

## **Tips and Tools for Working your A/R**

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### **Disclaimer**

- ▶ This course was current at the time it was written.
- ▶ Every reasonable effort has been made to assure the accuracy of the information.
- ▶ Proper coding may require analysis of statutes, regulations or carrier policies and as a result, the proper code result may vary from one payer to another.
- ▶ This program is not intended to be legal advice and your attendance should not be construed as a legal opinion of the presenter.

## **REV UP YOUR REVENUE**

**Know your Numbers**

**COLLECT THE CASH**

## **ARE YOU A BILLER?**

**or**

**A**

**REVENUE CYCLE SPECIALIST?**

**You already know the elements of the revenue cycle**

How can you improve?

**You cannot monitor what you do not measure**

## DAYS in A/R

- ▶ Days in AR = Total AR ÷ Average daily charge
- ▶ Average Daily Charge = 12 months of charges / 365
- ▶ Example:
  - Average Daily Charge is \$5,000.00
  - Total A/R is \$400,000.00
  - Days in A/R = an average of 80 days to collect.
- ▶ Is this acceptable?

## Review Reports

- ▶ Each month print an A/R aging report for insurance balances and patient balances
  - Print report by date of service
  - Compare month to month
    - Write notes on the report
- ▶ Print an adjustment report
  - Use detailed adjustment codes

## Insurance Aging Report

- ▶ Is there a problem payer or a payer with a problem?
  - Denials?
  - Clearinghouse reports?
  - **Identify the issue**

## Patient Aging

- ▶ How many statements?
  - One statement I received from a physician's office stated
  - *"This is your first and final statement, your balance is due immediately. Thank you for paying promptly"*

## Have you asked the questions?

- ▶ Ask front office staff for input on improving the revenue cycle.
  - What is working?
  - What is not?
- ▶ Ask the billing/coding staff for input on improving the revenue cycle.

## Do your patient's understand your expectations?

- ▶ Do you have a clear financial policy?
- ▶ Do they know what number to call if they have questions?
  - Can they get to a real person?
- ▶ Do you accept credit cards? Debit cards?
- ▶ Are you consistent in collecting copays? Are all of the front office staff comfortable asking for money due?
- ▶ If a patient has a question while in the office, is there someone they can talk to?

## Prepare the Claim

American Medical Association - Practice Management  
<http://www.ama-assn.org/ama1/pub/upload/mm/368/prepare-that-claim.pdf>

## Credentialing

- ▶ Are you providers properly credentialed?
  - Are you sure?
  - Do you have your physician's initial the CAQH document once a year?

## Health Insurer Contracts

- ▶ Do you know.....
  - Policies
  - Claims submission
  - Appeals
  - Web-site Access
  - Fee Schedule
  - Guidelines - CCI edits? Medicare rules?
  - Definition of "medically necessary" care
  - Prior authorizations

## Claims Management Process

- ▶ GOALS
  - Increased staff efficiency
  - Streamlined claims billing processes
  - Increased number of clean claims submitted
  - Reduced number of claims denied
  - Timely and accurate payment from the health insurer.

## Registration

- ▶ Pre-registration
- ▶ Health insurer benefit verification
  - Confirm benefits, use on-line resources
- ▶ Patient check-in
  - Copy/Scan Insurance card
  - Verify identify
  - Collect copays
  - Financial policy

## Pre-Authorization

- ▶ Is it required for the scheduled procedure?
- ▶ Document the authorizations number and forward to the billing department

**ABN**

- ▶ The Advanced Beneficiary Notice (ABN) is a simple, one-page form that explains to a patient why Medicare may not cover a proposed service/procedure, gives an estimated cost for the service/procedure, and asks the patient to indicate whether he or she would like to accept financial responsibility and continue with the service/procedure.

**GY – Item or Service Statutorily Excluded**

- ▶ Item or Service Statutorily Excluded or Does Not Meet the Definition of Any Medicare Benefit
- ▶ Non-covered by Medicare Statute (ex., service not part of recognized Medicare benefit)
- ▶ Optional notice only, unless required by COPs; beneficiary liable

**GA – Waiver of Liability Statement**

- ▶ Waiver of Liability Statement Issued, as Required by Payer Policy
- ▶ ABN required; beneficiary liable
- ▶ To signify a line item is linked to the mandatory use of an ABN when charges both related to and not related to an ABN must be submitted on the same claim

**Clinical Documentation**

- ▶ Verify that all services and procedures meet the documentation guidelines
- ▶ Internal audits monthly
  - Look for missed charges, proper documentation, proper coding
- ▶ External audits once a year. (WHY?)

**Principles of documentation**

- ▶ The medical record should be complete and legible.
- ▶ The documentation of each patient encounter should include:
  - reason for the encounter and relevant history, physical examination
  - findings and prior diagnostic test results;
  - assessment, clinical impression or diagnosis;
  - plan for care; and
  - date and legible identity of the observer.

**Documentation Basics**

- ▶ If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- ▶ Past and present diagnoses should be accessible to the treating and/or consulting physician.
- ▶ Appropriate health risk factors should be identified.

## Documentation Basics

- ▶ The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- ▶ The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

## Who is Assigning the Codes

- ▶ The physicians
  - Are they trained?
  - Are you auditing the codes?
- ▶ The staff
  - Certified or well trained?
  - Do they have the proper resources?
- ▶ A coding professional should verify and review the codes based on the documentation
- ▶ Is the superbill correct? Are the descriptions in the EMR correct?

