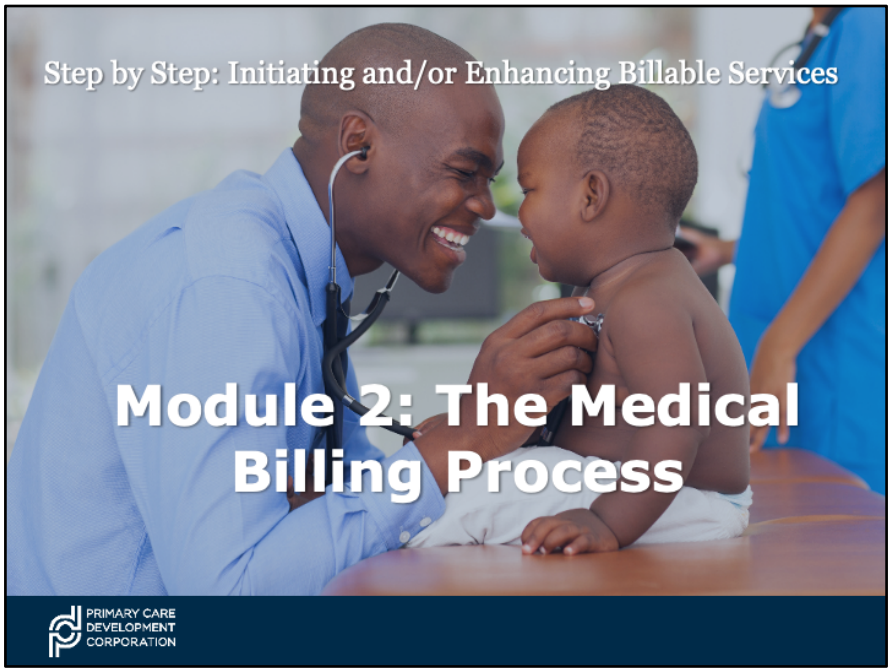


Welcome to the Step by Step: Initiating and/or Enhancing Billable Services Module 2: The Medical Billing Process.

RR Health Strategies

- Pam D'Apuzzo, CPC, ACS-EM, ACS-MS, CPMA
- Jean Davino, DHA, MS, CLT

PRIMARY CARE DEVELOPMENT CORPORATION

2

Learning Objectives

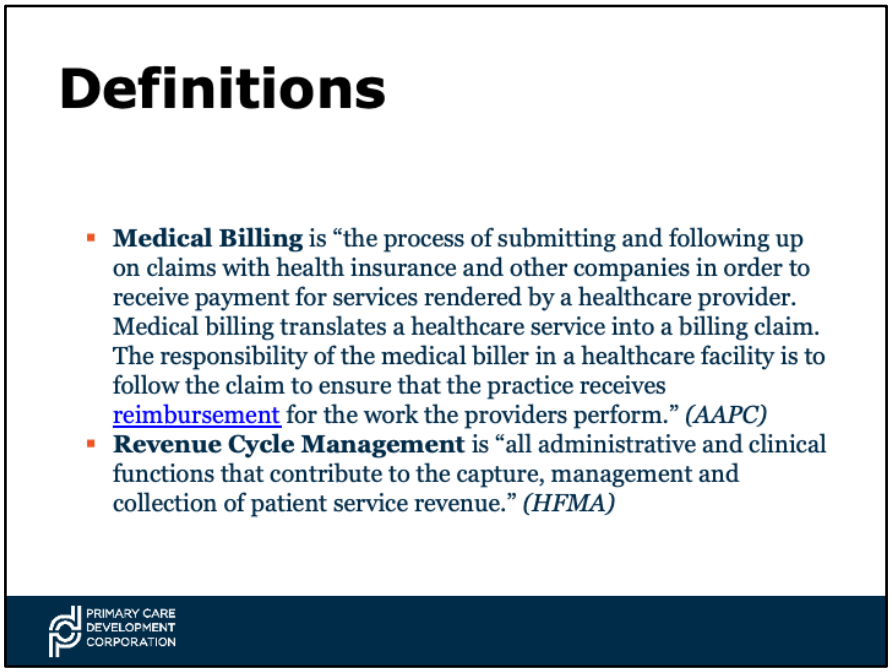
- To describe medical billing & revenue cycle management fundamentals
- To examine operational workflow
- To explore staffing your billing office

PRIMARY CARE DEVELOPMENT CORPORATION

Medical Billing and Revenue Cycle Fundamentals

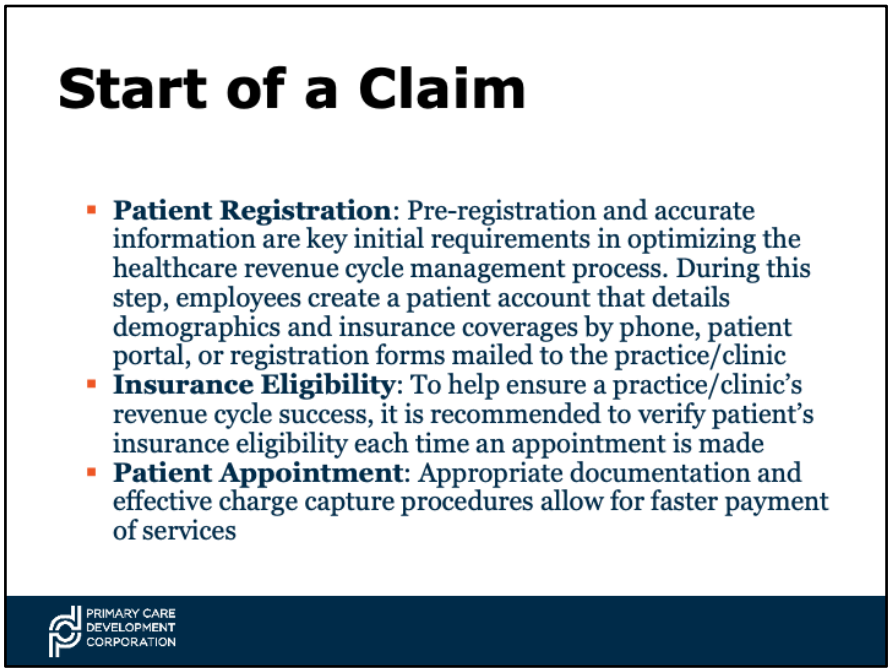
PRIMARY CARE DEVELOPMENT CORPORATION

4

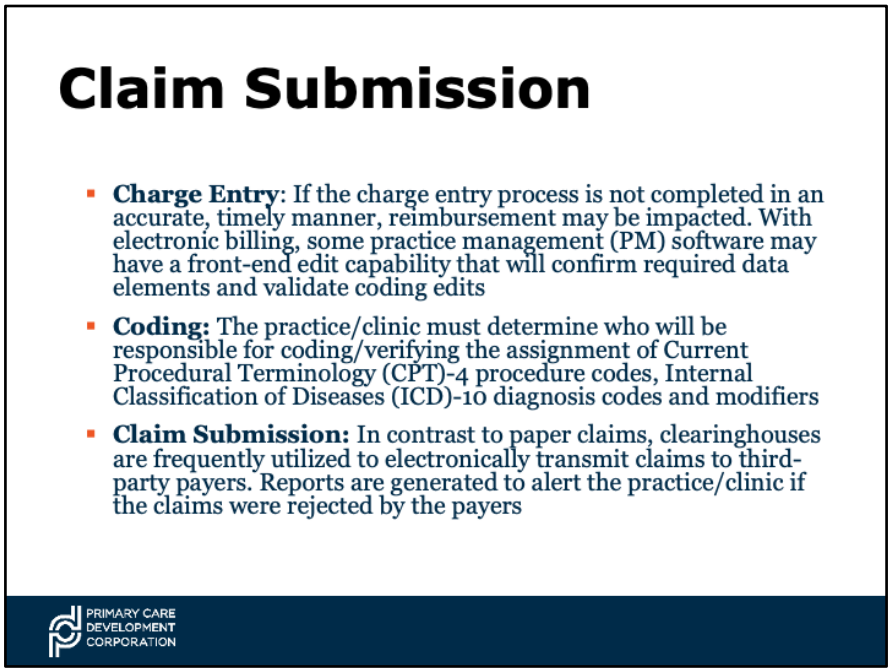


- Efficient medical billing processes optimize returns and shorten the revenue cycle process.

