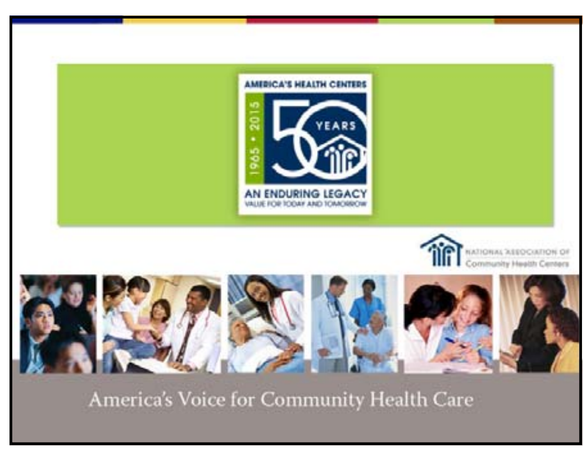
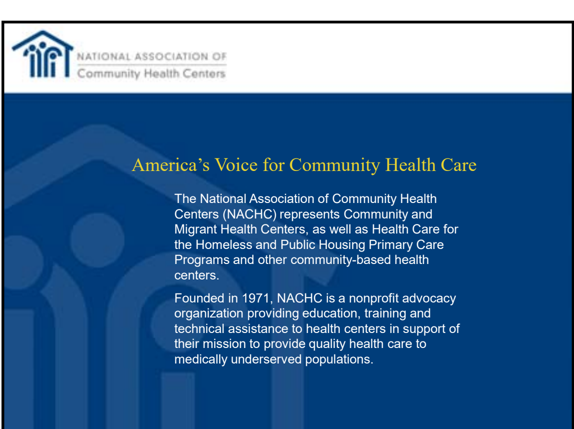
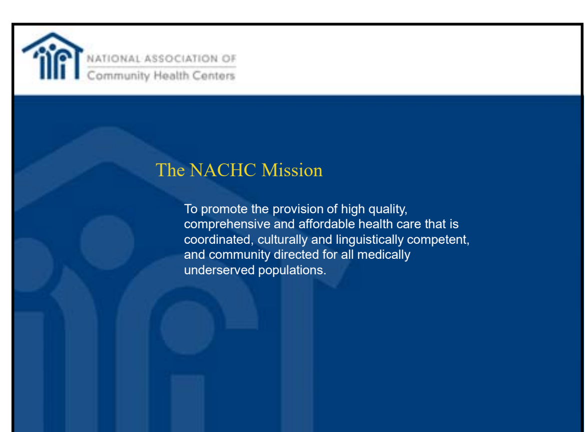
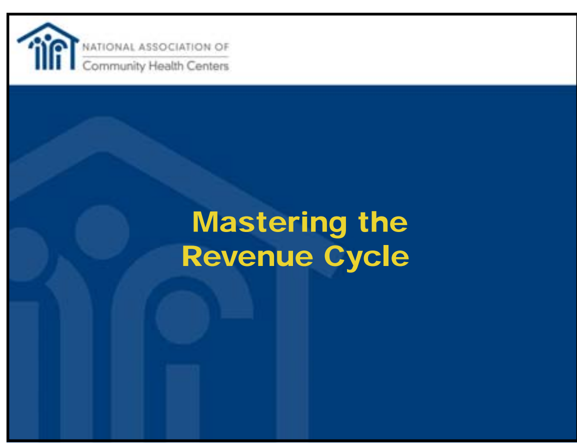
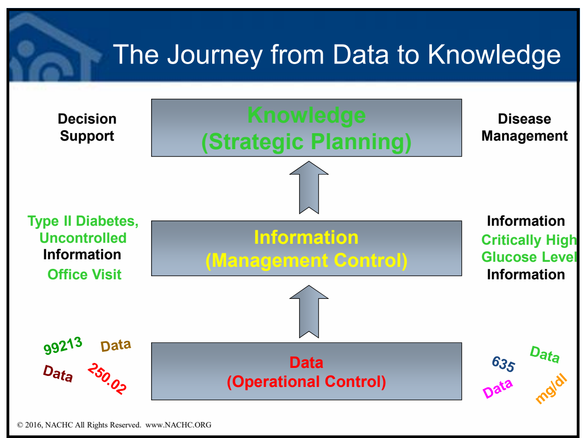

