REVENUE CYCLE FOUNDATIONS 102

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
2. Credentialing
3. Claims & Payment
4. Q&A

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

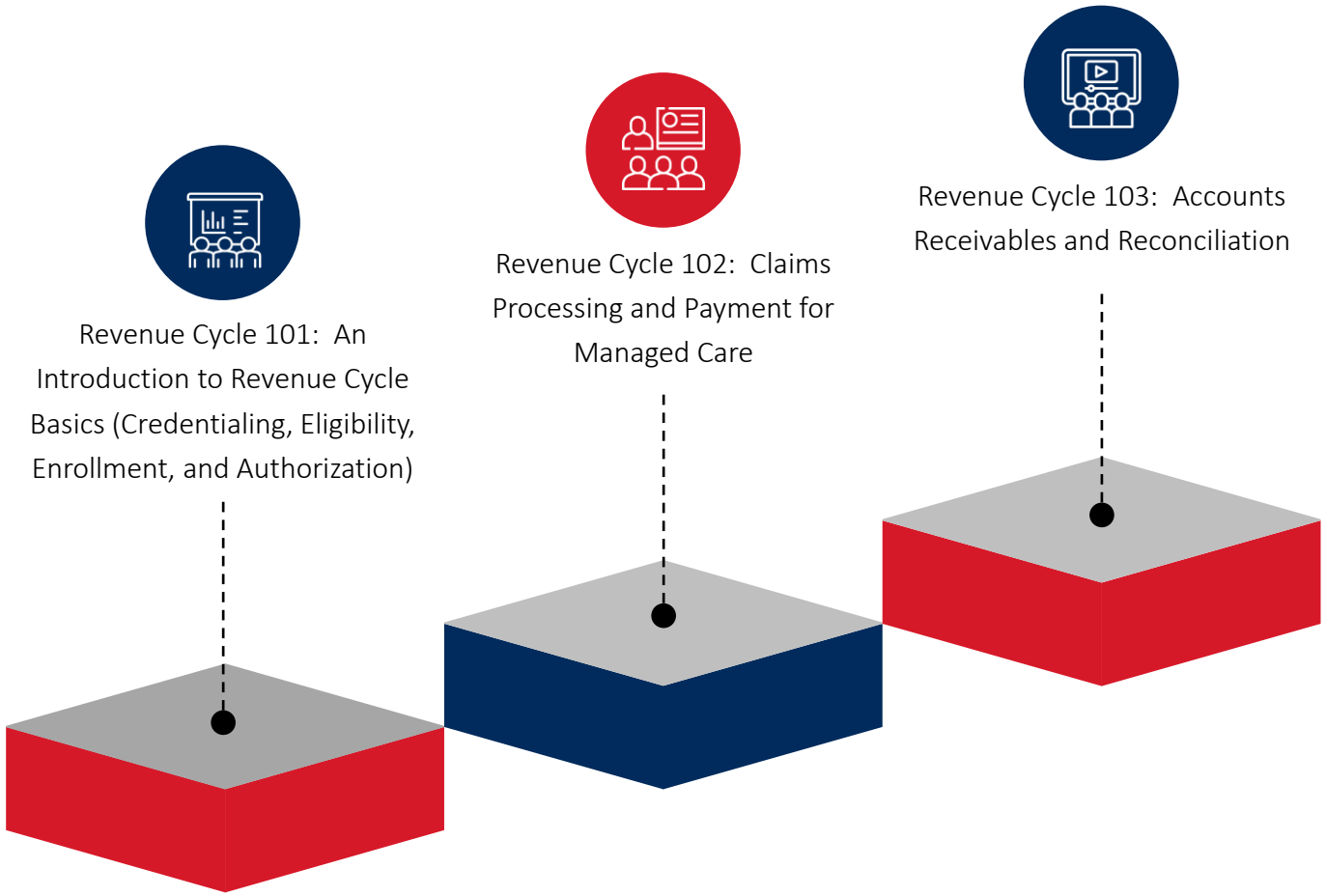
Common Revenue Cycle Management themes that are identified throughout our engagement with providers will be used to develop content to share via:

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:

1) What is a key tip to use when credentialing a Provider or Practice?

a) A copy of the providers Bio.
b) The NPI Number and License.
c) A Credential Checklist?

2) What is the timely filing period for Claims in the District of Columbia?

d) 160 days
e) 90 days
f) 365 days

3) What is the timeline to submit an Appeal or dispute of a claim ?