- Revenue Cycle Management is more than the billing of claims. The process begins at patient registration and the **accurate** collection of patient data



- Having specific policies and procedures for patient registration, insurance and benefit verification, charge capture, and claims processing is an essential step to maintaining practice viability.
- Investigate and incorporate automated and software-aided insurance eligibility verification into current practice/clinic work flows.
- The tracking of patient visits is essential for charge reconciliation (e.g., no shows)



- The charge entry process is where claims are actually created.
- Appropriate coding will assist in proper reimbursement.
- Coding is also critical for demographic assessments and studies of disease prevalence, treatment outcomes and accountability-based reimbursement systems (e.g., HEIDIS, MACRA)
- Electronic claims submission vs. manual claims submission

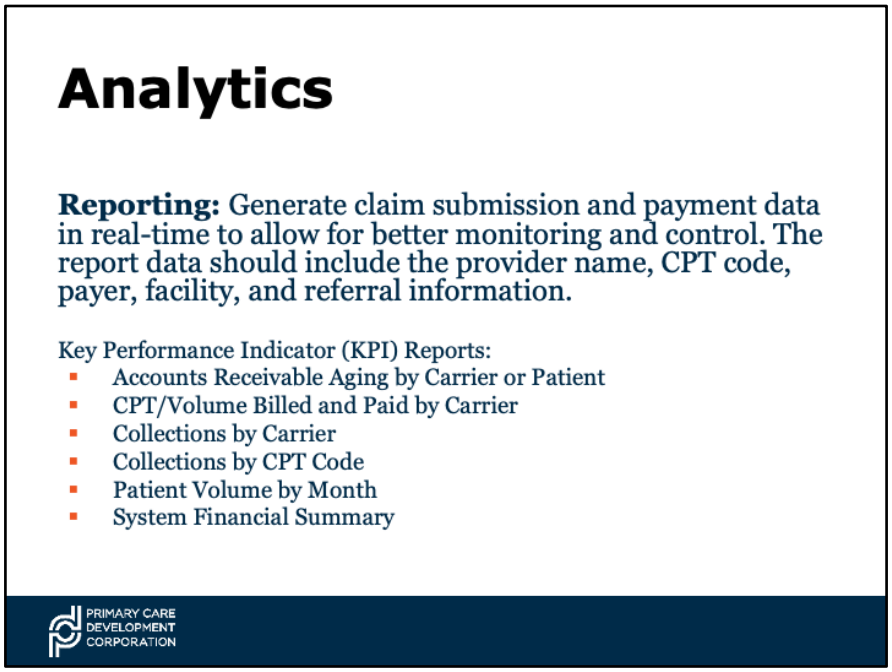
- Reduce the amount of time and resources physician practices devote to manual administrative functions—time that can be better spent with patients or focused on other practice efficiencies
- Pre-audit claim fields automatically for potential errors prior to submission.

Claims Management

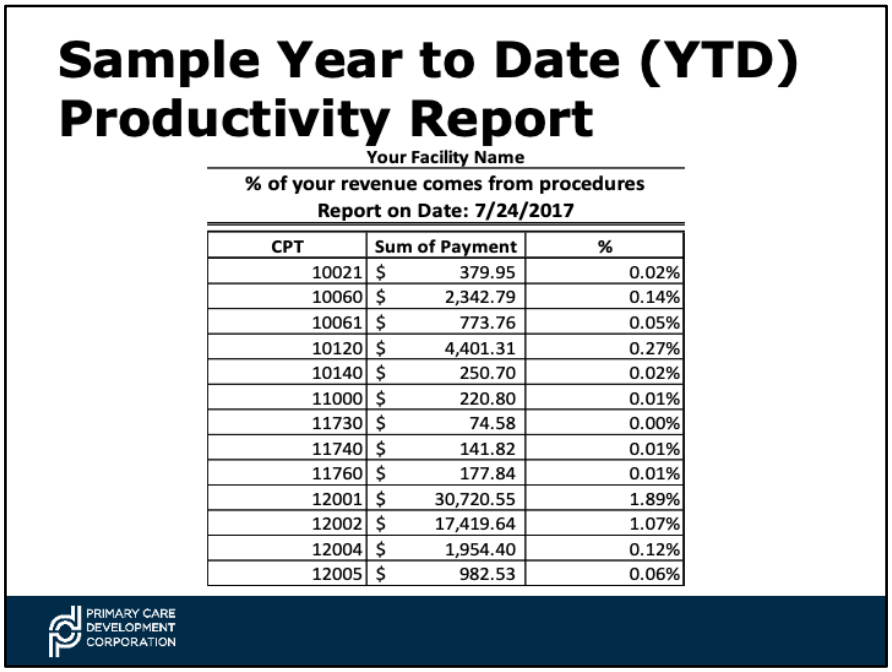
- **Payment Posting:** Whenever possible, electronic remittance should be set-up with payers, as opposed to manual payment posting. The electronic remittance process allows staff members to review and work from an "exception report." Including payer contract details and fee schedules into the software, will allow for more accurate payment posting
- **Denial Management:** Best practices recommendations include tracking and trending denials at the time of payment posting. Denials should be tracked by payer, denial type, and provider
- **Appeals:** Appealing a denied claim does not guarantee that it will be overturned. However, failing to follow the formal process and associated submission timeline, will guarantee non-payment

Accounts Receivable (A/R) Management

- **A/R Follow-up:** Most insurance carriers are required to pay or deny the claim within 30 days of receipt. Claim follow-up should begin as quickly as 7-10 days following claim submission
- **Patient Collections:** The practice/clinic should establish a policy and associated timeframe for transfer of responsible party from insurance to patient (e.g., 30 or 45 days after the claim is initially submitted). For all patient collection accounts, a timeframe in which the account will be reviewed internally before the account is written off and/or transferred to an external collection agency should also be established
- **Patient Statements:** Due to the large volume of carriers with higher deductibles, coinsurance, and copays, and services considered non-covered, more and more patients have outstanding balances with the practice/clinic. Patient statements should be issued on a regular basis to better manage the patient balances



- Physicians and practice administrators need to be astute in comparing and analyzing data and should ask for assistance from experienced professionals if there is difficulty in interpreting any practice/clinic financial reports
- Reports aid in determining areas that need the most focus, especially regarding revenue, productivity and efficiency
- Establish a broad spectrum of KPIs for long-term success (e.g., gross collection percentage – total charges/total collections informs a practice of what it collects relative to each dollar charged



Sample Year to Date (YTD) Productivity Report

Your Facility Name

% of your revenue comes from procedures

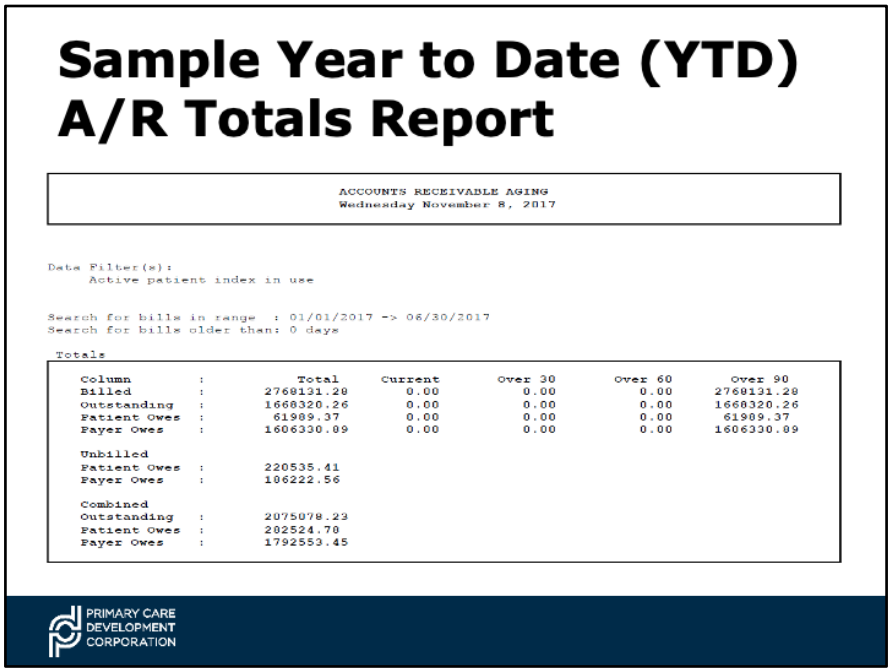
Report on Date: 7/24/2017

CPT	Sum of Payment	%
10021	$ 379.95	0.02%
10060	$ 2,342.79	0.14%
10061	$ 773.76	0.05%
10120	$ 4,401.31	0.27%
10140	$ 250.70	0.02%
11000	$ 220.80	0.01%
11730	$ 74.58	0.00%
11740	$ 141.82	0.01%
11760	$ 177.84	0.01%
12001	$ 30,720.55	1.89%
12002	$ 17,419.64	1.07%
12004	$ 1,954.40	0.12%
12005	$ 982.53	0.06%

