Billing Behind the Scenes: Techniques and Critical Insights

PRIMARY CARE DEVELOPMENT CORPORATION

Presenter

Tamisha McPherson

Chief External Affairs And Development Officer, Harlem United

Learning Objectives

- Learning the behind the scenes billing techniques
- Review and discuss staffing needs at front desk and Billing office
- Understanding why Denial Management is the key to consistent cash flow
- How important it will be to Get Paid in 2020
- Discuss how to remove the barriers payers created for agencies getting paid timely
- Understanding payer contracts (referrals, claims data, etc.)

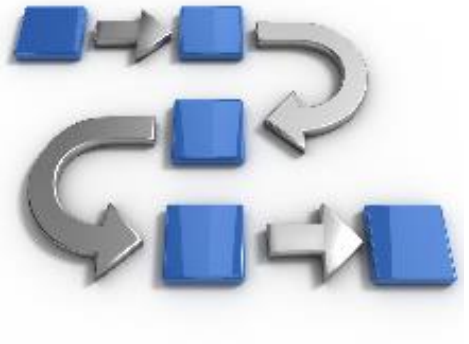
What are the behind the scenes billing techniques?

- Payers are expecting that only a small percentage of medical practices will follow up on claim denials and resubmit them corrected or as appeals.
- Insurance companies make money from claims that are not pursued.
- Investing in an experienced denial management team will be critical to capturing lost revenue within agencies (most agencies invest in billing specialists that can both bill and work denied claims).
- Each third-party insurance payer has a different procedure for correcting errors. Contact the carrier to find out their preferred method or consult their website and then refile a corrected claim.

What are the behind the scenes billing techniques? (Cont.)

Questions to know and ask your billing team:

- How are denied claims monitored and processed?
- Who tracks the major reasons for the denials?
- Do you have a tracking/reporting process that will allow your agency to measure your performance over time?



What is needed to have a successful Front Desk and Billing Department?

- Invest in hiring front desk staff that have the competencies to do the job; customer service, excellent writing and communication skills. Billing experience would be preferred.
- Have you considered hiring billers for front desk positions? Billers know and understand what is needed up front to get claims paid on the back-end billing process.
- Have you considered the front desk being supervised by Finance / Billing? Many agencies assign the Clinic manager to oversee the front desk. The business model of clinic managers overseeing front desk operations has expired.
- Do you test your billing team for billing 101 competencies? Consider giving all billers the attached test. You will be surprised how they do on the test! Here's a link to a billing test: https://www.tests.com/practice/Medical-Billing-Practice-Test
- Have you had an external billing review to assess and review basic billing practices /compliance? If so, how often?

Why is Denial Management key to capturing lost revenue?

Identify the major reasons for denial:

- In order to count the number of denials by reason, you first need to determine the categories that you are going to utilize to track all your claim denials. The list below identifies the most frequent denial reasons that medical practices experience[1]:
  - Registration (examples: Insurance Verification, Incorrect Payor, Cannot Identify Patient)
  - Charge Entry (examples: Invalid procedure or diagnosis codes
  - Referrals & Pre-authorizations
  - Information from Patient
  - Duplicates (example: 2nd CPT on same date)
  - Medical Necessity (example: ICD-9 and CPT mapping)
  - Documentation
  - Bundled/Non-covered (example: Modifiers)

1. https://www.kareo.com/blog/article/denial-management-101-medical-billing-remember-basics

Why is Denial Management key to capturing lost revenue? (Cont.)

Questions to think about within your agencies:

- Does the C-level staff in your agency receive, discuss and know or focus on how high denials are?
- Does your senior level managers understand and know how to run billing reports within the EMR? (Very important to ensure reports are accurate and can be verified)
- How often does your agency request denial reports from your health insurance companies? (Very important to ensure your internal billing and Aging reports are accurate)
- Do you have a collections process to ensure the financial health of your agency? (a step-by-step approach clarifies the procedures for all involved, and it can greatly improve revenue cycle by ensuring patients are properly and thoroughly informed of their responsibilities.

1. https://www.kareo.com/blog/article/denial-management-101-medical-billing-remember-basics
2. https://www.hapusa.com/6-proactive-medical-billing-tips/

The tricks behind getting paid for services within your payer contract:

- Payers have increased the sophistication of their computer systems so they can define different payment algorithms which mimic the contract requirements. (Who's reviewing contracts verses payments received)[1]
- There needs to be appropriate staff hired to manage the increased level of contract and payer contracts (who should oversee this task)
- Building meaningful relationships with staff at insurance companies (meetings should happen virtually for check-ins and issues regarding denied, delayed or underpayments)
- Most importantly negotiate appeals and work all unpaid claims. There needs to be appropriate talented staff to address denial management with insurance companies.

