WORKING TO MAXIMIZE REIMBURSEMENT
PRESENTED BY
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SOURCEMEDICAL
WHAT IT TAKES TO GET PAID!

REIMBURSEMENT PROCESS

MANAGEMENT
- FEE SCHEDULE
- MANAGED CARE
- FINANCIAL POLICIES

PHYSICIANS
- OPERATIVE REPORT

CLINICAL STAFF
- DOCUMENTATION

BUSINESS OFC.
- SCHEDULE SURGERY
- INS. VERIFY
- COUNSEL PT. $$

REIMBURSEMENT TEAM
"THE RIGHT STAFF"

CODING
BILLING
PAYMENT POSTING
COLLECTIONS

REIMBURSEMENT
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
Verify:
- Spelling of name
- SS#
- DOB
- Insurance information
- Identify Medicare or Medicare HMO
- Name, DOB of insured
- Necessary information for W/C and Liability
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.”
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
State Specific Differences

- Know your state’s filing and information requirements for:
  - Workers Compensation
  - Medicaid
  - PIP/Automobile
  - Attorney Cases
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
• 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*
Some larger payers allow direct entry into their web portal

**Pros**
- 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

**Cons**
- 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

SOFTWARE

Scrub for Errors

Correct Errors & Resubmit

CLEARINGHOUSE

Scrub for Errors

Return for Correction or Send to Payer

PAYER

EDI Dept. Returns or Accepts

Correct Errors and Resubmit or Confirm Receipt
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
• 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 POSTING

• 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 posting 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 POSTING

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

• 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

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<th></th>
<th>Before</th>
<th>After</th>
<th>Increase</th>
<th>% Increase</th>
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<tr>
<td>Gross Revenue per Case</td>
<td>$6,039.52</td>
<td>$7,157.94</td>
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<tr>
<td>Collection’s per Case</td>
<td>$2,909.45</td>
<td>$3,206.83</td>
<td>$297.38</td>
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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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