PRIMARY CARE DEVELOPMENT CORPORATION

- Productivity reports can expose opportunities for facilitating dialogue among the stakeholders in the practice, serve as a catalyst for changes in the operation such as maximizing revenue through changes in the fee schedule or hours of operation

Sample Year to Date (YTD) A/R Totals Report



ACCOUNTS RECEIVABLE AGING
Wednesday November 8, 2017

Data Filter(s):
Active patient index in use

Search for bills in range : 01/01/2017 -> 06/30/2017
Search for bills older than: 0 days

Totals

Column		Total	Current	Over 30	Over 60	Over 90
Billed	:	2769131.20	0.00	0.00	0.00	2769131.20
Outstanding	:	1668320.26	0.00	0.00	0.00	1668320.26
Patient Owes	:	61989.37	0.00	0.00	0.00	61989.37
Payer Owes	:	1606330.89	0.00	0.00	0.00	1606330.89
Unbilled						
Patient Owes	:	220535.41				
Payer Owes	:	106222.56				
Combined						
Outstanding	:	2075078.23				
Patient Owes	:	202524.78				
Payer Owes	:	1792553.45				

PRIMARY CARE DEVELOPMENT CORPORATION

- Each A/R report may be formatted differently
- The 0-30 day bucket for both patient and insurance should be the highest totals. This category represents the most recent claims submitted.

- The next highest will be the 31-60 day totals. Typically most of the claims due will fall in the 0-60 day period.
- The monies in the 61-90 day bucket should drop off dramatically, especially with insurance balances.
- The 91-120 day bucket amount should drop as claims are worked, patients are billed, carrier follow-up is performed and collection efforts are made.
- Generating this report monthly, will demonstrate your progress in each area.

Sample System Financial Summary Report

Your Facility Name

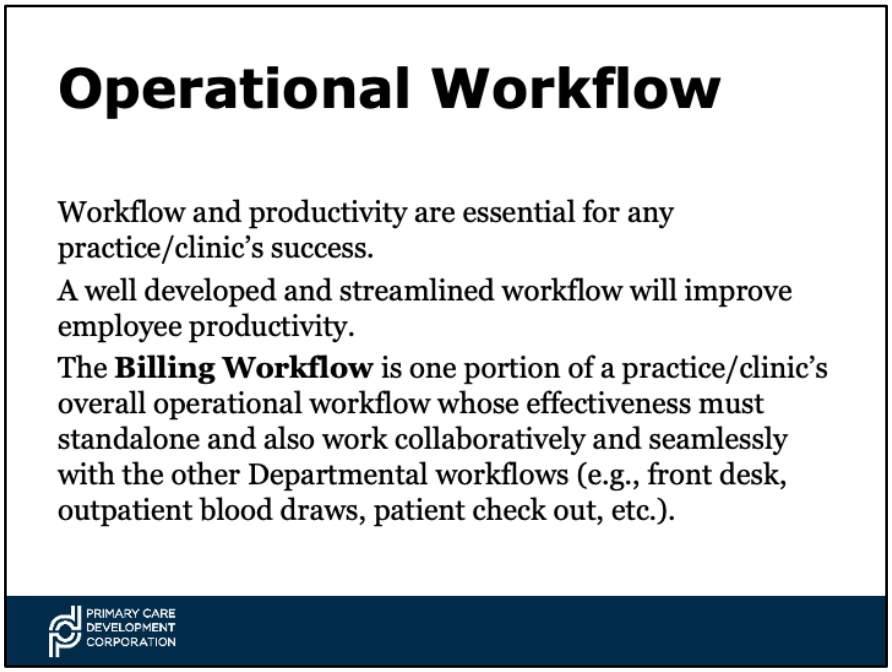
System Financial Summary 2016 and 2017 Report on Date: 7/24/2017

Months	Patient #	DOS #	Procedure #	Charge $	Ins Receipt $	Guar Receipt $	Adjustments $	Total Payments $	Balance $	Avg Charge Per Visit $	Avg Payment Per Visit $
Jan-16	269	288	310	$ 241,992	$ 30,690	$ 7,620	$ 154,323	$ 38,309	$ 49,360	$ 840	$ 133
Feb-16	157	171	207	$ 153,554	$ 20,203	$ 4,485	$ 105,538	$ 24,688	$ 23,328	$ 898	$ 144
Mar-16	194	221	271	$ 211,042	$ 32,140	$ 6,445	$ 119,023	$ 38,585	$ 53,435	$ 955	$ 175
Apr-16	347	367	416	$ 321,249	$ 52,098	$ 6,356	$ 204,981	$ 58,454	$ 57,815	$ 875	$ 159

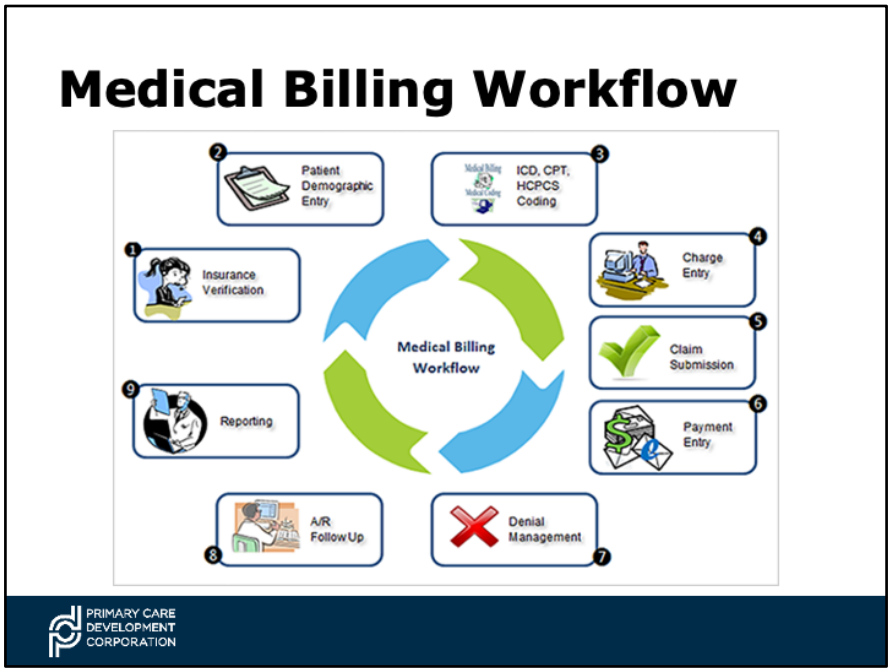
PRIMARY CARE DEVELOPMENT CORPORATION

- The Financial summary provides high level data of the total charges, adjustment and payment for a specified period of time.
- Provides a quick overview of the practice/clinic's financial status.

