Learning Objectives

• By the end of this webinar, participants will be able to:
  – Identify strategies for collecting payments and managing aged accounts
  – Discuss setting performance benchmarks and measuring outcomes
  – Create plans for engaging staff in continuous quality improvement

Disclaimer

The content provided in this course is intended for educational purposes only. It is not intended to serve as medical, health, legal or financial advice or as a substitute for professional advice of a medical coding professional, health care consultant, physician or medical professional, legal counsel, accountant or financial advisor.

Cardea encourages providers to contact third-party payers for specific information on their coding, coverage and payment policies.

Cardea

• Training
• Organizational Development
• Research & Evaluation

Improve organizations’ abilities to deliver accessible, high quality, culturally proficient, and compassionate services to their clients

Billing & Sustainability Series:

Implementation and Improvement Strategies for STD and Other Public Health Programs

✔ Setting Up for Success: Integrating Revenue Cycle Management
  Tuesday, February 25, 2014 - Recording available

✔ Reaching Full Potential: Quality Assurance and Improvement with Visit Documentation
  Wednesday, April 30, 2014 - Recording available

Bringing It All Together: Sustaining and Enhancing Billing and Reimbursement Efforts
  Thursday, June 26, 2014
Revenue Cycle Management Continuum

Cardea adapted the Transtheoretical Model of behavior change, or Stages of Change, developed by Drs. Prochaska and DiClemente, to identify benchmarks in organizational readiness leading to revenue cycle management.

Understanding the Shift

MISSION: Providing High Quality Patient Care in Public Health Services

Funding Changes
- Affordable Care Act
  - Increases the number of people with health insurance
  - May limit future grant funds provided for STD services
- State Guidelines
  - Have allowed for health departments to bill for STD services
  - Some have expanded Medicaid services
- Shrinking Budgets
  - Overall budget constraints mean local health departments and clinics are doing more with less
  - Recession has meant more people need health services that may not be able to afford them

Systems Changes
- Business Model
  - Running more like a business
- Staffing
  - Shifting from the staff you have to the staff you need
  - Creating new positions and roles and/or hiring new staff
- New Software
  - Choosing an EHR or PMS
  - Customizing your system
- Processes & Policies
  - Adapting new processes and new policies to manage and continue changes
  - Testing and improving the processes takes time and effort
Getting Staff On Board

- Engage all levels of staff throughout the process
- Answer the following for staff:
  - Why is this necessary?
  - What is happening?
  - How will it affect me and my work?
  - What is in it for me?
- Staff are experts in their role, ask for their advice and guidance on how to make changes successful

Map New Roles and Responsibilities

<table>
<thead>
<tr>
<th>Who does what chart</th>
<th>Step in the Process</th>
<th>Who is assigned?</th>
<th>Who is this task about?</th>
<th>Which it has landed out?</th>
<th>Whose else needs this information?</th>
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Preparation for Billing

Billing Process

Ready... Get Set... Bill!

- Set up contracts with third party payers (TPP)
- Credential your providers and enroll them in your plans

Third Party Payer Contracts

- Building third party (commercial) relationships can lead to successful contract negotiations:
  - Pricing / favorable rates
  - Add new services to contract
  - Increased length of time to submit initial claim
  - Prompt responses to issues identified
  - Explore new payment methodologies
  - Prompt payment terms...
Credentialing and Enrollment

- **Credentialing** - process by which providers who bill TPP for services provide documentation of their qualifications, experience, education, and licensure.
  - Required for participation
    - Can be a lengthy process so start early (90 days to 6 months)
    - Needs to be updated on a regular basis
    - Can be done internally or outsourced
- Once credentialed, you can **enroll** providers in plans you have contracts with to ensure appropriate reimbursement

Council for Affordable Quality Healthcare (CAQH)

- Standard application and a common database for credentialing process to submit one application to one source to meet the needs of all of the participating health plans, hospitals and clinics
- Obtain application information directly from the database, streamlining the process both ways
- Providers update their information quarterly to ensure data is current and accurate
  
  [http://www.caqh.org](http://www.caqh.org)

Policy and Procedures

- Developing and implementing policies and procedures to be followed:
  - Ensure compliant and timely billing
  - Create sustainable systems
  - Define staff roles and expectations
  - Develop training plans for staff
  - Engage staff in the change process

Confidentiality: Concern vs. Barrier...

