WORKING TO MAXIMIZE REIMBURSEMENT

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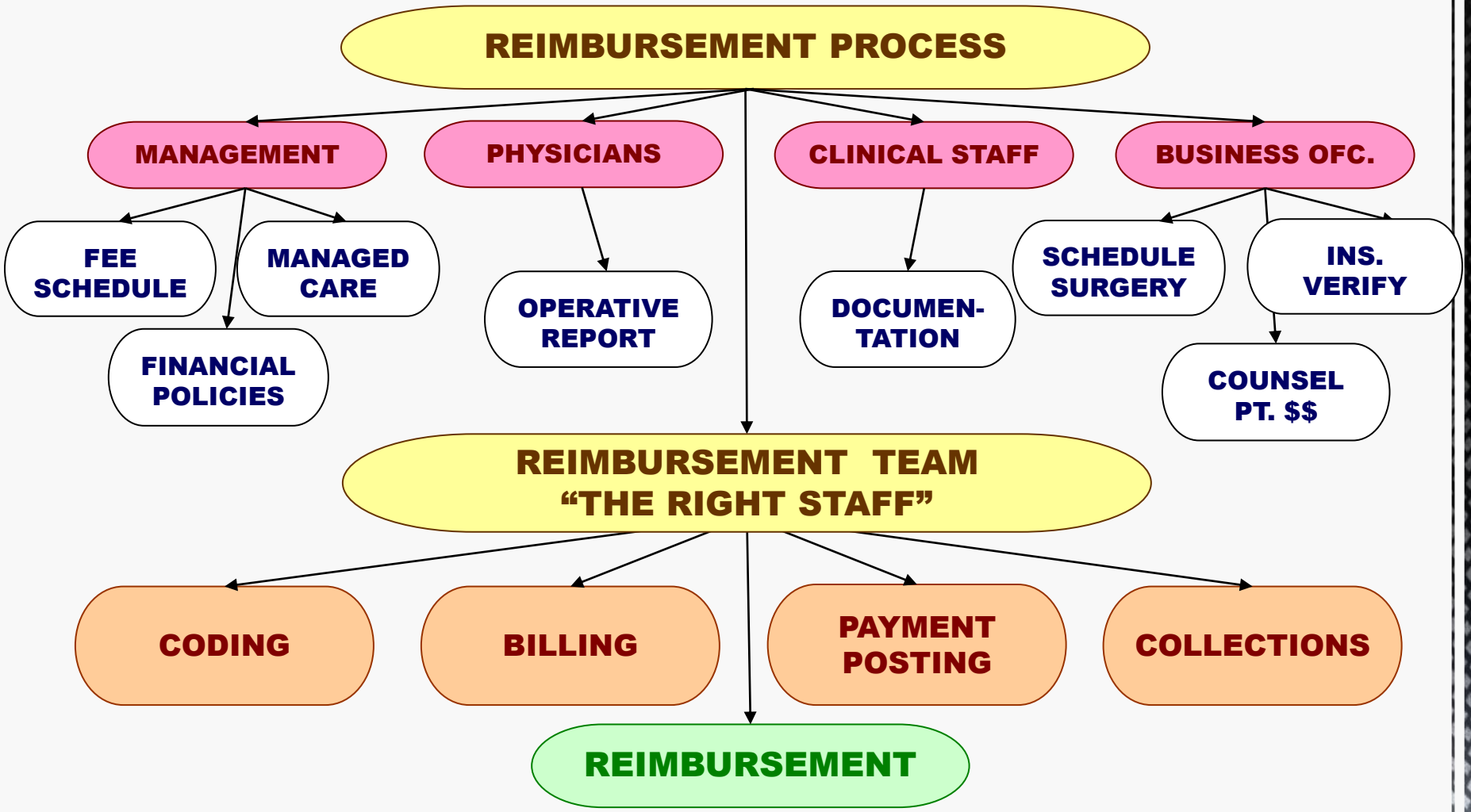
WHAT IT TAKES TO GET PAID!