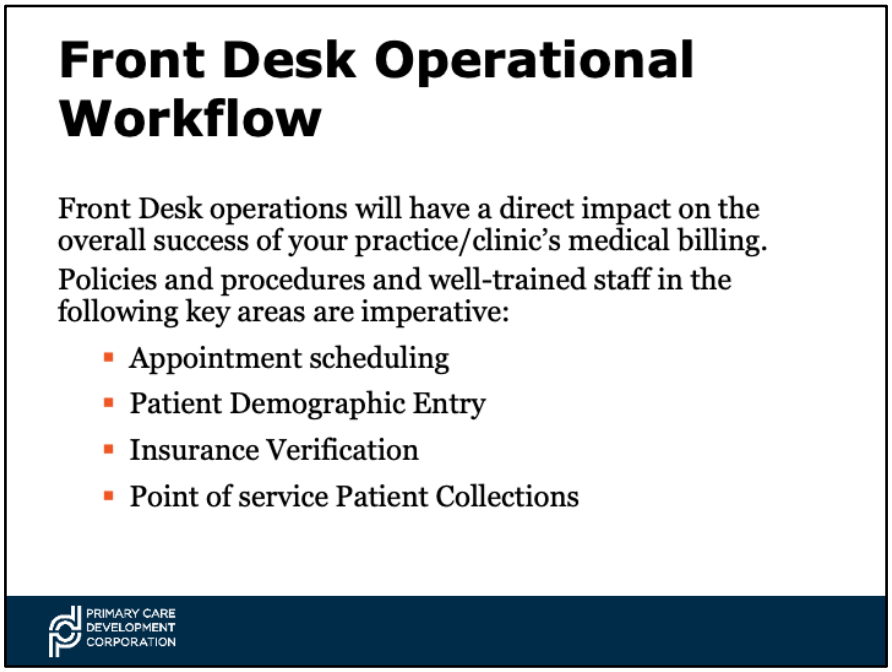
Operational Workflow



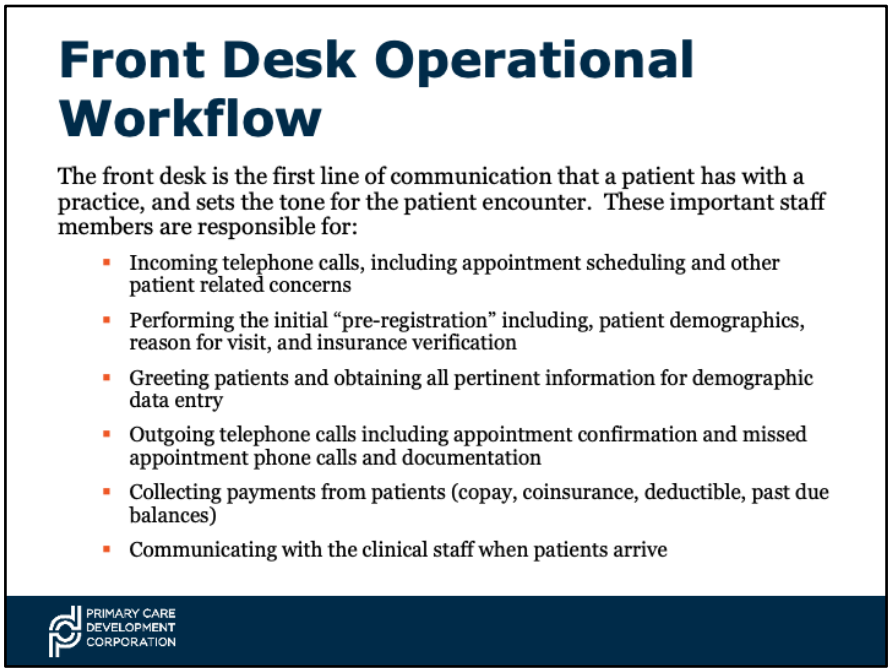
- A better defined regular process will allow for a more efficient team.
- To streamline work processes and improve workflow, assess **all** workflows, looking for opportunities for improvement in each area.



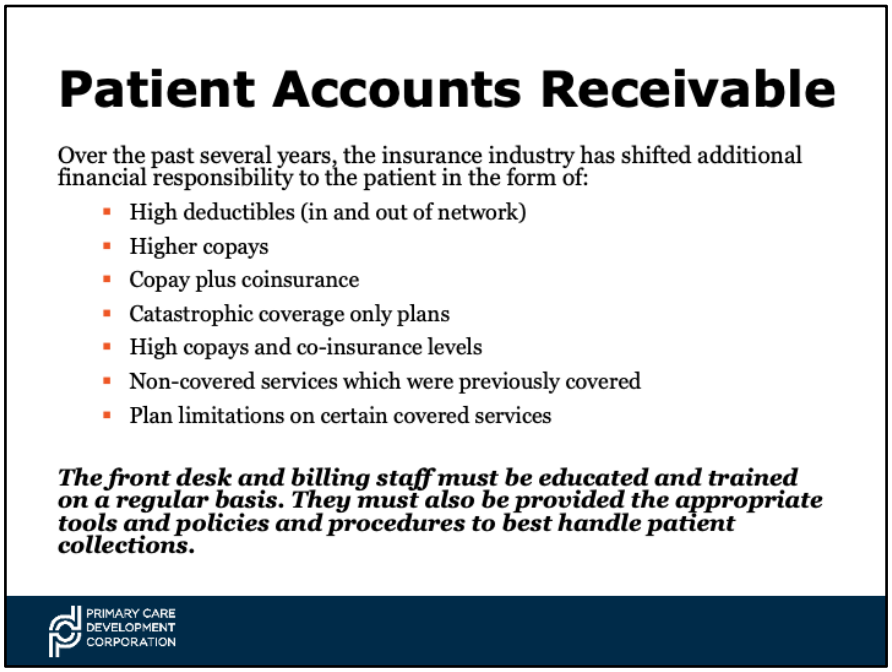
- There are many steps involved in the medical billing process.
- Each step is an integral part of the process and must be performed properly in order for the entire cycle to run smoothly.



- Front desk is a key and pivotal role in the success of the practice/clinic.
- Set goals. For example, patients are to be treated the way you like to be treated; always interact with a person.
- Set a goal for patient communication to occur within the first sixty (60) seconds of a phone call or in-person interaction at the front desk.

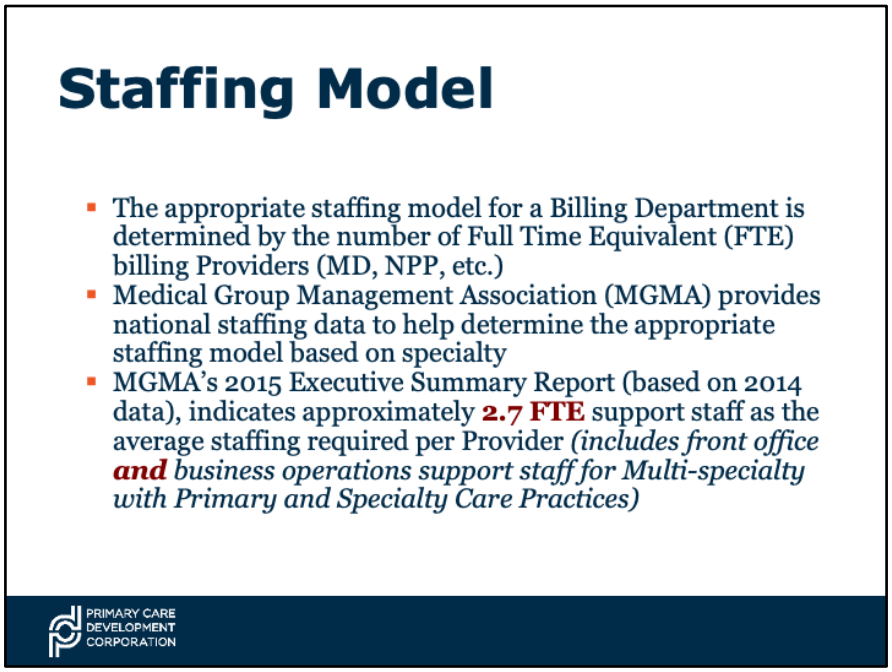


- Testing your phone system as a user. This is the easiest way to better understand the patient experience.
- Assess the equipment and its functionality.
- Front office staff must be trained and b able to operate each piece of equipment efficiently (e.g., credit card machine, fax, copier, ID scanners, label printers and multi-line phone systems)

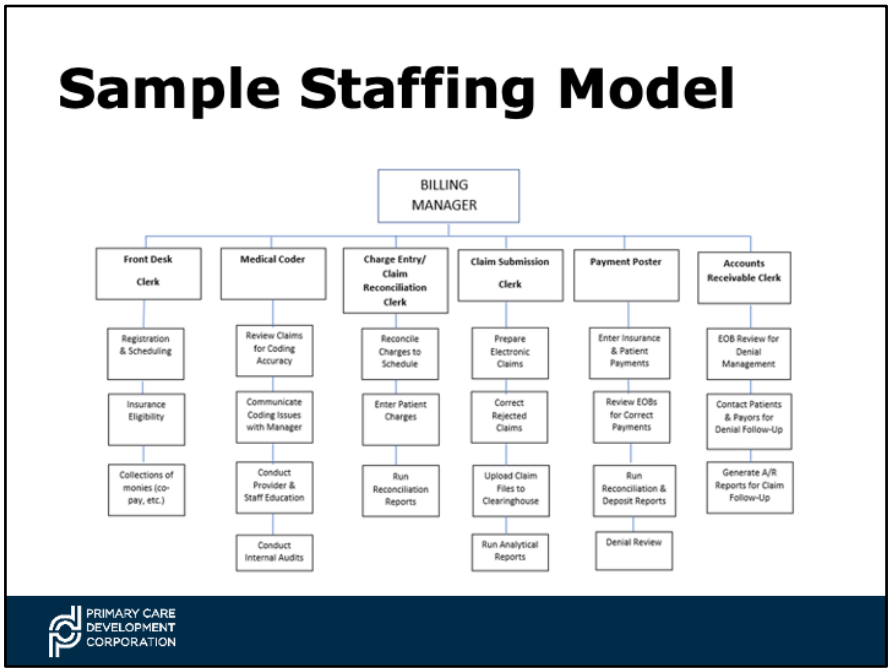


- A/R backlog and balances have increased dramatically due to the rise in patient financial responsibility for medical care.
- Many patients are unfamiliar with how their health insurance works or recent changes in their coverage,
- Prioritize insurance verification.

