PRESENTED BY
CARYL A. SERBIN
PRESIDENT / FOUNDER
SERBIN SURGERY
CENTER BILLING

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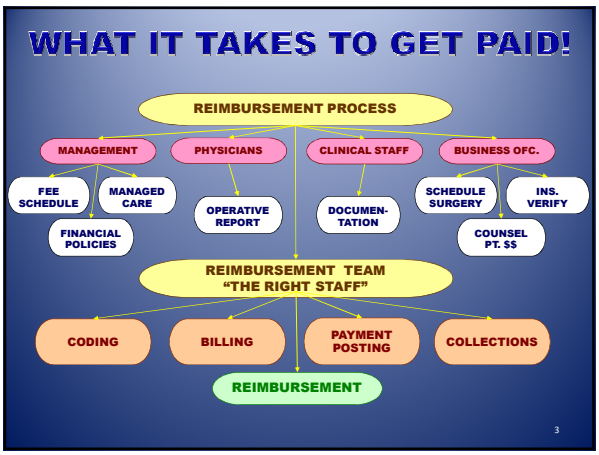

THE RIGHT STAFF – WHAT DO YOU LOOK FOR?

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STAFFING FOR REIMBURSEMENT

- Reimbursement knowledge requirements are increasing
  - more complex payer requirements
  - clearinghouse more important
  - government and payer rules and regulations continually changing
- Escalating staff costs
  - additional man-hours for IT, software, clearinghouse challenges
  - higher salaries* due to complexity
  - more office space / equipment required
  - less reimbursement

**Trended Median Administrative Staff Hourly Wages Summary ASC Statistics 2009 - VMG Health, LLC*

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STAFFING FOR REIMBURSEMENT

- Reimbursement is everyone's job
  - Physician & office staff
  - Administrator
  - Business Office Manager
  - Scheduler / Registration
  - Insurance Verifier
  - Patient Financial Counselor
  - Receptionist / Up-Front Collector
  - Coder/Biller
  - Payment Poster
  - Insurance/ Self Pay Collectors
  - IT Personnel

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STAFFING FOR REIMBURSEMENT

- Credentials for Coders – coders can optimize your reimbursement:
  - National coding certification required
    AHIMA - American Health Information Mgmt. Assoc.
    AAPC - American Academy of Professional Coders
  - Surgical coding experience required
  - ASC experience preferred
  - Knowledge of compliance requirements
  - Up-to-date on coding changes
  - Willingness to research
  - Good communication skills

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STAFFING FOR REIMBURSEMENT

- Requirements for Reimbursement Staff:
  - Billing experience/certification preferred
  - ASC experience preferred
  - Accurate, persistent, reliable, organized
  - Basic medical terminology
  - Medicare, Medicaid & Managed Care experience
  - Basic knowledge of codes and modifiers
  - Experience with Windows, MS Office, ASC software preferred
  - Ability to prioritize, meet deadlines/goals, communicate effectively, follow instructions

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HIRING THE RIGHT STAFF

- Develop an "ideal employee" template for each staff position
- Allow at least an hour for the interview as it should include:
  - application form completion
  - interview
  - test for general billing knowledge, as well as for the specific position

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HIRING THE RIGHT STAFF

- Interview Process
  - Use completed application as screening tool during interview process
  - Use a list of pertinent questions

    Example: "Is there a difference between co-pays and deductibles? If so, describe."

    You may be surprised at the answers!
  - Questions should cover general reimbursement information, as well as specific to the desired position

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HIRING THE RIGHT STAFF

- Interview Test
  - Test applicants on general information (communication and computer skills), as well as specific skills for the position
  - Coding applicants should be asked to code several sample operative notes, allowing them to use CPT, HCPCS, ICD-9 books during the test *(identifies those who are dependent on coding software)*

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TRAINING THE RIGHT STAFF

- At the time of hire, provide employee with:
  - introduction to rules and regulations
  - tour of center
  - orientation to job description
  - introduction to policy and procedure manuals (how-to's)
  - required in-services
  - explanation of probationary period and interim interviews
- Develop a training schedule for each position – length of training period varies with position (usually 2 to 3 weeks minimum)

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TRAINING THE RIGHT STAFF

- Each week of training should include measurable goals
- Provide detailed learning materials
- Monitor/test employee's skill levels
- Meet regularly with employee to answer any questions & discuss performance