- Confidentiality and protecting patient information is a real concern when billing for patient services
- Ensure systems in place to protect medical records and billing information
  - How will your TPP handle EOBs? Discuss with them when setting up contracts
  - What if the patient does not want to use their TPP insurance?
- Monitor policies / procedures and strictly enforce

Expectations for Submitting Claims for Payment

- Actually provided to the patient and documented
- Medically necessary for the treatment of the patient's illness or condition

Expectations...

- **Follow the rules** – Requires ongoing education as the rules change VERY frequently
- **ONLY** bill for what was actually performed
- **Use the correct codes** – It can get pretty complicated and education is the key
- **On the Record** – If it isn’t written in the medical record, it can’t be billed
- **Medical Necessity** – Only bill for services that were necessary to treat the patient’s illness or condition
Keeping Up-to-date

- Ignorance of new instructions, rules, or codes is not an excuse for incorrect billing:
  - Research about government regulations, payer billing updates, and code updates
  - Regularly check official websites
  - Coding forums – be careful as they are not official answers and often misleading or wrong
  - Webinars are fast way to learn and often at no or low cost

Keeping Up-to-date con’t

- Ensure staff has access to up-to-date resources
  - http://www.ama-assn.org
  - http://www.aapc.com
  - https://www.cms.gov

Claim Processing Options

- Whether on paper or electronic – we need to have a system in place to create and process claims
- Assess your options and staff capabilities to determine what will work best for your clinic:
  - In-House using internal staff
  - Outside billing agency

Medical Billing Clearinghouse

- Function as intermediaries, forward claim information from healthcare providers to insurance payers
- Can validate insurance eligibility ahead of time
- Claims are generated into a ANSI-X12 837 file and sent to clearinghouse
- Claims checked for errors and verify that it is compatible with payer software – “CLAIM SCRUBBING”
- Securely transfers claims to specified payers
- Clearinghouse can generate reports and help resolve issues

Collecting Payment From Patients

- Key Points
  - Having policies/procedures for check out staff ensures consistency
  - Simply changing the way you ask for payment can increase revenues:
    - “The fee for today’s services is $20”
    - “The fee for today’s services is $200, how much of this are you able to pay today?”
  - Provide a script for check out staff and training
  - Check out staff can be the first line quality check on patient documentation
Setting Fees

- In order to set up a Schedule of Charges – we need to understand the cost of providing each service
  - Cost Analysis - helps you understand what your cost of putting services out the door are and appropriately set patient fees
  - Understand the reimbursement tied to each service and other funding sources

- Sliding Fee Scale
  - Set fees for patients based on income who do not qualify for Medicaid or have other insurance, or decide not to use their insurance for confidentiality concerns

Preparing to Send a Claim

- If the patient's visit will be billed to an insurance:
  - Billing staff should review claims before submission and resolve initial issues to avoid payment delay
  - Multiple sets of eyes are needed for QA (Clinician, cashier, biller…)

What is a Clean Claim?

- A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment
  - Real cost to a clinic for resubmitting claims including staff costs and delayed revenue
  - Measurable quality goal - monitor how you are doing

Submission: Paper vs. Electronic

- Paper: CMS 1500, UB04
- Electronic: ANSI 837p, 837i
- Cross-over claims

Adjudication

- Process where Payers review claims
  - Claim goes through a series of steps designed to judge whether it should be paid
  - What the payer decides about the claim—to pay it in full, to pay some of it, or to deny it—is explained on report sent back to the provider with payment
  - If covered by more than one health plan, additional plans are then sent claims based on amounts still due
National Correct Coding Initiative (NCCI)

- CMS program designed to prevent improper payment of procedures that should not be submitted together
  - Procedure-to-Procedure (PTP) edits
  - Medically Unlikely Edits (MUE)

Modifiers should only be appended to CPT codes if clinical circumstances justify use of a modifier not to solely bypass an NCCI edit.