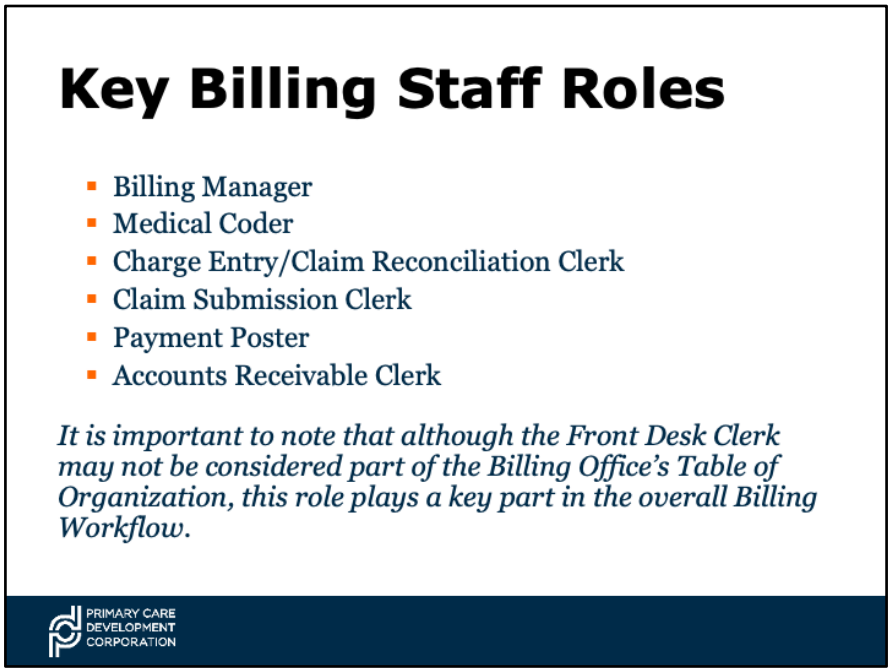
Staffing Your Billing Office



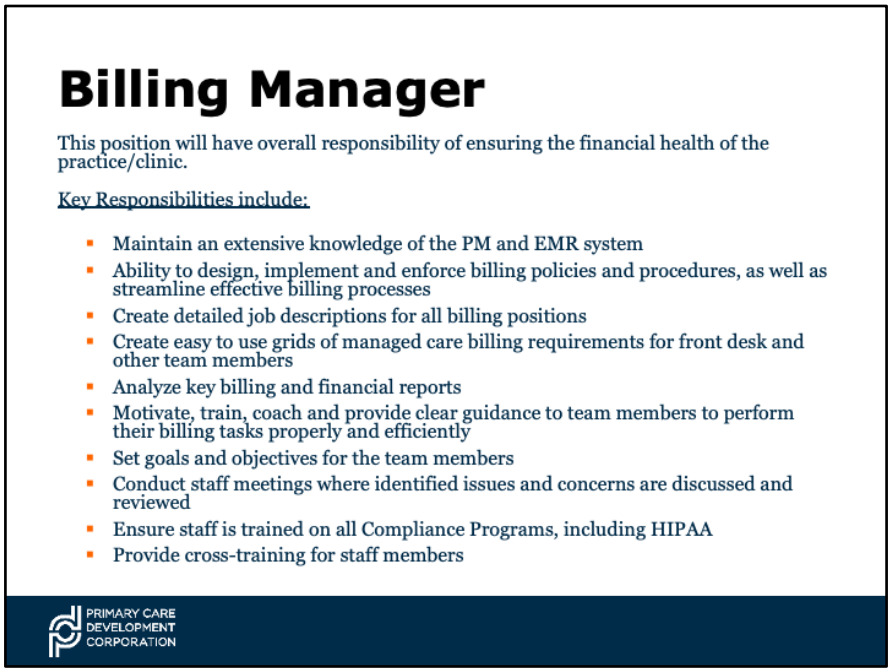
-The best performing practices/clinics tend to have more staff available to assist with the various tasks.



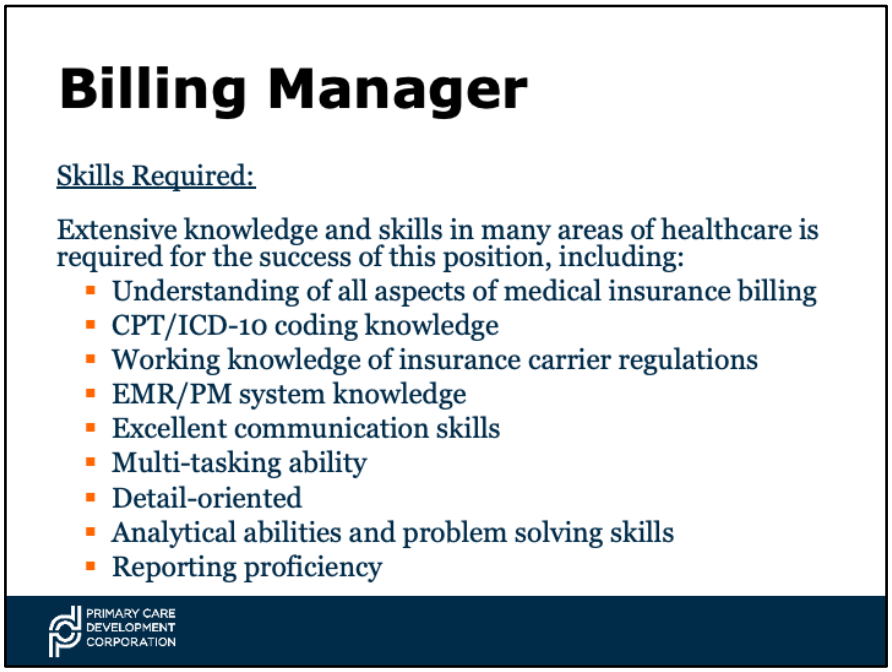
- Staffing models are not one size fits all.
- Resources will dictate the staffing model.
- Staffing levels will vary based on various factors - size of practice, specialty and services provided.



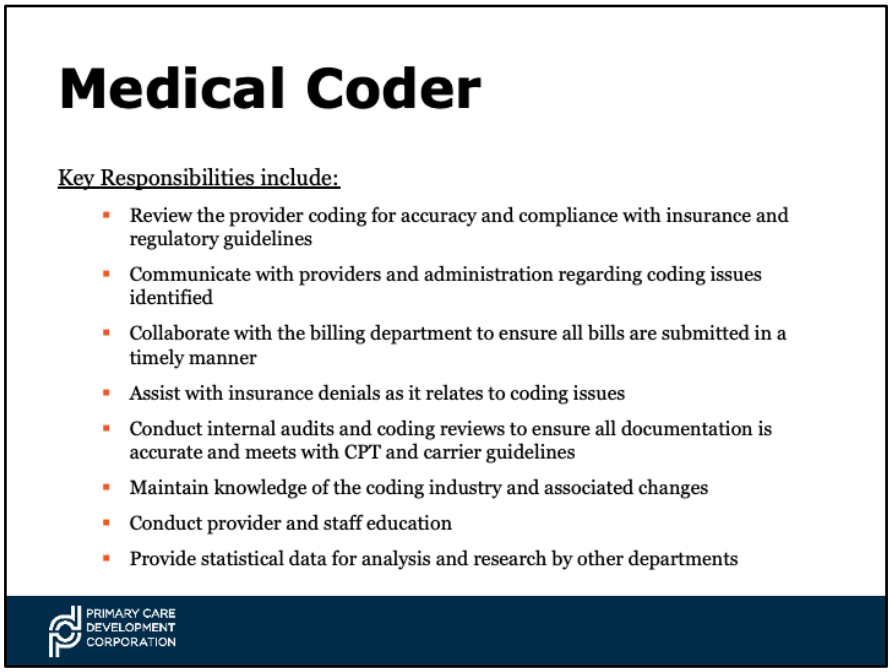
- A billing staff is the intermediary of the operations and accounting departments of a practice/clinic.