AMERICA'S HEALTH CENTERS
1965 • 2015
50
YEARS
AN ENDURING LEGACY
VALUE FOR TODAY AND TOMORROW
America's Voice for Community Health Care


NATIONAL ASSOCIATION OF
Community Health Centers
America's Voice for Community Health Care
The National Association of Community Health Centers (NACHC) represents Community and Migrant Health Centers, as well as Health Care for the Homeless and Public Housing Primary Care Programs and other community-based health centers.
Founded in 1971, NACHC is a nonprofit advocacy organization providing education, training and technical assistance to health centers in support of their mission to provide quality health care to medically underserved populations.


NATIONAL ASSOCIATION OF
Community Health Centers
The NACHC Mission
To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.





Overview

- The revenue cycle starts when the patient calls your office for an appointment and your staff captures the patient's name, phone number, and their insurance eligibility and coverage information.
- The cycle ends when the balance on their account is zero.
- The cycle is best supported by effective information systems
- Electronic billing is a mainstay among third party payers, managed care, Medicare and Medicaid
- The need for electronic billing will only grow

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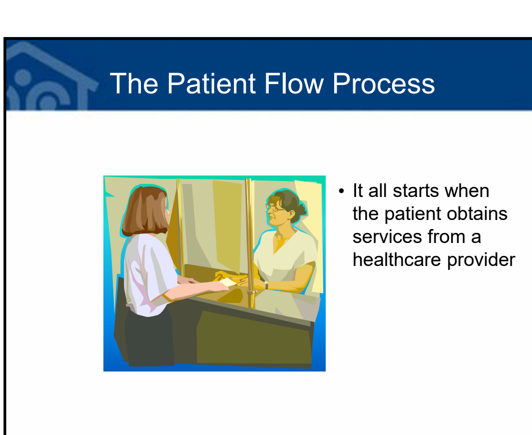
The Patient Flow Process



- It all starts when the patient obtains services from a healthcare provider

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Revenue Management & Patient Flow

- Revenue management works hand in hand with the patient flow process (from scheduling and registration through treatment, discharge and collection)
- The majority of revenue management issues start early when the provider is collecting and verifying patient information needed to ensure submission of a clean claim and receipt of full payment.
- Rather than address problems retrospectively, providers are urged to focus their efforts on front-end processes that help ensure the problems do not arise in the first place.

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Health Centers Performance Issues

- Inaccurate Data Front Desk… "El Nino "
  - –Demographics
  - –Sliding Fee Implementation
  - –Insurance Verification

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Health Centers Performance Issues Cont.

- Improper use of Practice Management System
  - Inadequate use of system
  - Flawed set up of system
  - Work around- The yellow sticky
  - Insufficient training

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Health Centers Performance Issues Cont.

- Documentation and Coding – Quotes from Providers
  - "It doesn't matter we are a FQHC"
  - "I don't want my patients to have to pay more"
  - "It's safer to under code"

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Clean Claims

- Objective: Paid all money anticipated on first claim submitted
- CMS Billing Formats:
  - 1500 (Part B/Professional)
  - UB-04 (Part A/Facility and UGS)
- Top reasons for non-payment
  - Demographic Issues
  - Eligibility
  - Prior authorization
  - Medical necessity (ICD)
- First Pass Rate: Clearinghouse
  - EDI Level Report
  - Payer Level
- Clean Claim Rate: Post Pay Adjudication

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How Many RCM Team FTEs?

