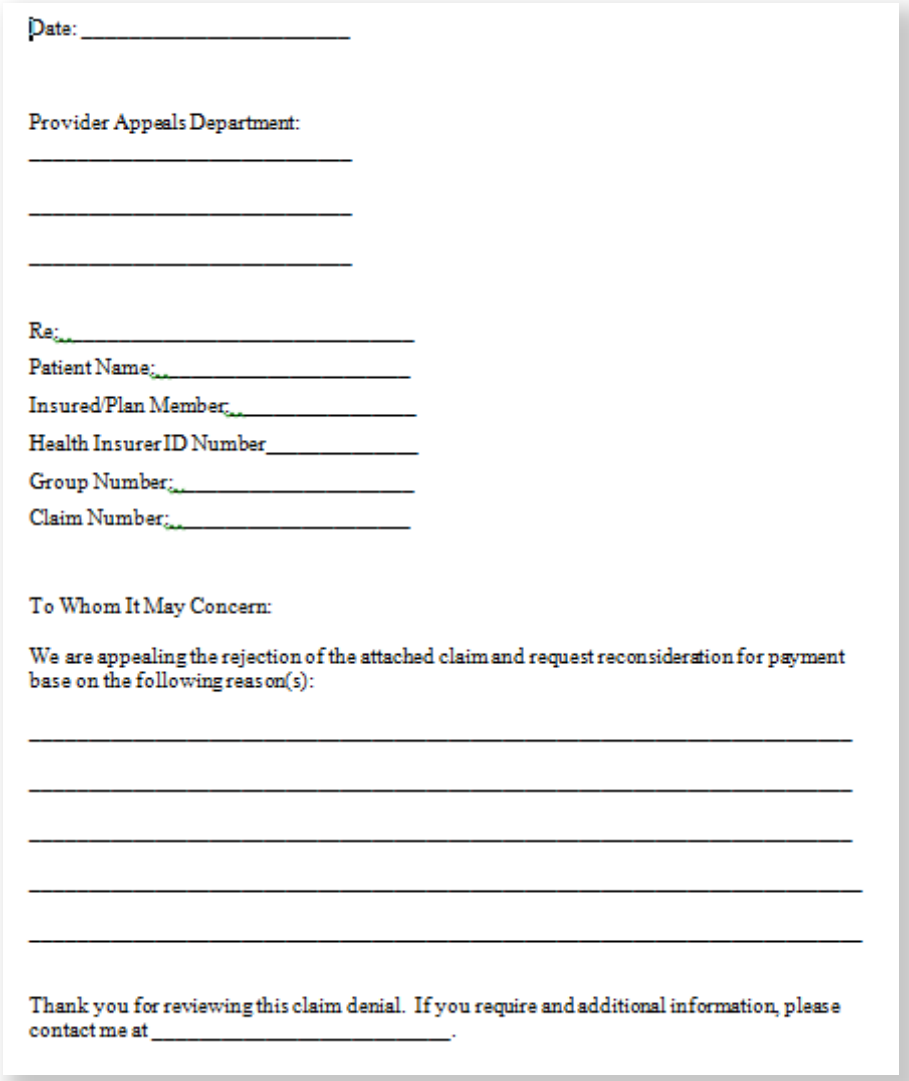
AMA Guide – Follow That Claim



CMS 1500 Claim Form



Sample Claim Appeal Form



Date: _____

Provider Appeals Department:

_____

_____

_____

Re:_____

Patient Name:_____

Insured/Plan Member:_____

Health Insurer ID Number_____

Group Number:_____

Claim Number:_____

To Whom It May Concern:

We are appealing the rejection of the attached claim and request reconsideration for payment base on the following reason(s):

_____

_____

_____

_____

_____

Thank you for reviewing this claim denial. If you require and additional information, please contact me at _____.