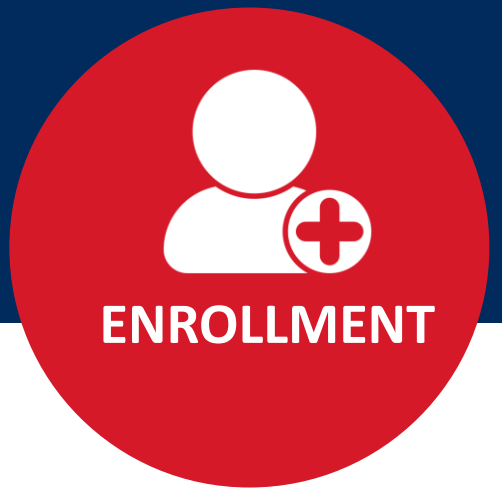
g) 60 days from date of service(DOS)
h) 90 days from the bill date
i) 60 days from date of denial
j) None of the above

LEARNING OBJECTIVES Foundations 102

1. Participants will determine strategies to enhance their practice's Credentialing capabilities.
2. Participants will identify critical steps in the Claims and Payment process to enable on-time payments for their practices.
3. Participants will be able to determine action steps to reduce their Claims denials.

REVENUE CYCLE OVERVIEW

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



WORKFLOW
REVENUE CYCLE

Revenue Cycle Management for Practice Transformation
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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 and Credentialing Guide

CREDENTIALING REVENUE CYCLE MANAGEMENT

MCO PARTICIPATION PREPARATION

Credentialing is a confidential formal review of a provider's qualifications when applying to a health plan or health system.

During the credentialing process, it is important that you complete the CAQH application (electronic application repository) in its' entirety. You must also attach all supporting documentation such as copies of your license to practice, board/specialty certifications, CV/Resume, Malpractice Insurance Dec Page, Work History and W-9 Tax Form.

Be sure to authorize access to the MCOs when completing the CAQH application. By providing authorization, the MCOs will be able to gain access to your electronic application and supporting documents.

The credentialing process approval process can take up to 45 days to complete but will vary for each MCO.

A checklist has been included in the Quick Reference Guide to ensure submission of necessary documentation.

Incomplete applications or missing documentation will delay the credentialing process and potentially cause delays in MCO provider network participation.

CREDENTIALING REVENUE CYCLE MANAGEMENT

Single Case Agreements

Single Case Agreements are created when a member in need of emergency treatment can only be rendered by a provider who may be pending credentialing approval or is out-of-network. Single case agreements are prepared by the Provider Relations department .

If services are rendered by a provider pending credentialing approval or is currently not participating in the MCO's provider network, the claim will most likely be denied.

Failure to obtain a single case agreement in this case will cause a loss of revenue.

CREDENTIALING
Scenarios

A member called the office to make an appointment as a new patient. All regular practice providers were booked for the next 4 months. The member wanted to see a doctor within 30 days. The Group has a new Physician (Dr. Drew). Since the doctor has an open schedule and an active NPI number, the representative verifies the members insurance and demographics and schedules the appointment. The appointment date is set for 02/11/2019. Since Dr. Drew recently joined the practice, he has not completed the credentialing process. The Credentialing department has his file in a pending status due to requested documentation. Currently, he also does not have a contract with the area MCO's since he just joined the practice. Dr. Drew also relocated from another state.
On 02/19/21, the member is seen by Dr. Drew. He provides a new patient visit and recommends a follow up appointment with lab work. The encounter data is entered, the charges are added, and the claim is submitted.

What do you think happened to this claim?
What process(es) should be in place to prevent this from happening again?

Result: The claim was denied as "not a Licensed provider/non- contracted provider. This claim may result in lost revenue since Dr. Drew was NOT a licensed provider in Washington DC on the date of service. He was also not credentialed for the assigned Manage Care plan.
MCO guidelines are specific by MCO and in some cases they do not pay out of network claims.
In some cases, a single case agreement may be obtained while a contract agreement is pending.

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

Valuable Revenue Cycle Tip – always follow the Revenue Cycle process to eliminate errors, denials and loss of revenue and quality of care.