- Ratio of 1:12,000… 1 FTE to 12,000
  - Visits are third party only
  - E.g., 60,000 visits but 20% Self Pay… 48,000 third party
- Charge Entry & Pay Post = 18%-28% of billing process
- Auto Charge Capture/Pay Post, 20% increase for each
- E.g., Automated charge capture
  - 20% of 12,000 = 2,400
  - New FTE target – 14,400
- PMG FTE targets 20,000+
- Historic PMG staff person… 32,000 visits
  - Across 3 clients
  - 18 DAR

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Production Benchmarks

- Automated
  - Single Remit $10,000 or $100,000… 10 minutes
- Manual Payment Posting
  - 18-28% of Process
  - Encounters equals visits equals units
  - Full Time Equivalent (FTE)
  - Just entering charges or posting payments 1 FTE…
    - Manage 60,000 visits annually (easily)

Charges or Payments	
Daily Units (Units = EF/Visit)	240
Units Per 5 Day Week	1,200
Monthly Units (4 weeks)	4,800
Annual Units (48 weeks)	57,600

NOTE: Daily Units- 6 Hours @ 40/hour

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Getting the Money… Deposits

PAYABLE TO GROUP… NEVER INDIVIDUAL

•EFT = Electronic Funds Transfer

•EFT vs. Paper checks

TAKE EFT WHENEVER POSSIBLE!!!

•Advantages of EFT
- Streamline cash flow
- Automate payments
- Eliminate lost, stolen or misdirected checks
- Saves time and resources

•New Medicare providers… Required to use EFT

•Changes to Medicare Enrollment… Require 588 (EFT)

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Explaining the Money… Claim/Line-item Details

- **Remits, RAs, EOBs, EOMBs, etc.**
- ERA = Electronic Remittance Advice
  - ANSI Standard 835
  - Paperless (electronic NOT paper storage)
  - Allows for electronic posting
- SPR = Standard Paper Remittance (Advice)
  - Paper… Storage (Ugh.)
  - Manual posting

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Tracking the Money

- Never miss $$$
- Develop and implement internal process
  - No notification from payer
  - Deposits need to be tracked
  - Notify billing to retrieve ERA
  - If paper remit, match up to EFT total
- Learn & Post Payer Schedules
  - Medicare – 10 days from billed date
  - Medicaid… What works for your state?
  - Other Payers

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Controls for Tracking Money

- How do you know how it goes?
  - Benchmarks: DOS to Payment to Posting
- Entries based on:
  - Payer scheduled check write dates
  - Actual Deposits

Deposit Date	Payer	Deposit Amount	Receipt Date of ERA
2/15/14	Medicare A	$6,582.14	2/19/14
2/16/14	Medicare B	$752.91	
2/27/14	Medicaid	$4,483.20	
3/1/14	Medicare A		

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Retrieval Options

- Direct from payer OR Clearinghouse
- Lists available files by payer:
  - 837 I/P, 835, 270/271, 276/277
- Posting Options:
- Manual vs. Electronic
  - PM system limitations
    - Line item or batch posting… options exist? –
  - After autopost run PM reports for number & total
    - $ posted and finalized
    - $ posted and not finalized
    - $ not posted

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Tools to Convert Payment Files

- Must be in readable format
- MREP (Medicare Remit Easy Print)
  - Converts 835P into Part B EOMB format
  - http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html
- PC-Print
  - Converts 835I
  - http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/Downloads/MedicareRemitEasyPrintDemo.pdf
- Clearinghouse Options
  - Typically provide conversion tools
  - E.g., www.ClaimRemedi.com

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Deposit Batch Controls

- Create Deposit Log or modify EFT tracking log
- Reconcile each deposit date or ERA or SPR
  - Find best system for your CHC

Deposit Date	Payer	Deposit Amount	Receipt Date ERA/SPR	Batch Number	Amount Posted	Variance
2/15/14	Medicare A	$6,582.14	2/19/2011	0215MA	$6,582.14	
2/16/14	Medicare B	$752.91				
2/27/14	Medicaid	$4,483.20				

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If a Variance Exists…

- Variance is unavoidable… Manage and move on
- Retractions of *previously paid claims*?
  - If yes, document variance & close batch… Example:
    - $500 worth of claims paid
    - $100 retracted on previously processed claim
    - Post $500 in payments…
      - On historic claims (DOS) manage retractions
- Variance = whole dollar amount… Usually mistyped
- Variance amount divisible by 9… Transposed numbers
  - $41 posted instead of $14
  - Variance Calculation: $41 less $14 = $27
  - $27 is evenly divisible by 9

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Rejected Claim vs. Denied Claim

What's the difference?