Remittance Advice

- Payers send back your claims on a report called the Remittance Advice (835 file)
- Claims and service lines often are noted with "Reason and Remark Codes" to help you verify payment

Modifiers should only be appended to CPT codes if clinical circumstances justify use of a modifier not to solely bypass an NCCI edit.

Verify Payment

- Billing staff compares each payment with the claim to ensure that:
  - All procedures and codes that were listed on the claim also appear on the payment transaction?
  - Any unpaid charges are explained?
  - Payment listed for each procedure is correct according to the contract with the payer?
  - Resubmit repaired claims as needed

Denial Management

- Denials take place for many reasons, some can be addressed with minimal outlay of time, others take more effort
  - Prioritize and fix easy fixes first
- Understand the root cause of each denial
  - Is it a person, process, or system?

Common Denial Reasons

- Claim is Missing Information
- Claim is Not Specific Enough
- Codes are Not Specific Enough
- Patient Not Eligible for Service
- Claim is Not Filed on Time
- Claim is Not up to Payer Standards

Managing Denials

- Understand why a claim has not been paid
- Define the rejected claims specifically - does a particular TPP routinely reject a certain service?
- Identify processes you need to adjust and systems that you need to improve
- Identify which companies you want to continue to work with, based on payment performance
Meeting Performance Targets

<table>
<thead>
<tr>
<th>Denial Management Key Performance Indicators</th>
<th>Target</th>
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<tr>
<td>Overall denial rate as % of gross revenue</td>
<td>4% or less</td>
</tr>
<tr>
<td>Clinical denial rate as % of gross revenue</td>
<td>5% or less</td>
</tr>
<tr>
<td>Technical denial rate as % of gross revenue</td>
<td>3% or less</td>
</tr>
<tr>
<td>Rate of appeals overturned</td>
<td>40-60%</td>
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Managing Aged Accounts

Managing Receivables

- Once your claims have been sent to health plans, it is important to collect payments as soon as possible
- Money due from the plans, as well as payments due from patients, add up to the practice’s accounts receivable (A/R)—the money that is needed to run the practice

Managing Accounts Receivable

Unpaid account worklists → A/R Reports → A/R Follow-up

Reports are Key

- Summary and trending reports
  - % Initial Claim Denials against Target
  - Top 3 Claim Denial Reasons
  - Denials by Payer and Reason (monthly)
- Compare payers
- Root cause analysis and corrective action monitoring reports

Holding Payers Responsible

- Review payer performance and measure it against other payers
  - Understand denial rates and types by payer
  - How often can you get the denial overturned?
  - How long does it take to resolve with payer?
- Stay attuned of changes in payer behavior and follow-up on sources of changes – befriend your representative!
Timely Submission

- Payers often have strict guidelines for submission and adjustments of claims
  - Billing processes must be adaptable to changing timeframes and rules

Leverage Technology

- Do you have proper internal and external support for your electronic systems?
  - Training
  - Upgrades and expansions
  - Template development / upgrades
- HIPAA controls (sharing data, Rx, lab results…)?
- Correct codes available?
- Documentation modules flexible?
- Export availability of claims, reports and statistics

Using Your Data

- Can you get at your submission and remittance files and easily query and manipulate data for management reporting and claim validation?

Why Measure Performance?

- View a snapshot of performance at an individual, group or department level
- Assess current situations and determine root causes of identified problem areas
- Set goals and expectations
- Trend the performance over time
  - Benchmarks and key performance indicators can motivate employees, giving them measurable goals to achieve. They can help you see how your company measures up to others in the industry.

What is a Benchmark?

