# REVENUE CYCLE FOUNDATIONS 101

FOR DC MEDICAID BEHAVIORAL HEALTH PROVIDERS


# Disclaimer:

The Rev Up DC Revenue Cycle Management for Practice Transformation Program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,764,326.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government


AGENDA
1. Overview Rev-Up DC Training
2. Revenue Cycle Management
3. Eligibility
4. Authorizations
5. Enrollment
6. Credentialing
Revenue Cycle Management for Practice Transformation
REV UP
DC

# WHY FOCUS ON REVENUE CYCLE MANAGEMENT?

**Integrated Care DC** is responding to providers' request to support and help with the transition to managed care

**Managed Care** participation will require providers' operations to be more efficient in managing payment requirements and account receivable processes

**Revenue Cycle Management** includes activities that are structured to identify, collect and manage revenue from payers for services rendered by a practice

# OVERVIEW
# REV-UP DC TRAINING

**Integrated Care DC's** new program to support DC Medicaid Behavior Health providers entry into Managed Care

**Participating Providers** will focus on Revenue Cycle Management to successfully guide their Practices' transformation into Managed Care

**Rev-Up DC** will provide revenue cycle technical support and training thru individualized assistance, customized to providers' specific needs

# HOW REV-UP DC WORKS

Revenue Cycle Management for Practice Transformation allows providers and their teams to participate in three (3) ways:


A comprehensive **Revenue Cycle assessment**, geared towards answering questions and meeting your needs

**One-on-One** individualized **Technical Assistance** sessions with one of our coaches about your practice

**Focused Revenue Cycle** Training Classes, launching with The Foundations of Revenue Cycle class series

# FOCUSED **REVENUE CYCLE** TRAINING

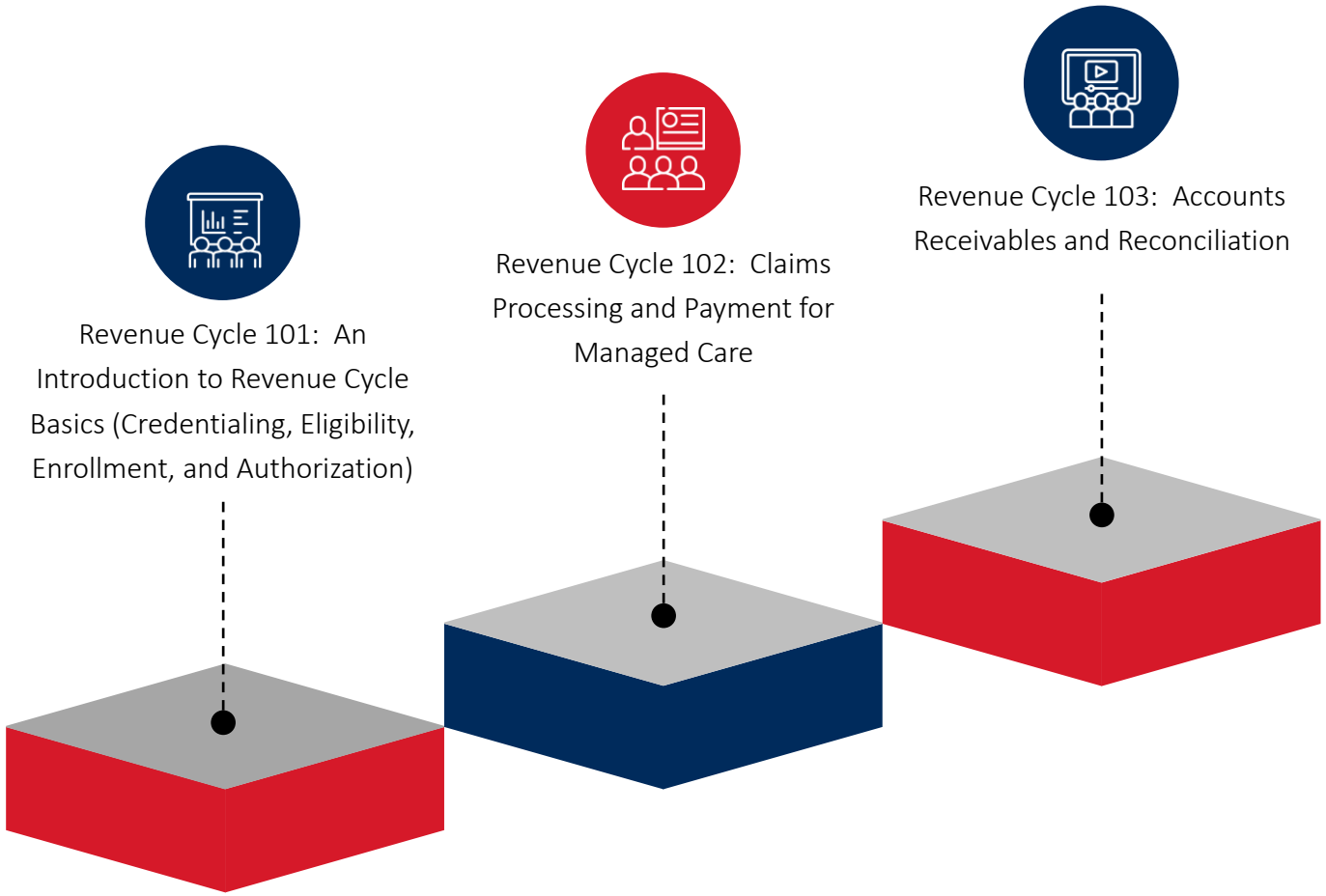
Common Revenue Cycle Management themes that are identified throughout our engagement with providers will be used to develop content to share via:

# FOUNDATIONS OF **REVENUE CYCLE** COURSE(S)

## Foundation Level Courses

Accessible to Anyone

Three (3), 60-minute, virtual training sessions created to provide basic skills and knowledge needed to be successful in a Managed Care setting with Billing, Payments, Accounts Receivables and Reconciliation.
Sessions will include:



# Pre - Assessment:

Q1: When should you verify eligibility for a member?

a) When Scheduling an appointment

b) During the visit

Q2: Which is the best practice to use to obtain authorization for service?

a) When scheduling appointment

b) 72 hours Prior to the visit

c) After the visit (retroactive authorization)

Q3: Which steps can you skip in the Revenue Cycle Flow?

a) Eligibility

b) Authorizations

c) Credentialing

d) None

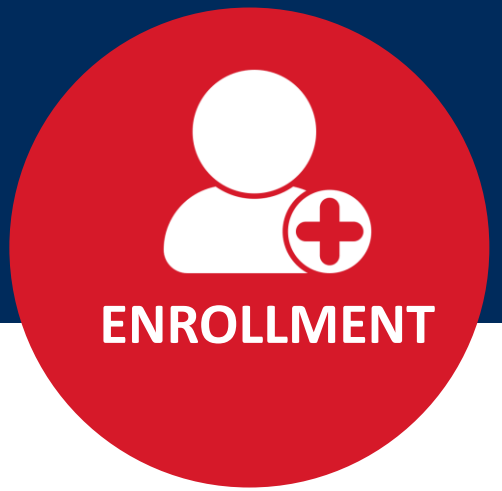
# LEARNING OBJECTIVES Foundations 101

1. Participants will be able to identify the impact of Managed Care on their practices' Revenue Cycle.
2. Participants will be able to identify for their practices foundational Revenue Cycle processes for improvement.
3. Participants will be able to implement Revenue Cycle best practices for their practices.

# REVENUE CYCLE OVERVIEW

Revenue Cycle Management consists of processes that support payment capabilities, focused on:










# WORKFLOW
# REVENUE CYCLE


Revenue Cycle Management for Practice Transformation
REV UP
DC

# OVERVIEW
# REVENUE CYCLE MANAGEMENT


## GETTING STARTED

Scheduling the appointment

Front desk

Confirm practice participation with the MCO (contract could be pending) and temp auth may be provided

Verify member MCO eligibility

Validate prior authorization requirement; plan max # of visits

Secure online plan access for submitting claims, reviewing claim status, obtaining authorizations, online appeals, if applicable

Registration

Front desk

Accurate capture of patient demographics
Accurate capture of insurance information

Tools to reference
Intake Form(s)
DHCF Link to Eligibility login

**Valuable tip** - The customer experience begins with the member's first encounter with the practice; quality care starts with a compassionate and competent front desk experience for the member

# ELIGIBILITY
# REVENUE CYCLE MANAGEMENT

## ELIGIBILITY

Eligibility/Registration

Organizations should verify and complete a pre-service audit at least 72 hours prior to the service being delivered. The elements of a pre-service audit include:

- Demographic information of the consumer
- Changes to demographic information (name, addresses, etc.) that do not match other systems can lead to billing errors and denied claims
- Contact information updated for purposes of communicating with the consumer for not only financial and operational reasons, but also for clinical and treatment purposes
- Payor verification
- Authorization verification for service
- Credential(s) of the provider
- Intake Questionnaire
- Dates of any releases of information
- Payor specific requirements

# ELIGIBILITY
# REVENUE CYCLE MANAGEMENT

## ELIGIBILITY

Can be determined by checking the EVS

Can be confirmed utilizing the MCO website(s):

AmeriHealth Caritas DC ACDC
www.amerihealthcaritasdc.com

Care First Community Health Plan
www.carefirstchpdc.com

MedStar Family Choice DC MSFCDC
www.medstarfamilychoice.com

Health Services for Children with Special Needs
https://hscsnhealthplan.org

DHCF Link to Eligibility login:
Department of Health Care Finance - Home Page (dc-medicaid.com)
Medicaid - 202-639-4030 /1-800-408-7511
Alliance - 202-842-2810/1-866-842-2810

# ELIGIBILITY
# Scenario

An established patient calls the office to schedule an appointment for 12/15/21. The registration representative identifies that the member had coverage during their last visit from 11/01/21 to 12/31. Since the visit is within that time frame, the representative, does NOT re-check eligibility for the date of service. The representative does not ask if the member has new insurance or if there have been any changes to the insurance since the last visit. The representative also does not confirm a phone number or change of address. The appointment is scheduled for 12/15/21 with the same insurance. The chart is prepared for the visit. The member is seen by the physician and the services are billed as an established patient.