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Denials & Underpayments

- **"OK to adjust" Denials** – Post adjustment or transfer
  - Paid < charge – Outpatient Mental Health Reduction
  - MSP
  - Eligibility – transfer claim to correct payer
  - Medicaid T1015
- **Denials to be Appealed** (FIGHT!!)
  - NPI linking issue
  - Additional information needed
  - POS issues
  - ICD missing digit/not valid for DOS
  - CPT not valid for DOS
  - Medical Necessity

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Denials & Unpaids

- **Characteristics of Denials**
  - Easy to correct during PayPost
  - MUST be defined (set expectations)
  - Examples: Missing (but present) referral or authorization, wrong primary insurance, mistaken demographic error, etc.
- **Characteristics of Unpaids (i.e., Unpaid (Project) Claims)**
  - NOT easily fixed during PayPost
  - MUST be defined… with written plan to rectify
  - Examples: Credentialing, POS dispute, medical necessity, ALJ appeal, etc.

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Denial Analysis

Reason	Total Denied Visits #	% of Total
Charges covered under a capitated agreement	890	6.7%
Claim not filed timely	506	3.8%
Correct tooth info needed	89	0.7%
Duplicate claim	5,798	43.5%
Incomplete or incorrect coding (CPT, Diag, HCPCS)	207	1.6%
Lack of authorization/referral	206	1.5%
Lacks other info needed for adjudication	1,335	10.0%
Paid current / conflicting claim	52	0.4%
Patient ineligible	181	1.4%
Patient ineligible (Another plan)	3,283	24.6%
Patient ineligible at time of service	355	2.7%
Provider ineligible	44	0.3%
Service not covered - Plan	168	1.3%
Service part of more global procedure	22	0.2%
Unknown / Other	77	0.6%
TOTALS	13,323	100.0%

Payment Plans

- Patient Centered
- Multiple Options
- Training

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Billing Policies and Procedures

- Before you do anything:
  - Know your compliance requirements
  - Know requirements by payers
  - Know the capabilities of your PMS

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Billing Policies and Procedures Cont.

- Policies and Procedures
  - Compliance requirements should be incorporated in policies
  - Job Descriptions included
  - Don't forget to take into consideration of the patient experience

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Billing Policies and Procedures Cont.

- Ensure the Billing manual is a "live" document
  - Review the manual regularly
  - Train staff to perform consistent with procedures
  - Make sure appropriate internal controls are included

Best Practices – Appointment Scheduling

- Schedule the appointment within time desired by patient
- Inform patient to bring insurance card and co-payment
- Language Counts

Appointment Scheduling Process

- Pre-registration
- Begin the revenue cycle
- Eligibility verification of insurance
- Authorization
- Financial obligation policy

Best Practices – Appointment Scheduling

Improve Communication With Patients		
Situation	**What NOT To Say**	**What To Say**
Confirming an appointment:	Let me know if you can't make it. ***Message:*** *We know you might not make it, and that's okay.*	We're expecting you. We've dedicated this appointment to you. ***Rationale:*** *Strong words reinforce the patient's obligation.*
Booking an appointment:	I'm squeezing you in. ***Message:*** *You'll never be missed if you don't show up, and you can expect to wait when you get here.*	I have an opening for you at 2:00 pm ***Rationale:*** *We have time for you and want to see you.*
Call the no-show appointment:	I'm calling to reschedule the appointment you missed. ***Message:*** *Missed appointments are not your responsibility.*	We're concerned that you missed an appointment. It's important that you come in. ***Rationale:*** *Emphatic, but empathetic.*

Best Practices – Patient Assessment/Encounter

- Reasonable and timely access to care and services
- Complete clinical services
- Services are informative and effective
- Thorough and accurate clinical documentation for correct billing