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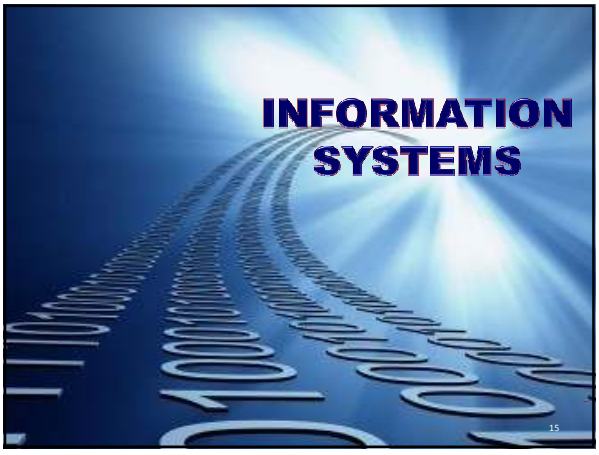

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INFORMATION SYSTEMS

- Increasing complexity of electronic communications:
  - presents challenges in multiple areas
    - . connectivity
    - . clearinghouse
    - . software
  - expensive to keep up with changes
  - requires more sophisticated electronic "know-how"

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INFORMATION SYSTEMS

- Connectivity - the speed and dependability of your connectivity is directly related to the timeliness of your reimbursement
- Types of connectivity
  - DSL
  - T-1
  - Modem
  - Smoke signals
- Reliance on electronic connectivity is essential in most areas of billing / collections
  - Internet
  - Clearinghouse
  - Direct entry sites
  - Claim status sites (collections)

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INFORMATION SYSTEMS

- Equipment
  - Age of computers
  - Printer age and compatibility with software
- Software
  - Specific to ASCs
  - Clearinghouse compatible
  - Security levels

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INFORMATION SYSTEMS SECURITY

- Regular back-up procedures
- HIPAA compliant connectivity
- Virus protection software
- Management should set up:
  - security levels in software
  - establish online access to payer web portals
  - maintain list of passwords for all accounts and employees (HIPAA)
  - cancel access when employee leaves employment

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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

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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.

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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!
COPY CARD!
SCAN CARD!
COPY CARD!

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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)

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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 duefor co-pays/deductibles
  - Obtain reference call number
  - Verify claim mailing address

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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 & document

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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

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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."

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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

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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

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CODING THE PROCEDURE(S)

- Accurate coding is the key to getting paid
  - understanding optimization versus unbundling
  - know coding & 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

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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

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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

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CHARGE POSTING

- State Specific Differences
  - Prompt payment legislation varies by state.
  - Know your state's filing and information requirements for:
    . Workers Compensation
    . Medicaid
    . PIP/Automobile
    . Attorney Cases

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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

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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

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CHARGE POSTING – BENEFITS OF DIRECT ENTRY

- 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

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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

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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

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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

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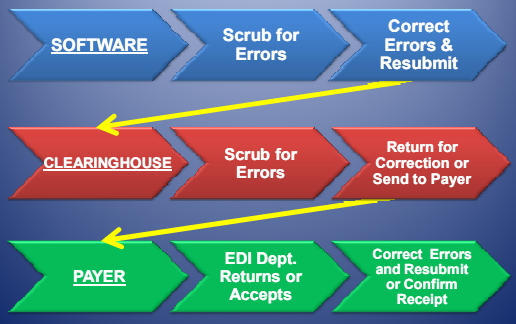
FOLLOWING THE CLAIM TRAIL



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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

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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

44

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

45

INSURANCE COLLECTIONS

- Establish claim follow-up dates by payer. Times will vary by contract and industry standards
  Example: Medicare versus WC claims
- Utilize a good tracking system so follow-ups dates are not missed
- Develop protocol for handling delinquent payers
- Respond immediately to payer requests, i.e., operative notes, invoices, etc.

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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"

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INSURANCE COLLECTIONS

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

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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

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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

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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

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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

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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

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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

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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

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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

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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)

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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.

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PAYMENT POSTING

- 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

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PAYMENT POSTING

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

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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

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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

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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

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

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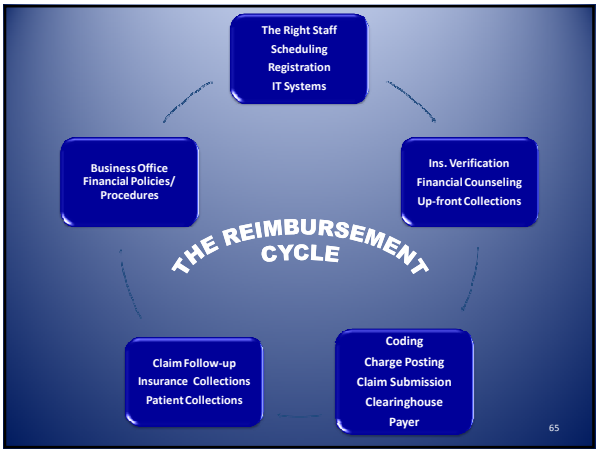

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