## Check out

- ▶ Collect any past due balances or arrange payment plans
- ▶ Schedule next appointment

## Follow that Claim

<http://www.ama-assn.org/ama1/pub/upload/mm/368/follow-that-claim.pdf>

## Billing Cycle

- ▶ Entering the service
- ▶ Generating and reviewing claims
- ▶ Reviewing pre-submission edits
- ▶ Reviewing clearinghouse reports
- ▶ Receiving payment
- ▶ Posting payment
- ▶ **Auditing explanation of benefits or remittance advice for accuracy**

## Auditing the EOB/RA

- ▶ You should not rely on the health insurer to correctly process and pay the claim
- ▶ By auditing you will be able to pinpoint and address underpayments and denials based on a health insurer's inappropriate adjustments

### **Most common health insurer edits based on CCI and Medicare**

- Bundling Issues
- Modifier required
- Procedure and age conflict
- Procedure and gender conflict
- Global service package
- Diagnosis and age conflict
- New Patient E & M not allowed

### **Most common health insurer edits based on insurer proprietary edits**

- Procedure is not allowed
- Procedure is not allowed with other procedure
- Modifier code and place of service conflict

### **Billing**

- Verify your accuracy
- Run a pre-submission edit report
- Review clearinghouse reports

### **Payment posting**

- Monitor adjustments
- Do assume the claim has been processed correctly
- Monitor fee schedules
- How are denials handled?
  - What are the denials?
  - How can they be reduced?
  - Do the claims need to be corrected?

### **Common procedure codes in which the physician's charge were less than contracted amount**

- Immunization administration
- Immunotherapy
- 99213
- Injection administration
- Visual Acuity Screen

### **Practice Report Card**

- % of explanation of benefits denials
- % of collection of co-payments at time of service
- % of charge entry within 24 hours
- % collection of past-due balances
- % of registration accuracy
- % of coding accuracy

## Appeal that Claim

American Medical Association - Practice Management  
<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/claims-management-revenue-cycle.shtml>

## Why Appeal?

- ▶ Physician practices are entitled to payment for the procedures and services they provide when they have coded and documented the procedure or service appropriately.

## Sample Appeal Letters

▶ <http://www.appealletteronline.com/>

• 1199

- ▶ AMA has letter templates for:
  - Generic Appeal
  - Inadvertent Coding Error
  - Claims Underpayment
  - Lack of recognition of modifier 25 or 59
  - Inappropriate E/M Downcoding

## Top reasons health insurers deny

- ▶ Non-covered service
- ▶ Patient not eligible
- ▶ Claim lacks information
- ▶ Prior authorization required
- ▶ Claim sent to the wrong health insurer
- ▶ Documentation required

## Insurer report card

▶ [http://www.nhxs.com/docs/upload/2009\\_AMA\\_National\\_Health\\_Insurer\\_Report\\_Card\\_L.pdf](http://www.nhxs.com/docs/upload/2009_AMA_National_Health_Insurer_Report_Card_L.pdf)

## Appeal ALL inappropriately paid and denied claims

- ▶ By not appealing your practice will lose revenue and the opportunity to recover payments that the health insurer contractually owes.
- ▶ When you help your practice - you are helping the health insurer change their business practices

## Tools to Use

Your secret weapon.....knowledge

## Michigan

- ▶ What health plans are subject to the prompt payment procedures?
- ▶ Health insurance companies, Medicare supplement insurers, long-term care insurance companies, multiple employer welfare arrangements (MEWAs), health maintenance organizations (HMOs), and non-profit health care corporations (Blue Cross/Blue Shield of Michigan).

## Michigan Prompt Pay

- ▶ **When can I file a complaint against a health plan for not paying the claim?**
  - Complaints can only be filed on the appropriate Clean Claim Report form (FIS-0284) for services that were performed on or after October 1, 2002. As a provider, you must allow the health plan 45 days within which to pay the claim before you can file a complaint with the Commissioner, so the earliest date you could file a claim would be November 15, 2002. **Please note you must fill out a separate form FIS-0284 for each claim.**
  - [http://www.michigan.gov/documents/cis\\_ofis\\_fis\\_0284\\_50170\\_7.pdf](http://www.michigan.gov/documents/cis_ofis_fis_0284_50170_7.pdf)

## Workers' Compensation Agency

- ▶ <http://www.michigan.gov/wca/0,1607,7-191-26922---,00.html>

## RBRVS Data Manager 2010

- ▶ The *RBRVS Data Manager* provides access to proprietary information related to the assignment of the relative value units, provides a rationale for each code valuation.
- ▶ Ten years of Medicare utilization data for each CPT code, including the specialties that perform the service, site-of-service, diagnosis and patient demographics  
Physician time data for each physician service



## CodeManager 2010

- ▶ CPT, ICD-9-CM, HCPCS, CCI Edits, Medicare rules, clinical examples, Dorlands Medical Dictionary
- ▶ <http://www.codemanager.com/> (free demo)



## CPT Assistant

▶ 20 years of CPT Assistant newsletters



## Time for discussion

*Thank you for your time and attention*  
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