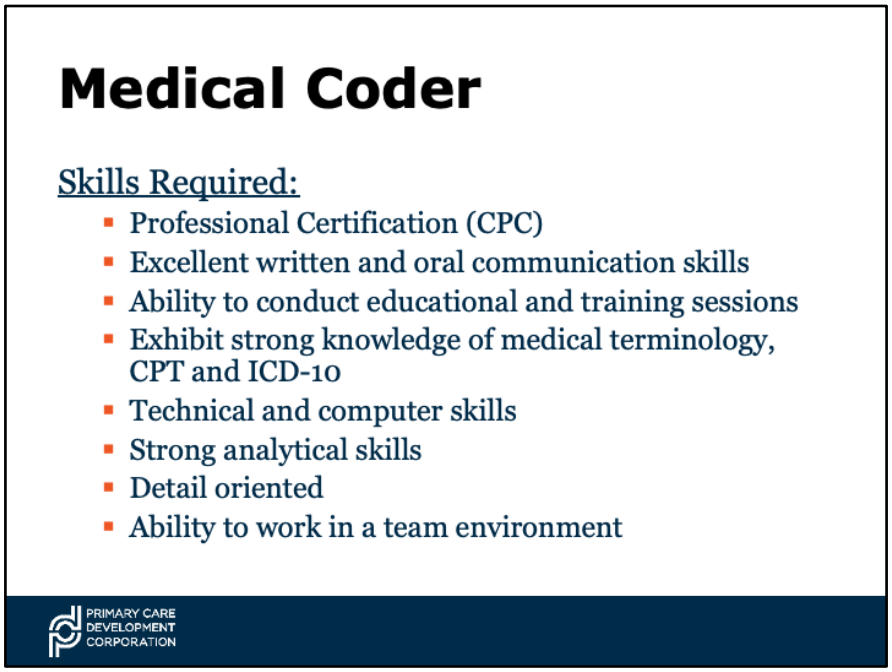
- Understanding the medical billing process requires specific knowledge coding and collection processes.
- The billing manager must understand the entire accounts receivable process, as well as personnel management.



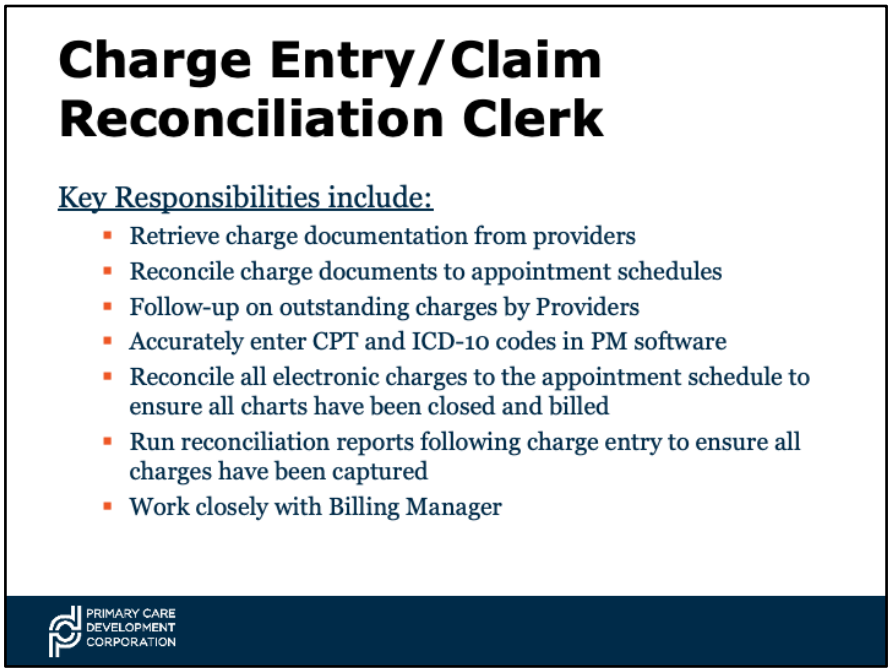
- The billing manager will not likely be involved in transcribing and coding patient services. However, he/she must have a strong understanding of the service being rendered by the practice/clinic and the associated codes.
- Some smaller practices/clinics may have only one medical billing representative to manage all accounts receivable.



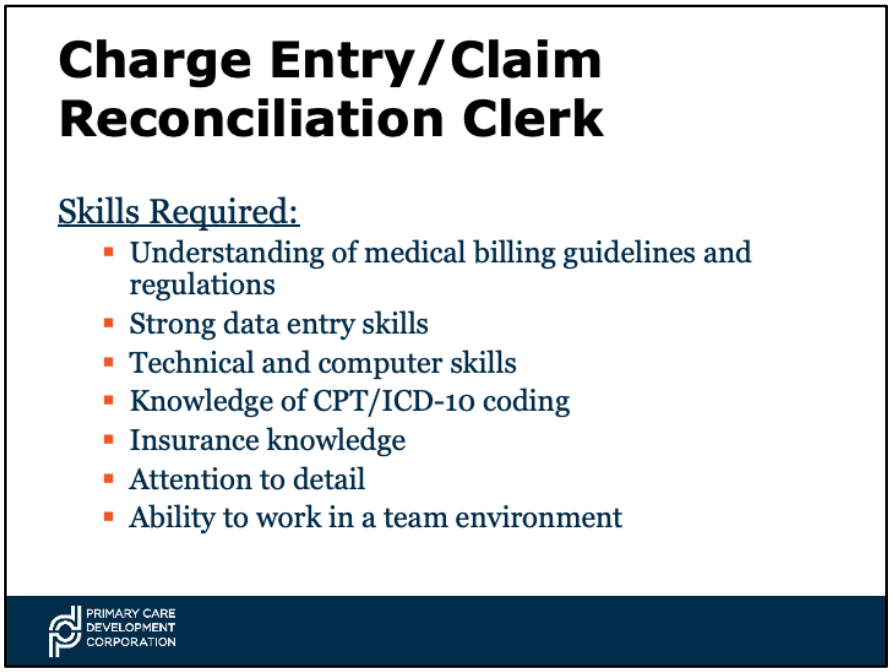
- Practices/clinics should must submit accurate coding in order to receive proper reimbursement.
- Provider education and training can reinforce accurate coding of services.
- The practice/clinic should always have internal/external coding reviews to validate documentation and coding.



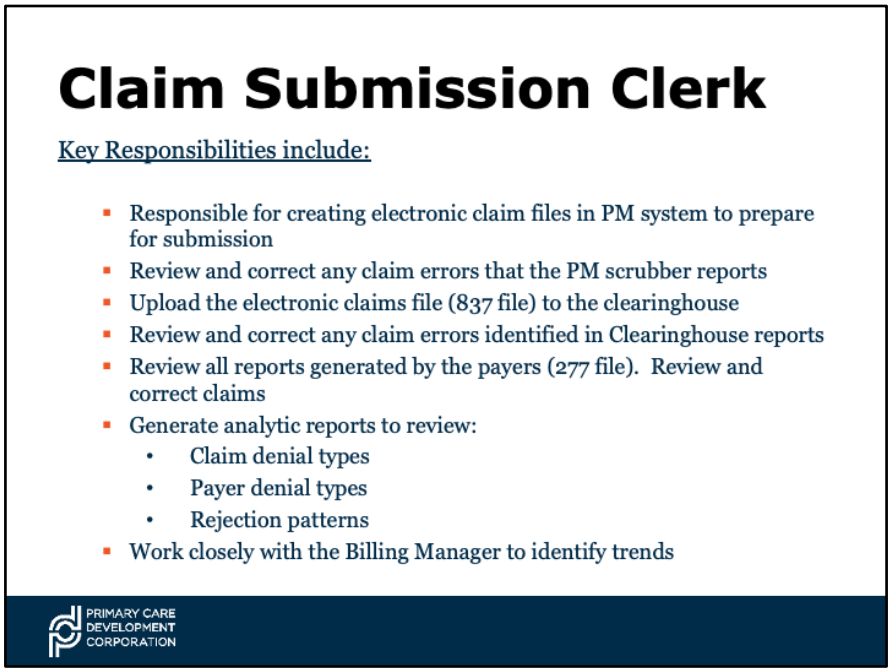
- Although not identical, medical billing clerk and medical coder positions are often combined due to the similarity and required expertise for these roles.