What steps should have been taken during registration?
What steps should the representative have taken to ensure eligibility?

Result:
- The member was not eligible for the date of service
- The claim was denied, Member not found/Submit with plan id.
- Denial representative re-worked the claim
- Delay in reimbursement
- Possible loss in revenue

Because the representative did not verify a phone number and address, the Claims department has no way to contact the member for new/valid information from the file.

What can the Claims representative do to obtain new/valid insurance information?

**Reminder:
Failure to follow each step in the revenue process creates a delay in reimbursement.

Valuable tip – ALWAYS verify complete demographics and Insurance with member interaction.

# AUTHORIZATIONS
# REVENUE CYCLE MANAGEMENT

## AUTHORIZATIONS

Some MCO's require prior authorizations to receive BH services

It is very important that the step of verifying authorization requirements is done at the same time of verifying eligibility

If not, there is a strong possibility that the claim for services rendered will be denied!!!! And the provider will not receive payment for services rendered

If required, in most cases, authorizations can be obtained on the MCO website

# AUTHORIZATIONS
## Scenario

A member had an appointment with a Physician 1/16/2021. The representative verified eligibility and all demographics for the member. The appointment was scheduled. The services to see this specialist required an authorization. The Utilization team has been working overtime to catch up on outstanding authorizations. The representative noted the account, made copies of the benefit requirements, initiated the auth and placed the chart in the bin label "Authorizations Required". The member's visit was within 5 business days. The turnaround time for the health plan was 14 days for outpatient services.

Since the visit was within a week, the representative sent an urgent request to the utilization team. On 01/16/21, the member came in to see the specialist. The physician completed the consult and recommended additional treatment. The additional test was ordered and the claim for 1/16/21 was billed as an evaluation with treatment. The pre-auth was entered on the claim, but *not* an Authorization for services rendered with clinicals.

What steps should have been taken by both the Utilization Team and the Registration Representative?
What should you do if you are unable to secure an authorization prior to a patient's appointment?
What do you think happened to the claim?

Result: Denied for no authorization on file for DOS (dates of service)
Retro authorizations are not available for most MCO/Medicaid payors. That means this claim has a low probability of being paid. That results in a loss of revenue and is considered a write- off. Charges are not billable to a Medicaid recipient.

**Reminder:
Failure to follow each step in the revenue process creates a delay in reimbursement.
Valuable tip – always follow eligibility guidelines for services. Always request and obtain an authorization when required for services that requires one.
*While an authorization does not guarantee payment of services, it is a requirement for specific services based on insurance guidelines.*

# ENROLLMENT
# REVENUE CYCLE MANAGEMENT

## ENROLLMENT

Providers are not responsible for patient MCO enrollment

Providers can be a resource to DC Healthy Families thru DHCF, if they are not currently showing eligible via Eligibility Verification System (EVS)

District Direct has recently launched to support new benefits application: https://districtdirect.dc.gov/ua/

# CREDENTIALING
# REVENUE CYCLE MANAGEMENT

## MCO PARTICIPATION PREPARATION

### Provider Credentialing

Confirm provider participation with the MCO (contract could be pending) and temp auth may be provided

Primary contractual way to process claims with the participating provider(s) and receive reimbursement through timely processing

Validation eliminates probability of denials, aging claims, increases A/R and improves Auto Adjudication rates

### Practice Administrator

Key tool is  Credentialing Checklist

Various vendor applications available

EHR-EMR

# CLAIMS & PAYMENT
# REVENUE CYCLE MANAGEMENT

## CLAIMS & PAYMENT

Creating & Submitting claims
- Manual (HCFA)
- Clearinghouse
  - Review of submission report -Error review
  - Correction and resubmission

Posting payments
- SME-understanding of contract agreement
- Rejections -research, appeal resubmit
- Over payments
- Retractions

Follow-up and collections
- 30, 60, 90-day review of all unpaid claims

# Post - Assessment:

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b) Authorizations

c) Credentialing

d) None

# QUESTIONS?

Sign up is starting now and continues into the new year. Register at

Rev-Up DC: Behavioral Health Provider Survey

Questions? Contact us at

RevUpDC@integratedcaredc.org

More information on Integrated Care DC is available at https://www.integratedcaredc.com/