COMMON PROBLEM AREAS

- Finding sufficient and experienced staff
- System/clearing house rejections
- Lack of appropriate follow up on:
  - Claims
  - Denials
  - Appeals
- Implant reimbursement vs. implant cost
- Not appealing to highest available level
- Not knowing and following Managed Care billing policies
- Unfavorable A/R Trends

PRIOR TO BILLING

SCHEDULING

- **Information from Physicians office:**
  - **demographics – name, address, SS#, etc.**
  - **insurance Information – payer name, ID numbers, address, telephone number**
  - **pre-authorization number for physician and ASC**
  - **Document physician's request for ancillary equipment, special drugs, implants, etc.**
  - **Contact patient directly if you need additional information**

REGISTRATION

- Complete and accurate data entry
- Information entered into software program is what is transmitted on the insurance claim
- Complete and accurate patient information is the 1st step to a clean claim - most claim errors are related to inaccurate registration information
- Medicare's #2 reason for claim denials is incomplete or invalid information

REGISTRATION

Verify:

- Spelling of name
- SS#
- DOB
- Insurance information
- Identify Medicare or Medicare HMO
- Name, DOB of insured
- Necessary information for W/C and Liability

SCAN CARD!

COPY CARD!

SCAN CARD!

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SCAN CARD!

COPY CARD!

INSURANCE VERIFICATION

- A good verification form is invaluable
- Determine patient responsibility (check state regulations and contract language regarding what is permissible to collect prior to DOS)
- Obtain all required information (varies with type of claim, i.e., W/C, Medicare, etc.)
- Use payer web portal for online verification where possible
- Subscribe and obtain Medicare eligibility and information at Cortex EDI

  (www.medicareeligibility.com)

INSURANCE VERIFICATION

- Recommend verifying insurance 5-7 days prior to date of surgery, obtain:
  - Pre-authorization number
  - Eligibility or benefits information
  - In and out of network information for OON
  - Information regarding patient balance due for co-pays/deductibles
  - Obtain reference call number
  - Verify claim mailing address

PATIENT FINANCIAL COUNSELING

- Reverify demographic and insurance information with patient
- Advise patient of ASC's financial policies (CMS regulation)
- Explain monetary responsibility - prior to and following procedure
- Outline methods of payment available
  - cash / check / credit card
  - healthcare credit companies (Care Credit)
  - automatic monthly debits of checking account or credit card (Paytrace, Tigertranz)
  - promissory note, if applicable
- Obtain commitment from patient and document

UP-FRONT COLLECTIONS

- Collect pre-agreed-upon amounts from patient on DOS
- If applicable, provide necessary documents to be signed
  - application for healthcare credit company
  - form for automatic debits
  - promissory note
- Have patient sign ABN for Medicare non-covered services

STARTING THE REIMBURSEMENT PROCESS

OPERATIVE NOTE DICTATION

- Physician must dictate in a timely manner in order to receive the most expedient reimbursement
- Educate physicians on information necessary to obtain optimum reimbursement
- Accuracy and completeness of the operative note is essential - “If it’s not documented it didn’t happen.”

OPERATIVE NOTE DICTATION

- Areas often needing additional attention in dictating are:
  - Bilateral or multiple procedures, right/left
  - Identification of surgical site, e.g., fingers, toes
  - Specific areas treated, e.g., medial / lateral compartment
  - Detailed implant information
  - Ancillary procedures performed
  - Deviation from normal, i.e., time, complications
  - Postoperative pain management details

TRANSCRIPTION

- Use a reputable and dependable company or individual
- Transcription services must be fast, complete and accurate
- Discuss requirements with provider
- Include performance criteria in transcription contract

CODING THE PROCEDURE(S)

- Accurate coding is the key to getting paid
  - understanding optimization versus unbundling
  - know coding and documentation requirements for implants and supplies
- Must be aware of:
  - OIG billing compliance regulations
  - state-specific requirements
  - managed care requirements
- Need certified and surgery-experienced coders

CODING THE PROCEDURE(S)

- Coding must be coder's main responsibility
- Double check for accuracy
- Utilize proper coding edits
- Coders must have access to up-to-date reference materials
- Coders must receive implant information in a timely manner

CHARGE POSTING

- **Accurate charge entry is the first line of defense against denials**
  - **Charge posters need to be familiar with various payers and contracts**
  - **General knowledge of CPT-4 / diagnosis codes and modifiers is a requirement**

Examples:

. ***CPT-4 codes should be entered by highest allowable, if unknown, post by highest charge***

. ***If using 50 modifier, fee should reflect 1 and 1/2 times the regular fee***

CHARGE POSTING

- **State Specific Differences**

  - Know your state's filing and information requirements for:

  - **Workers Compensation**
  - **Medicaid**
  - **PIP/Automobile**
  - **Attorney Cases**

CHARGE POSTING

- **Payer Specific Differences**
  - **Know your Medicare carrier's policies and procedures for adjudicating claims (Local Carrier Determination - LCD)**
  - **Claim form requirements**
  - **Requirements for submitting implants for reimbursement**

CHARGE POSTING

- **Payer Specific Differences (continued)**
  - **Payers periodically update coverage and submission rules**
  - **Timely filing deadlines (payers are shortening these in an effort to avoid payments)**

    Example: Some secondary payers are attempting to change timely filing from primary payer payment date to date of surgery

CHARGE POSTING – BENEFITS OF DIRECT ENTRY

- Some larger payers allow direct entry into their web portal
- <u>Pros</u>
  - Quicker payment
  - Meets payer requirements for clean claim
  - Use of payer website often provides:
    - Acceptance / rejection of claim
    - How much will be paid
    - When payment will be made
- <u>Cons</u>
  - Double data entry = increased cost

CLAIM SUBMISSION

- Clearinghouse – most claims are submitted via a clearinghouse
- The clearinghouse:
  - scrubs claims prior to submission to payer
  - allows for correction to be made if errors are detected
  - submits claims to payers
  - provides reports on claim status