Best Practices – Documentation and Coding

- Provider documents services
- Services coded:
  - CPT codes
  - HCPCS codes
  - Modifiers
  - ICD-9
- Stay on top of Coding Changes

Best Practices – Documentation and Coding

- Documentation complete and signed by provider
- Codes accurately reflect patient service(s)
- Coding reviewed to ensure it reflects documentation

Best Practices – Charge Processing

- Accuracy of service and charge
- Appropriate edits in place to scrub data
- Charges entered timely for prompt payment

Best Practices – Charge Processing

- Data Entry and Coders enter data into Billing System
- Fee entered automatically or manually
- Billing Manager or automated claim software scrubs entries for correctness
- Problems sent to department work file for processing
- Reconciliation performed to ensure all entries received and entered into practice management billing system

Best Practices – Claim Submission

- Claims edited to ensure completeness and correctness
- Accurate claims sent daily to health plans
- Claims flow electronic and paper
- Increase % of electronic claims
- Keep average cost per claim better than benchmark
- Get statements out to patients for self-pay balances every week within the current billing cycle (30 days)

Best Practices – Payment Processing

- Electronically or manually post remittances from payers and patients
  - Co-pays and plan payments
  - Denials or rejections
  - Adjustments
- Reconciliation of charges, payments and adjustments
- All payments and denials processed within 24 hours of receipt
- Process all refunds in a timely manner

Best Practices – Resubmission, Secondary Billing and Appeals

- All invoices requiring an appeal processed are completed within one week of receiving rejection
- Process all responses from clinical departments within one day of receiving information
- All secondary claims submitted within a week of receiving primary payment

Best Practices – A/R Follow-up

- Process all denials within a one week of receipt of reject.
- Follow-up on all outstanding requests with clinical departments within one week of initial request.
- Follow-up on all “no response” claim invoices within 45 days of claim submission

Collections

1. At time of service
2. Following adjudication of claims
3. Repeat attempts to collect

Pre-Service Cash Collections

- Accept the philosophy and the fact that it's ok to collect cash from your patients. The economically-distressed can be put on a sliding scale. Collect something.
- Clearly post a message in your lobby and elsewhere setting the expectation that co-pay is due at the time of service, prior to seeing the clinician. Most commercial contracts <u>require</u> that you collect co-insurance.
- Train staff in collecting cash. Assertive language is key.
- Establish a cash management policy and procedure with checks and balances
- Establish target performance indicators
- Measure progress and performance
- Hold everyone accountable including clinicians who can be instrumental in this process

Post-Service Cash Collections

- Clearly post a message in your lobby and elsewhere setting the expectation that you will make every effort to collect payment from third-parties but that the client is ultimately responsible for payment
- Review Remittance Advice and denials with patient, helping them understand how it is that the third-party will not be paying and how it is that they are now responsible
- Consider sliding scales and payment plans
- Hold everyone accountable including clinicians who can be instrumental in this process
- Remember that <u>failure to collect co-insurance is often deemed breach of contract</u> with payers unless you are an out-of-network provider

Facts About Collections - *When all else fails*

Tips about using collection agencies:

- Only 5 percent of accounts over 90 days past due will ever pay voluntarily
- It is estimated that accounts that are:
  - 90 days past due are 90 percent collectible
  - 180 days past due are 67 percent collectible
  - 1 year old are 40 percent collectible

Facts About Collections

Why patient collections matter:

- Rapid growth in consumer-directed health plans mean you will be faced with the need to collect on co-pays/deductibles to a far greater extent
- Annual growth in bad debt write-offs due to consumer-directed plans means you could be providing more *free* services than ever

Strategies

- Require photo ID for all patients
- Simplify the Sliding fee procedures
- Implement a continuous process improvement team
- Perform internal audits
  - Individual front desk employee audits
  - Sliding fee, especially self declaration forms
  - Chart audits

Summary

- Streamline Cash Flow – Enroll in EFT
- EFT & Deposit Process… Locked Down!
- Reconciliation
  - EFT and ERA
  - Payment Batches
- Have a plan to work the denials and rejections
- Educate and Train