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

CLAIMS & PAYMENT DEFINITION

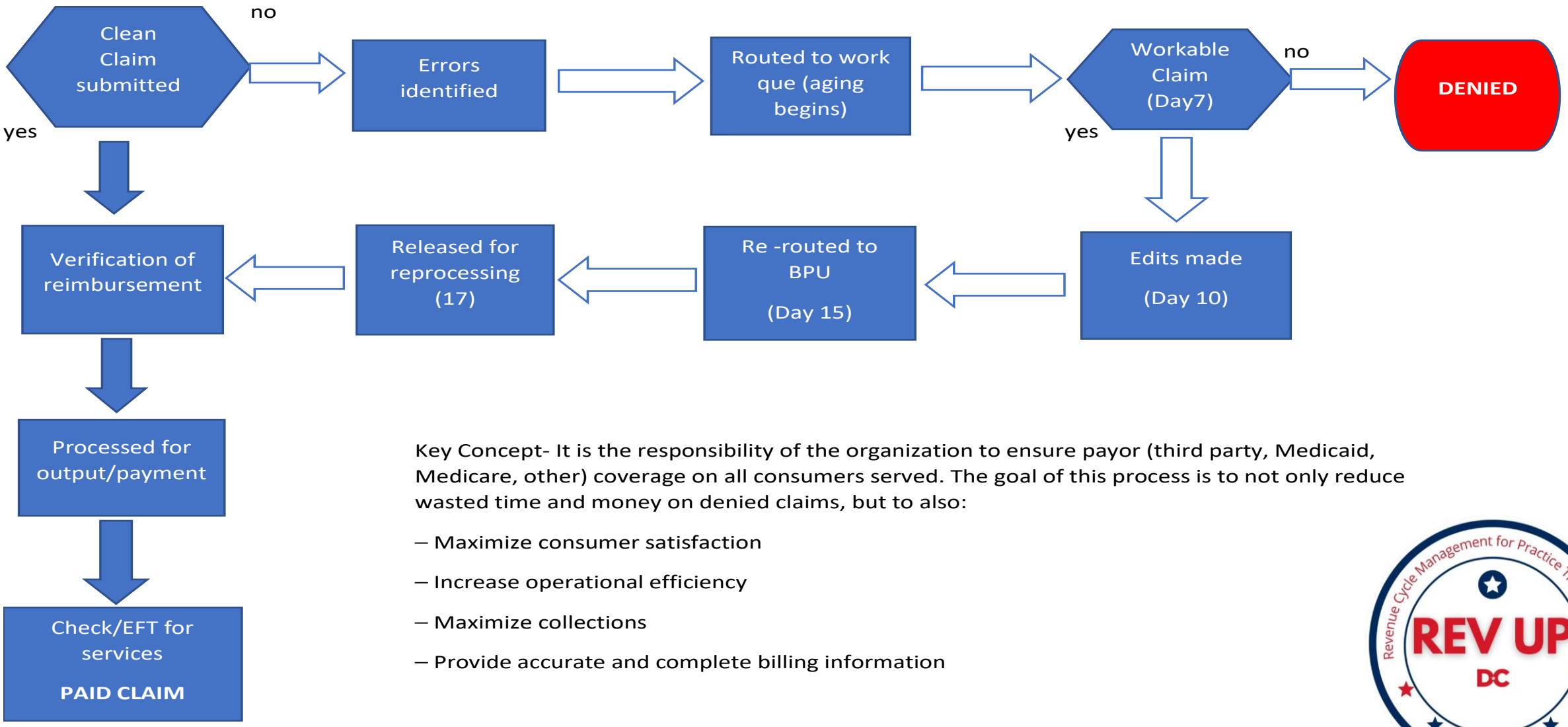
CLEAN CLAIM: DEFINITION

CLEAN CLAIM has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment.

The claim should include the following, which supports the service rendered:

- ✓ Member demographics
- ✓ Provider/vendor Information -name, address, NPI, Tax ID #, Date(s) of service
- ✓ Place of service code(s)
- ✓ Authorization codes
- ✓ Diagnosis code(s)
- ✓ CPT4 procedure/HCPCS codes,
- ✓ Charge per service,
- ✓ Provider signature.

Claim Process Flow



Key Concept- It is the responsibility of the organization to ensure payor (third party, Medicaid, Medicare, other) coverage on all consumers served. The goal of this process is to not only reduce wasted time and money on denied claims, but to also:

– Maximize consumer satisfaction

– Increase operational efficiency

– Maximize collections

– Provide accurate and complete billing information

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CLAIMS & PAYMENT SCENARIOS

A member had a scheduled appointment with a Traverse behavioral Health 1/20/2021. The registration representative verified eligibility for the date of service from 1/1/2021 -1/31/21. The member was seen by the Behavioral Health Provider January 20,2021. During the visit the provider determined the member would require additional services. The Provider requested outpatient Therapy for six sessions at 30 minutes with the following dates:
1/24/21 ,1/26/2021, 01/28/21, 01/31/21, 02/02/21,02/04/21,
The representative initiated a request for authorization for the Outpatient Therapy sessions for January. The member started the Outpatient therapy sessions as scheduled. The sessions were completed on 02/04/21, the claim was closed with the authorization for the dates were indicated on the claim.

What steps should the representative have taken to secure reimbursement?
What steps should this Utilization Representative have done to secure authorization for the complete Therapy Sessions?
What do you think happened to the claim?