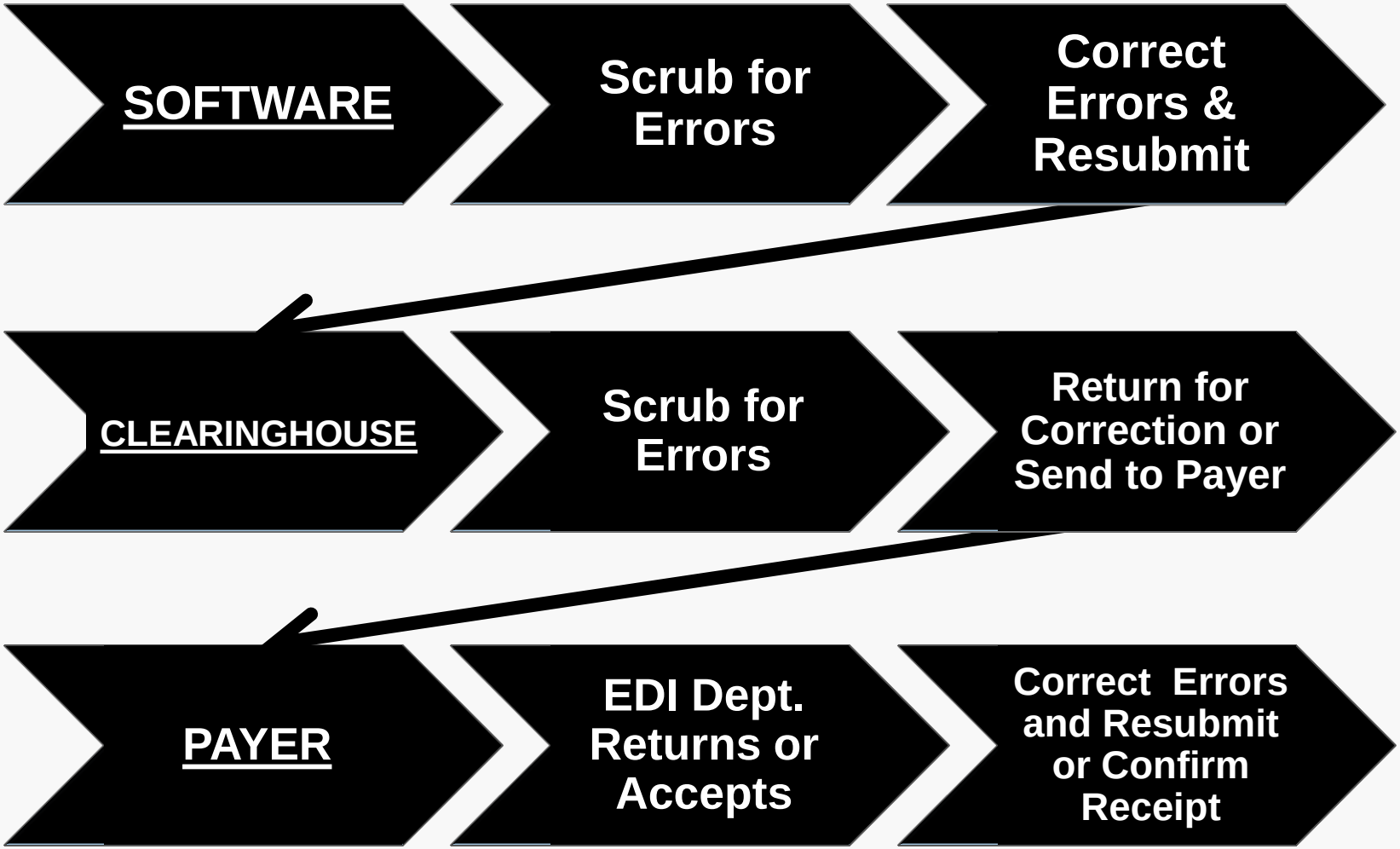
CLAIM SUBMISSION

- Review your clearinghouse reports:
  - claim accepted by clearinghouse and sent to payer
  - Claims accepted/rejected by payer
- Consider receiving Electronic Remittance Advice (ERA) through clearinghouse

CLAIM SUBMISSION

- Software must meet payers' specific requirements to produce clean claims
- Know which claim form is required for specific payer
- Recheck claim for accuracy - submitting "Clean Claims" results in faster, more accurate reimbursement
- Submit claims in timely manner
- Upload claims to clearinghouse daily

FOLLOWING THE CLAIM TRAIL



FOLLOWING THE CLAIM TRAIL

- Prior to submitting claim, ASC software should check for errors
- Once corrected, send to clearinghouse, they also scrub claims for errors
- After claims are corrected, obtain report from clearinghouse showing that claims were sent to payer
- Review report from clearinghouse that shows payer accepted claims
- Correct any payer rejections and resubmit

INSURANCE COLLECTIONS

- Recommend loading and maintaining contracts in software – include:
  - Rates by CPT
  - Discount on multiple procedures
  - Implant allowance
- Maintain up-to-date copy of contracts
- Provide personnel with current insurance matrix
- Maintain implant fee matrix

WHEN WILL THE CLAIM BE PAID?

- Some direct-entry electronic claims are paid in less than a week
- Electronically submitted claims – follow-up in 1 to 2 weeks after payer acceptance

INSURANCE COLLECTIONS

- **Establish claim follow-up dates by payer. Times will vary by contract and industry**

  Example: Medicare versus WC claims

- **Utilize a good tracking system so follow-up dates are not missed**
- **Develop protocol for handling delinquent payers**
- **Respond immediately to payer requests, i.e., operative notes, invoices, etc.**

INSURANCE COLLECTIONS

- Set collection goals
- Provide collectors with a report showing an trending comparison of daily goals versus actual collections

INSURANCE COLLECTIONS

- **Collectors need to:**
  - **review payer aging weekly**
  - **work A/R by payer, age and $$ amount**
  - **use websites for claim status information when possible**
  - **understand contract allowances**
  - **enforce contract language**
  - **enforce state prompt payment legislation**
  - **be alert to common payer responses**

"Claim not on file"
"Claim processing"
"Check is in the mail"

INSURANCE COLLECTIONS

- Collectors need to:
  - call accounts by payer – discuss all outstanding claims with one call
  - document claim status
  - request interest payments where applicable
  - understand payer's appeal process
  - use appeal letters with information needed to support claim
  - follow up on appeals promptly
  - take appeals to highest level available

INSURANCE COLLECTIONS

- Follow claim denials using a denial log – some suggested categories include:
  - registration errors
  - form errors
  - clearinghouse errors
  - payer error
  - no pre-authorization
  - coding error
  - needs additional information

INSURANCE COLLECTIONS

- Be alert to payer trends:
  - Slower processing
  - Requesting extra discount
  - Rental network game
- What to do if they just won't pay
  - Appeal to the highest level
  - Enforce contract language
  - Contact state insurance commissioner
  - Don't give up

INSURANCE COLLECTION TIPS

- Be firm and persistent
- Build relationship with payer reps
- Don’t depend on websites for all information, speak to a representative
- Get definitive date of payment
- Request reference call number
- Document dates, names, promises, etc.
- Enforce state prompt payment regulations
- Immediately send any requested information
- Follow-up again within a few days