[1]. https://www.kareo.com/blog/article/denial-management-101-medical-billing-remember-basics

The tricks behind getting paid for services within your payer contract: (Cont.)

Filing Claims 101

Once you're credentialed and contracted with one or more insurance companies in your state, you're ready to file your first claim. Each claim filed will involve conducting an eligibility and benefits check, filing a claim, and getting paid.[1]

- ***Conducting an Eligibility and Benefits Check***
  An eligibility check is used to verify the services that your patient's health insurance covers. You're checking to see whether the patient's plan covers nutrition counseling services and any additional diagnosis codes. Get comfortable, as you may be on hold for a while, but once you reach a representative, the following are questions to ask:

- **Are there diagnosis restrictions?** Learn whether the visit is for preventive or another nutrition-related diagnosis and inquire which procedure codes are covered by the plan.

- **Is there a deductible?** A deductible has to be met before insurance companies will pay. It's important to know whether patients have met their deductibles, because if they have, then they'll be covered for services. If they haven't, they'll have to pay out-of-pocket until they meet their deductibles.

- **Is there an out-of-pocket max?** This information is the amount that the client needs to reach before coinsurance kicks in.

1. https://www.todaysdietitian.com/newarchives/0217p40.shtml

The tricks behind getting paid for services within your payer contract: (Cont.)

- **Are there additional copayments or coinsurance?** Copayments may be required at each office visit even after deductibles are met. Coinsurance is the percentage of the service that the insurance company covers. This usually applies after the deductible and out-of-pocket maximum have been met.[1]
- **Is a referral from a primary care provider required?** Patients may need a form from their primary care provider giving them permission to see you for specialty services.
- **Is there a maximum number of visits allowed?** Inquire whether there are restrictions on how many visits patients can have covered by insurance in the contract year. Be sure to clarify when the contract year starts.
- **What's the reference number for this call?** In case the claim gets denied and you need to appeal it, a reference number will help you cite the information you were told on this call.

[1]. https://www.todaysdietitian.com/newarchives/0217p40.shtml

The tricks behind getting paid for services within your payer contract: (Cont.)

Monitor Insurance Claim submission

It's important that claims are accurate and complete upon submission. This involves inputting the information correctly and double-checking claims for any possible errors before submitting the insurance claim.

Agencies must manage the most common sources of error:

- **Incorrect patient information:** Name, date of birth, insurance ID number, etc.
- **Incorrect provider information:** Address, name, contact information, etc.
- **Incorrect insurance information:** Policy number, address, electronic payer ID, etc.
- **Duplicate billing:** Failure to verify that a service has already been reported or reimbursed.

[1] https://www.hapusa.com/6-proactive-medical-billing-tips/

The tricks behind getting paid for services within your payer contract (Cont.)

- **Poor documentation:** The provider submitted incorrect, illegible, or incomplete documentation of a procedure or visit, making it more difficult to verify and complete the claim. In these cases, the biller should contact the provider for more information.

- **No EOB on a denied claim:** For insurers still requiring physical claims, they may fail to attach the Explanation of Benefits (EOB) to a denied claim, making it more difficult to spot and correct the error.

- **Missing or unclear denial codes or claim number references on a denied claim:** Many insurers allow electronic or online submissions of appeals and corrected claims. Instead of an EOB, these claims are returned with a claim number and denial codes to explain the source of error. If these codes are missing or unclear, it can be more difficult to spot and correct the error.

Telehealth: are you getting paid? Areas you need to monitor:

List of COVID-19 State Related Actions

- https://www.cchpca.org/resources/covid-19-related-state-actions
- https://www.aafp.org/patient-care/emergency/2019-coronavirus/telehealth.html

Agencies are struggling to get paid for Telehealth visits. Why?

- Provider payments vary by states, plans, and shifting policies

- The Centers for Medicare & Medicaid Services (CMS) pledged that Medicare would reimburse providers at 100% of the in-person rate for many of these virtual visits, and private payers followed with similar policies. But providers, analysts, and other insiders say some bills are being returned and only partially paid.[1]

- Many insurance company representatives are not aware or familiar with the telehealth reimbursement

1. https://www.medpagetoday.com/infectiousdisease/covid19/85990

Questions?

PCDC's Sustainable Strategies Team

Kristin Potterbusch
Program Director

Email: hrsa@pcdc.org
(212) 437-3960

Chaim Shmulewitz
Project Manager

Sustainable Strategies TargetHIV Link: https://targethiv.org/ta-org/sustainable-strategies-rwhap-community-organizations

PrimaryCareDevelopmentCorp @PrimaryCareDev

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