- Goals to aim for - who is the very best, who sets the standard, and what that standard is
- Identify areas where you need to improve

If you don’t know what the standard is, you cannot compare yourself against it.
Benchmark Metrics

- Benchmarking metrics usually can be classified in one of four categories:
  - Productivity
  - Quality
  - Time
  - Cost-related

- Process or activity that you are attempting to benchmark will determine types of measurements used

Sources - Benchmarks

- Industry Publications
- Historical Facility / System Performance
- External Auditing Firm
- Networking with Peers
- Industry Organizations
- State Organizations

Key Performance Indicators (KPI)

- Way to measure your progress toward the benchmark goal and to gauge how close you are to reaching that goal

Best Practices - KPI

- Use multiple tools and techniques
- Monitor goals
- Pay attention to detailed outcomes
- Understand benchmarks
- Hold team accountable

Keep It Simple...

- More data and longer reports are not always better
- Understand and train staff on data analysis and pitfalls
- Understand your variances and trends

Monitor Progress – Be Transparent

- Build reports that quickly tell the story
  - Dashboard of Key Performance Indicators (KPI)
  - Summary and trending reports
- Share with staff and management
- Provide updated progress reports
In Summary...

• Effective and timely revenue cycle management is critical to your overall success
  – Engage staff
  – Encourage accountability
  – Resolve root causes of issues
  – Choose benchmarks and performance measures that fit to your goals – be realistic

Internal Reviews for Quality Assurance

Why Perform Internal Reviews?

• Can be a compliance requirement
• Reduces risk of an unwanted outside audits, take-backs, fines
• Improves staff performance and attitudes
• Creates a more reliable accounts receivable
• Improves overall patient experience

Quality Assurance – Internal Reviews

• Identify, prioritize and evaluate risks
• Review efficiency of operations and reliability of financial reporting
• Deter and investigate fraud, safeguard assets

Review Examples

• Documentation and coding reviews (Chart, Chart to Bill)
• Billing / claims data reviews including denial trends
• A/R - Aged accounts, payer performance
• Patient surveys
• Employee feedback
  – What’s worked well for your group?

Setting Parameters

• Risks - Who or What is to be audited?
• Current internal capacity for an audit?
• Expected start and completion dates?
• Announced or unannounced?
• Tools, data and people needed?
• Report expectations?
• Schedule of follow-up reviews set?
• Actions defined and measured
Quality Improvement

Engaging Staff in Quality Improvement

- Change can be hard!
- Engaging staff helps them design and take ownership of the new processes
- Make quality improvement an ongoing conversation
- Build ownership and accountability for QI

Online Learning Community

Building Sustainability for Public Health Programs
A project of Cardea’s STD-Related Reproductive Health Training & Technical Assistance Centers
www.cardeastdrh.groupsite.com
Community Foundation
- Shared interest in strengthening revenue management strategies and billing practices
- Open to agencies at all stages of billing implementation
- Sharing of experience, knowledge, and resources

Online Learning Community Features

- Resource Library
- Peer-to-peer discussion
- Continued / follow-up learning from training and technical assistance activities, including webinars
- Access to exclusive training and learning opportunities

Questions?

Plan, Do, Study, Act

Plan
- Plan the change
- Gather information
- Identify expected results

Do
- Test the change
- Document problems, outcomes
- Analyze data

Study
- Complete data analysis
- Compare data to expected results
- Summarize outcomes and reflect

Act
- Refine the process based on what was learned
- Determine modifications
- Prepare for next test
Resources from Cardea

- Billing Guide with TX/OK AETC
- An online learning community to help you connect with peers and access resources
- Case studies of public health programs that are currently billing
- Webinars and other online learning tools
- Customized training and technical assistance

Visit our STDRHTTAC page:
www.cardeaservices.org/ourwork/projects/stdrhttac

Billing & Sustainability Series:
Implementation and Improvement Strategies for STD and Other Public Health Programs

Thank you!

Contact Information

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