SECONDARY CLAIMS

CHASING THE BALANCE

- Once correct payment is received from primary payer, transfer the balance to secondary payer
- If Medicare is primary, determine whether claim has been automatically forwarded to the secondary payer
- If not, send copy of original claim and EOB to secondary payer immediately
- Use same guidelines as for primary claim follow up

SELF-PAY COLLECTIONS

- In most cases the patient is the ultimate responsible party – insurance contracts are between the patient and the payer
- Establish an effective self-pay policy to maximize self-pay collections
- Send patient statements at least monthly
- Assign a specific person to answer patient statement questions

SELF-PAY COLLECTIONS

- **The cost to send a patient statement is estimated to be between $8 and $10 (be prudent of time spent in collection efforts)**

  Example: $5 balance – 2 statements and a phone call?

- **Establish small balance write-off policy so you don't spend more collecting than you stand to collect**

SELF-PAY COLLECTIONS

- Customized professional-appearing statements (clearinghouse vs software)
- Send first statement immediately after correct insurance payment received
- Recommend 2 statements, courtesy phone call, final notice, then send to collection agency
- Select collection agency carefully and monitor regularly

SELF-PAY COLLECTIONS

- Payment plans require management approval – use promissory note
- Follow up on payment plans regularly to ensure compliance
- Offer alternatives:
  - healthcare finance companies
  - monthly credit card or checking account debits, etc.
  - discounts for paying balance in full (requires approval by management)

PREPARATION FOR PAYMENT PO$TING

- Pre-loaded contracts in software provide:
  - payment allowance per CPT
  - coverage of implants, drugs, supplies
  - multiple procedure allowance
- Pre-verified coverage loaded into patient software account provides:
  - deductibles, co-pays, co-insurance, contract allowances, etc.

PAYMENT PO$TING

- Payment posters are your first line of defense against erroneous reimbursement. They should:
  - Check all facets of payments for accuracy, i.e., rates, # of procedures, ancillary charges
  - Call on all denied and erroneous payments
  - If indicated, start appeal process right away
  - Send account to collector for further follow-up
- Be aware of new rules for some Medicare supplement plans - some plans may require that providers have a patient's signed authorization to appeal

PAYMENT PO$TING

- If payment is correct:
  - Post the payment
  - Reassign balance to appropriate responsible party
    - Send to secondary insurance
    - Send patient statement

PAYMENT PO$TING

- If payment does not reflect expected amount:
  - determine specific reason(s) for difference, i.e., deductible, co-insurance percentage, disallowed procedure codes, allowance differs from contract, etc.
  - review coding to make sure it is correct
  - call payer to question payment discrepancy, if possible, obtain payment correction on phone without having to file appeal
- If your payer has sufficient information available online, a phone call may be unnecessary
- Always fully document answers

FILING A DENIAL

Steps for an Appeal

- Check to ensure payment deficiency was not because of a coding or billing error
- Review payer requirements to file a denial (found in payer's contract or their website)
- If applicable, use payer's special forms and send to specified address
- Include all attachments, i.e., EOB, operative note, invoice, etc.
- If necessary, take to the highest level of appeal available

MONITORING / MEASURING YOUR ACCOUNTS RECEIVABLE

- Industry benchmarks are helpful but are not always the best indicator of the health of your A/R
- Center-specific benchmarks should be established that include a combination of:
  - Total A/R
  - A/R by Payer
  - Aging of A/R
  - Days in A/R
  - Patient Portion of A/R

MEASURABLE RESULTS

	Before	After	Increase	% Increase
Gross Revenue per Case	$6,039.52	$7,157.94	$1,118.42	18.5%
Collection's per Case	$2,909.45	$3,206.83	$297.38	10.22%

INTERNAL PROCESS AUDITS

GUARANTEE PROCESS IS RUNNING SMOOTHLY

- **Audit your processes for accuracy and efficiency:**
  - **Coding – accuracy, timeliness**
  - **Claims Processing – accuracy, timeliness**
  - **Payment Posting – accuracy, timeliness, error follow-up**
  - **Collections – timeliness, effectiveness, denials**

BEST PRACTICE GUIDELINES

- Regular internal process audits
- Business office/financial policies
- Review fee schedule at least annually
- Evaluate managed care contracts

HOW TO IMPROVE

- Implement best practices
- Monitor all areas for improvement
- Measure improvement

ADDITIONAL INFORMATION?

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