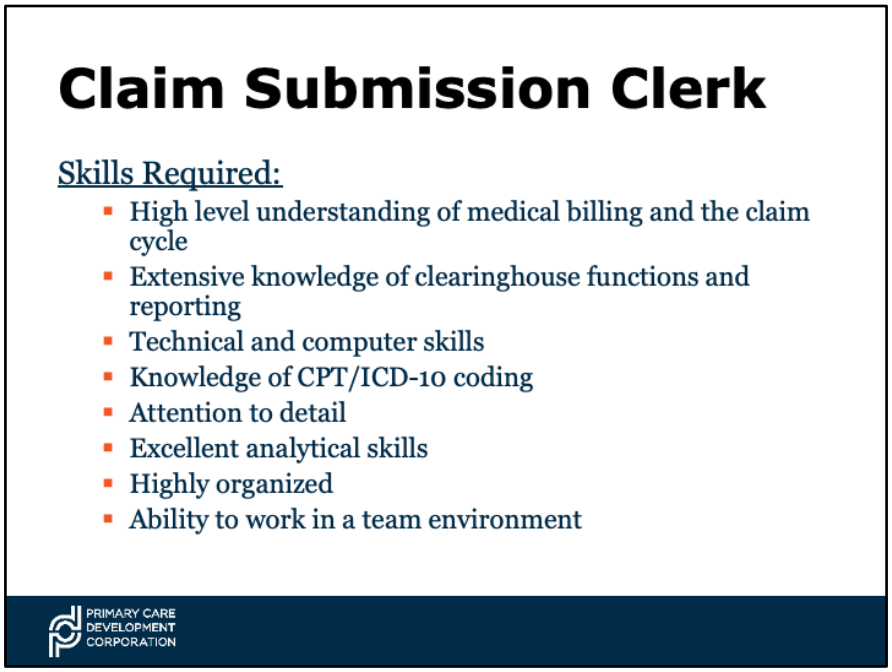
- The process requires attention to detail and accuracy of data entry.
- When charges are entered, the insurance and patient demographic information should have been entered accurately in the billing system.



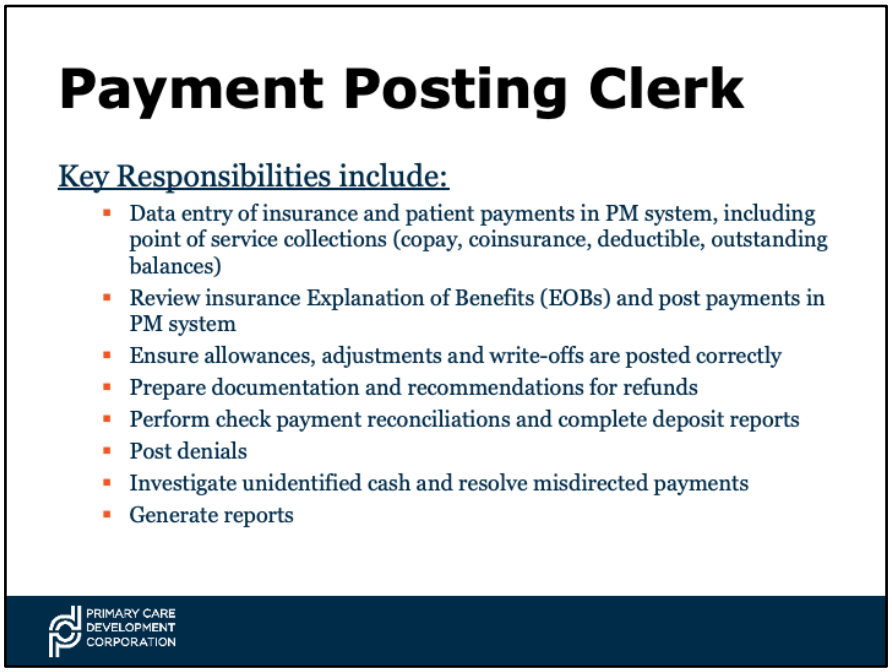
- Instituting an effective reconciliation process is important process that should not be overlooked.
- Missing charges (e.g., appointments that do not have charges posted, lost encounters, unclosed chart notes in EMR) has a large impact on the practice/clinic's overall financial performance.



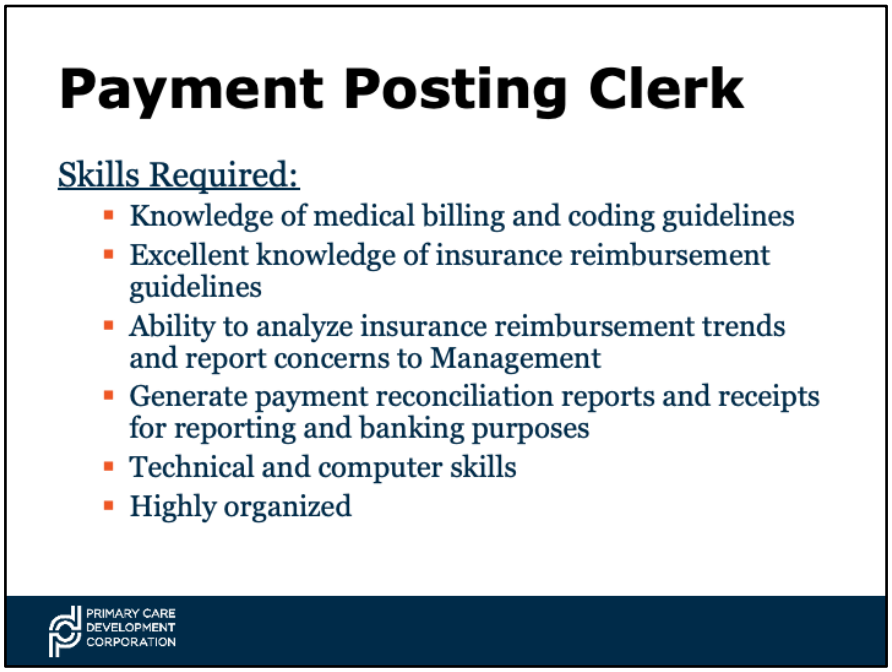
- The Claim Submission Clerk works closely with commercial and government payers to ensure the practice/clinic receives the maximum reimbursement.
- Claims must be submitted accurately and timely.



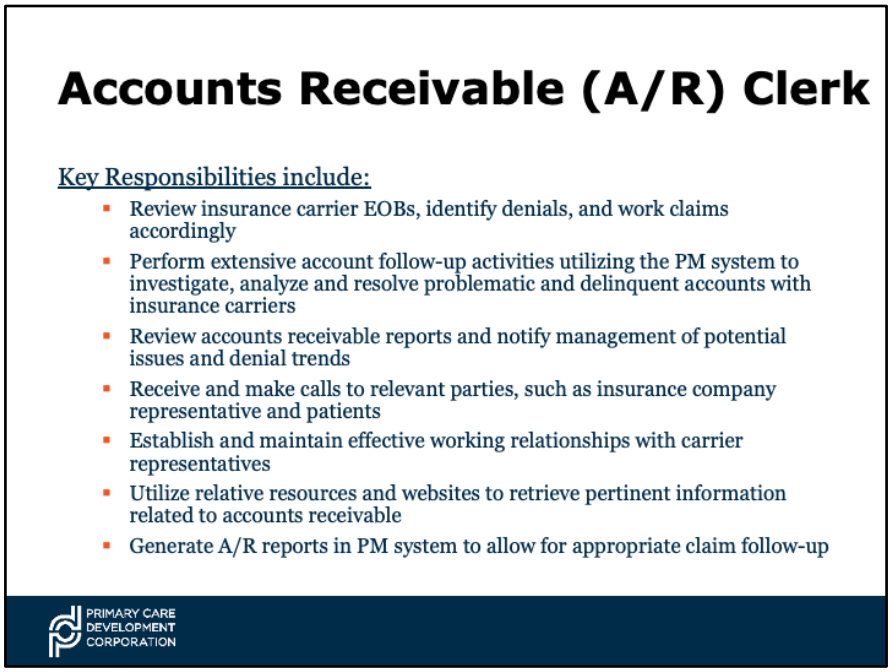
- When billing problems arise, the Claim Submission Specialist will assist with rejections, appeals and corrections.



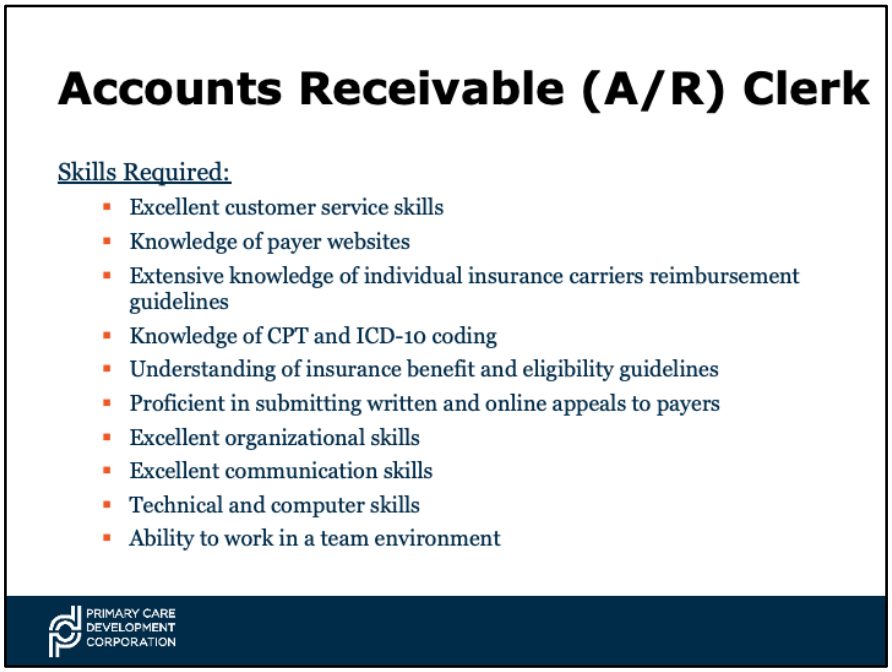
- The payment posting process affects many other functions of the medical office and can have a major impact on patient satisfaction, efficiency, and overall financial performance.