Immunization Billing Project Work-Plan

- Practice Management Billing System
- Clearinghouse Set-up
- Front-end Processes
- Back-end Processes
- Forms and Materials
- Policy and Procedures
- Billing Compliance
- HIPAA
- Contracting
- Credentialing

Immunization Billing Project Work Plan Guide for _____ County Health Department

ID	Description of Activities	Include			Assigned To	Start Date	Due Date	Complete Date	Notes
Practice Management Billing System		Yes	No	NA					
1.00	Verify the correct CPT codes are used								
1.10	Verify the correct CPT codes are in PMS								
1.15	Verify the correct NDC codes are used								
1.20	Verify the correct NDC's are in the PMS								
1.25	Verify the correct ICD-9 codes are used								
1.30	Verify the correct ICD-9 codes are in PMS								
1.35	Verify the Fee schedule is correct								
1.40	Verify that the Fee schedule is correct in the PMS								
1.45	Verify the correct Tax ID is in the PMS								
1.50	Verify that correct NPIs in are in the PMS: ___ clinic ___								
Set-Up with Clearinghouse, Payers, PM System		Yes	No	NA					
1.60	Set up electronic statements								
1.65	Set up superbill/charge document in the PM system								
1.70	Set up electronic eligibility verification in PM system								
1.75	Set up scanning capabilities in the PM system								
1.8	Set up Electronic Remittance Advice (ERA) with the payers								
1.85	Set up electronic funds transfer (EFT) with the payers								

FRONT-END PROCESSES

Payers			Yes	No	NA					
2.00	Educate staff how to identfy, collect appropriate information and process the different payers	Self-Pay								
2.10		MA								
2.15		MCO								
2.20		Payer								
2.25		Medicare								
Insurance Eligibility Verification			**Yes**	**No**	**NA**					
2.30	EVS	Phone								
2.35		Web								
2.40		Elec.								
2.45	Payers	Phone								
2.50		Web								
2.55		Elec.								

Charges & Reconciliation			Yes	No	NA					
3.00	Educate staff how to correctly determine/calculate charges									
3.10	Educate staff how to capture all charges									
3.15	Educate staff on charge reconciliation processes									
3.20	Create/review/update charge capture policy and procedures	Calculation								
3.25		Posting								
3.30		Reconciliation								
Payments & Reconciliation			**Yes**	**No**	**NA**					
4.00	Educate staff on payment collections									
4.10	Educate staff on payment posting into PMS									
4.15	Educate staff on payment reconciliation									
4.20	Create/review/update payment policy and procedures	Collection								
4.25		Posting								
4.30		Reconciliation								
4.35	Create a daily work packet									

BACK-END PROCESSES

Charges & Reconciliation			Yes	No	NA					
5.00	Educate staff how to correctly determine charges									
5.10	Educate staff how to capture all charges									
5.15	Educate staff on charge reconciliation processes									
5.20	Create/review/update charge capture policy and procedures	Calculation								
5.25		Posting								
5.30		Reconcile								
Payment & Reconciliation			**Yes**	**No**	**NA**					
6.00	Educate staff on payment collections									
6.10	Educate staff on payment posting into PMS									
6.15	Educate staff on insurance payment posting									
6.20	Educate staff on payment reconciliation									
6.25	Create/review/update payment policy and procedures	Collection								
6.30		Posting								
6.35		Reconcile								

Claim Processing and Training			Yes	No	NA					
7.00	Educate staff how to pre-edit claims									
7.10	Train staff how to submit claims	Paper								
7.15		Electronic								
7.20	Train staff how to verify electronic claim submissions (clearinghouse)									
7.25	Train staff how to identify and correct electronic claim denials from the clearinghouse and payers									
7.30	Train staff how to process denials that come in the mail									
7.35	Educate staff how to send an appeal to a payer									
Account Receivables (A/R)			**Yes**	**No**	**NA**					
8.00	Train billing staff how to manage insurance A/R									
8.10	Train staff how to manage patient A/R									
8.15	Train staff how to review and print/sent patient statements									
8.20	Train staff on how to obtain PM reports									

FORMS and MATERIALS									
9.00	Charge Capture Form								
9.10	Registration Form								
9.15	Front office cheat sheet to help identify payers								
9.20	Daily Reconciliation Sheet								
9.25	Glossary of LHD and Billing Terminology								
9.30	Sample copies of a payer's insurance cards for reference and								
9.35	List of payer websites - to enable billers access to provider								
POLICY and PROCEDURES									
BILLING COMPLIANCE									
HIPAA									
CONTRACTING									
CREDENTIALING									

Questions and Answers