Result - Claim was processed and a partial payment was made for (1/24/21,26,28the & 30) January dates of service. The claim posted a denial for dates of service 02/02/21 through 02/04/21 as member not found/incurred after term date. Since a payment had been processed, the Denial representative did not review the claim for proper/full reimbursement.
The member had a new plan assignment effective 02/01/21 under a new MCO. This MCO does *not* complete retro authorizations. This resulted in loss revenue for the Behavioral Health Provider and a partial payment of the claim.
*Since a pre or post audit of the claim was **not** conducted an opportunity to correct/edit the claim was missed.*
Best Practice - always include all authorization numbers and records for a claim. Always review claim edit check for proper provider and covered dates of service.

Valuable Revenue Cycle Tip- always verify eligibility for ***all*** dates of service (60 days/2 months). Make sure an authorization is captured to cover all service dates for the order/services provided. i.e inpatient, therapy sessions. Include all authorization #'s on claim to cover all dates/months of service.

** *In some cases, this claim would have suspended for additional review or requested documentation, however since the member was under a new MCO for the month of February the reconsideration factor was lost.*

CLAIMS & PAYMENT
REVENUE CYCLE MANAGEMENT

CLAIMS & PAYMENT

TOP Denials

Denial Reason	241	$	121,596.40
No Referral/Expired/Invalid Referral	29	$	5,967.00
Exceeds max filing limit	50	$	18,595.72
Expensed incurred after coverage termed	83	$	41,637.70
Expenses incurred prior to coverage	20	$	13,957.13
No Auth on File For DOS	12	$	4,509.53
No Valid Precert on File	39	$	20,367.68

- ✓ Use the data as a teaching tool
- ✓ Identify Trends
- ✓ Track reimbursement/loss
- ✓ Measure Denial Ratio

Most claim denials and rejections are due to errors in eligibility, resulting in wasted time and re-work or services performed without reimbursement. Reconciliation of claim reports timely, eliminates the risk of aging. An audit process, pre/post of claims creates value to the management of revenue and should be incorporated in standard operating practices.

CLAIMS & PAYMENT
REVENUE CYCLE MANAGEMENT

CLAIMS & PAYMENT

Reconsideration - VS - Appeal

Reconsideration - A MCO may determine the claim requires additional review if, the MCO has made an error when determining payment or if additional configuration of reimbursement is required on the MCO's end to correct their payment process or any fault of the MCO. The Billing Processing Unit(BPO) will make the correction, pull a report of claims previously denied due to this configuration error and reprocess the claims in good faith. The MCO will/should notify vendors and providers of this error by News Flash or EFAX Notification.

Appeal – If a claim or a portion of a claim is denied for any reason or underpaid, the provider may dispute the claim within 60 days from the date of the denial or payment. Claim disputes may be submitted in writing, along with supporting documentation. This process could take up to 90days and results in aging A/R.

Valuable Revenue Cycle Tip - always verify eligibility, submit appropriate documentation, authorizations and codes with your claim. Timely filing period is 365 days. Establish good billing practices to submit a clean claim, verify all the codes, authorizations prior to submitting a claim. Follow all steps within the Revenue Cycle process to secure payment timely.

ACCOUNTS RECEIVABLES & RECONCILIATION

REVENUE CYCLE MANAGEMENT

ACCOUNTS RECEIVABLES & RECONCILIATION

Practice Management System(s)

Daily Reporting
- Reconciliation of daily activity
- All services are captured and billed properly

Monthly Reporting
- Profitability of the practice
- Payer performance
- Medicaid
- Commercial
- Pay for Performance status (P4P)
- Capitation
- Aged Receivables (AR)
- Bad debt ratios

Productivity by provider

Identify non-compliant patients (HEDIS, EPSDT, Annual screenings and test

Appeals, if applicable

Post - Assessment:

1) What is a key tip to use when credentialing a Provider or Practice?

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Foundations 101 Follow-Up

Foundation 101 session covered Eligibility, Authorizations, Enrollment and touched on Credentialing. Outstanding discussion items:

Q: How will Recovery Services coverage for denied Claims be managed by MCOs?

A: The MCO Contract uses the DC SPAs and DBH Regs to describe the covered services. The RFP can be viewed here Ariba Spend Management (dc.gov).

Q: When will MCO Behavioral Health coverage begin?

A: MCO Behavioral Health coverage will be initiated at contract launch, currently scheduled for October 1, 2022.

Q: Who will provide authorizations after migration to MCOs?

A: Generally, payers (and their contractors) review requests and issue authorizations, as will the MCOs. Specifically, we cannot provide a process because the MCOs have not been selected.

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/