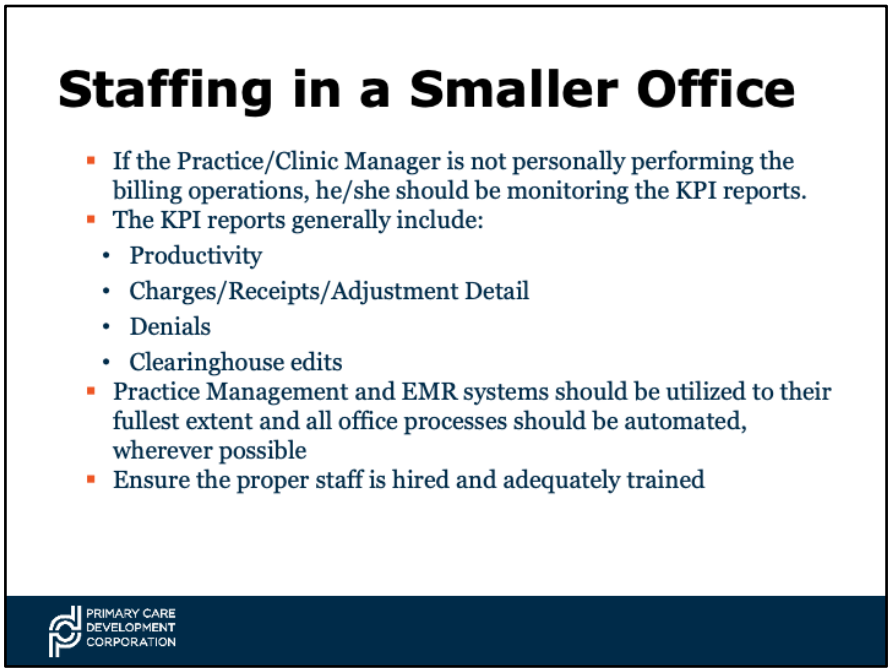
- A Payment Posting Clerk must be able to spot trends and issues hidden in the payment amounts and EOB comments.



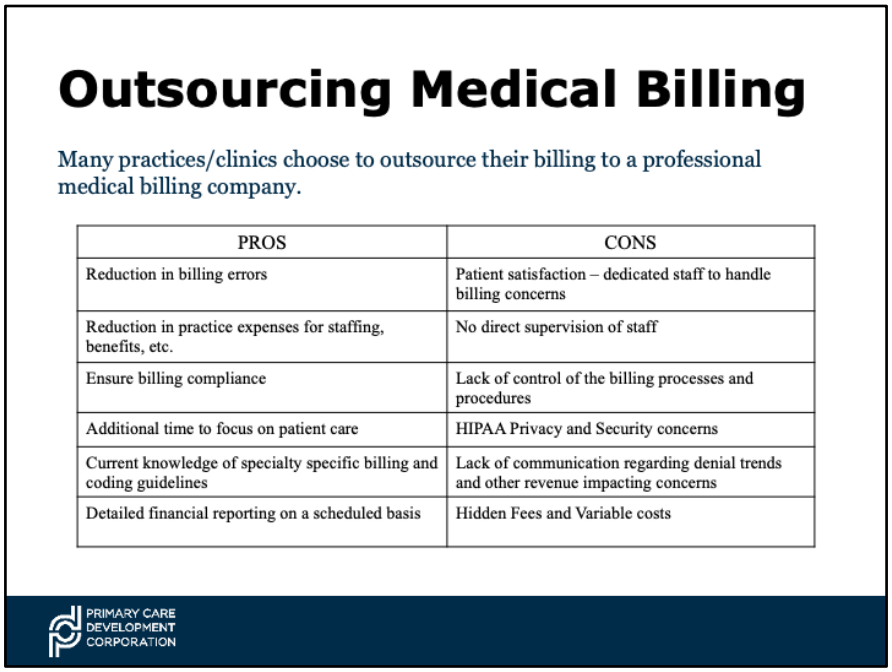
- This position requires attention to detail, organization and the ability to work independently in determining the hierarchy of A/R account follow-up.



- The A/R Clerk has frequent verbal and face-to-face interactions with patients and insurance carrier representatives.
- Must have strong customer service skills.



- The quality of the staff is more important than the quantity of staff members available.
- A solo physician practice seeing an average of 30 patients per day (without any ancillary services), may have as few as three (3) staff members (e.g., manager, front desk, and MA) and maintain an effective and efficient work flow.

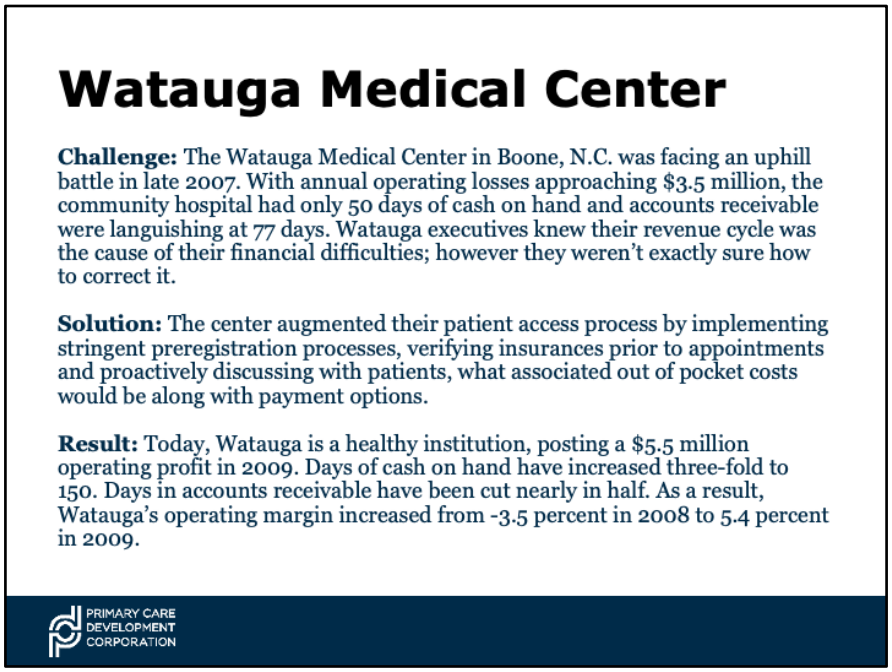


- A good outsourced medical billing service will provide feedback regarding:
    - Ways to increase productivity and profitability
    - Monitoring performance standards of staff, both in the office and the outsourced staff
- Ensure the outsourced billing service is performing all the duties as outlined in their contract.

Case Study

PRIMARY CARE DEVELOPMENT CORPORATION

39



Reference: Case Studies. (n.d.). Retrieved from http://www.revenuecyclesolutions.com/communications/case-studies/

Session Highlights

- Medical Billing: Maximize collection and reduce time to payments with effective workflows and skilled staff.
- Revenue Cycle Management Processes
- Staff Models: Design cohesive front and back office billing functions
- Job descriptions and skill sets for efficient billing operations
- Determining the health of your Revenue Cycle through billing reports

PRIMARY CARE DEVELOPMENT CORPORATION

Session 2 Mini-Assignments

- Review your office policies and procedures. Create a list of deficient front desk and billing operational policies
- Compare your current front desk and billing department job descriptions to those outlined in the presentation. Create a list of missing job descriptions
- Review the required skills for the job descriptions and evaluate the skills to your current staff members
- Assess the training programs available to your staff for certification (e.g.; billing, coding, etc.) and ongoing continuing education
- Create an outline of a billing staffing model for your practice/clinic
- Review A/R and productivity reports for 2016 and 2017. Identify any significant trends

PRIMARY CARE DEVELOPMENT CORPORATION