REVENUE CYCLE BILLING FORUM

SEPTEMBER 14TH, 2022

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. REV UP DC Introduction
2. Billing Review
3. Denials Reporting Review
4. Best Practices Vignettes
5. Q&A

REVIEW: 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

Pre - Assessment:

1.) What is the primary reason to focus on Billing?
- a.) Verify Member Eligibility
- b.) Proper reimbursement for services rendered
- c.) Identify the place of service for treatment

2.) Which of the following is NOT an example of a Denials report?
- d.) 834
- e.) 835
- f.) 837

3.) Reimbursement of services rendered are received on:
- g.) 835
- h.) Payment file
- i.) ERA (Electronic Remittance Advice)
- j.) All of the above

LEARNING OBJECTIVES
Billing Forum

1. Participants will review Billing best practices, as presented in RC Foundations 103 and identified through Technical Assistance process.
2. Participants will develop skills to support interpretation of Denials reporting.
3. Best Practice Vignettes will be discussed with participants by the Technical Assistance coach/panelists.

WORKFLOW
REVENUE CYCLE

Revenue Cycle Management for Practice Transformation
REV UP
DC

CLAIMS & PAYMENT SCENARIO

A member had a scheduled appointment with Traverse Behavioral Health on 1/20/2021. The registration representative verified eligibility for the date(s) 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 unit/sessions at 30 minutes each for 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 in January. The member started the outpatient therapy sessions as scheduled. The sessions were completed on 02/04/21, the claim was closed with the authorized dates in January indicated on the claim.

What steps should the representative have taken to secure full 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 (24th, 26th, 28th & 31st) 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*** process retro authorization requests. This resulted in a loss of 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. Since eligibility for the full range of services was not verified, the claim resulted in partial payment. The Utilization rep also did not confirm* ***FULL*** *authorization for all service dates.*
Best Practice - Always verify eligibility for all dates of services (2 months). Authorizations should cover all dates of service. Always review claim edit check for proper payor 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 numbers 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.

BILLING 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.

BILLING
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

BILLING WORKFLOW

ACCOUNTS RECEIVABLES & RECONCILIATION STEPS

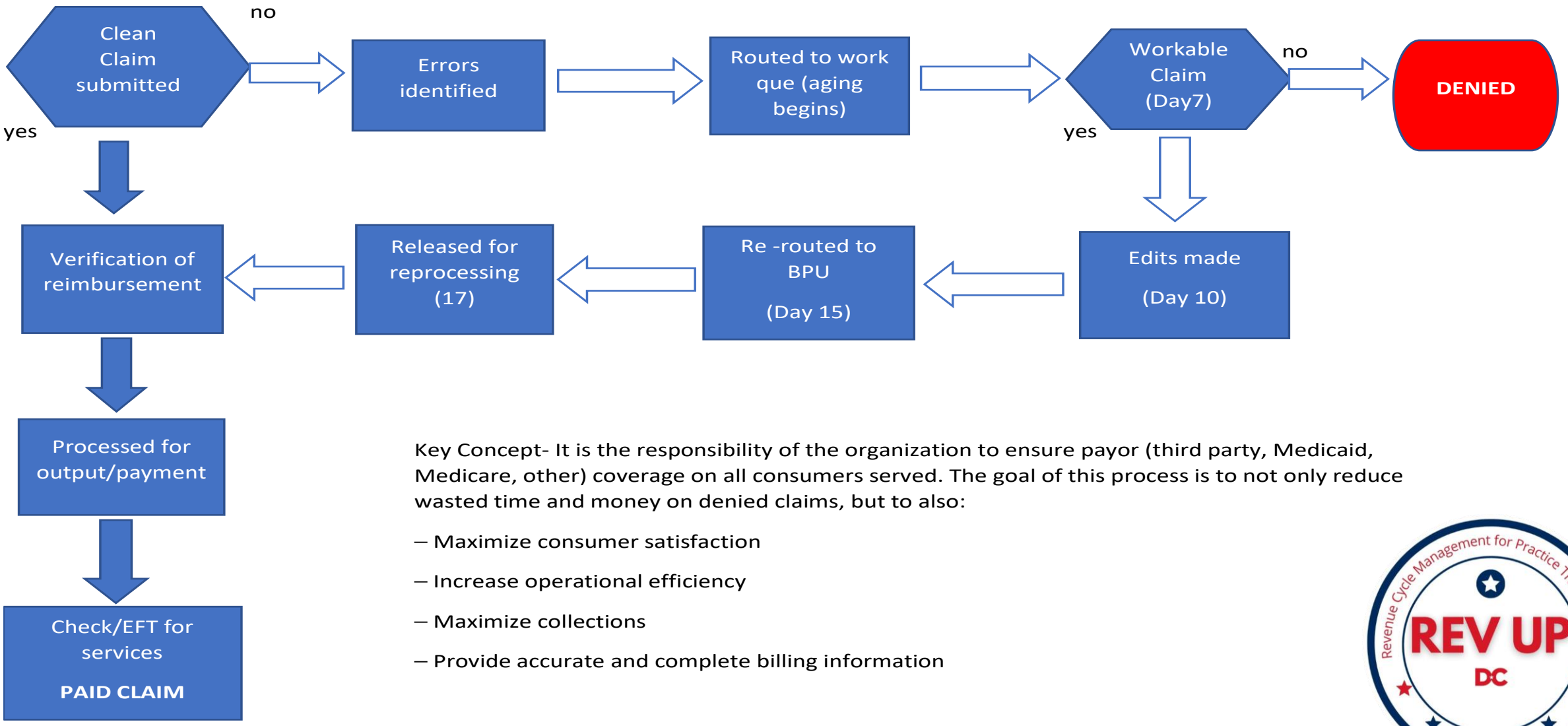
Once claims are submitted (electronic or manual), the aging process for receivables begins.
(0-30 days) – (31-60 days) – (61-90 days) – (Over 90 days) – (Over 120 days) – (Over 180 days)

Claims follow up – All submissions over 30 days without payment must be followed up per payer (MCOs) as part of A/R management.

Payment posting – When you receive 835 (Electronic Remittance Advice), payments are posted automatically, and errors are worked manually. Some balances will be written off or adjusted per bill line/procedure depending on contractual adjustments, zero pay procedure(s), patient responsibility if applicable and other reasons.

Denials Review – All denied bill lines are reviewed depending on denial reason. Some denials can be appealed. For example, if denied for lack of authorization and an authorization was obtained prior, timely filing if there's proof to the contrary. Appeal(s) must be initiated within 60 days of denial date. Unappealable denials include lack of eligibility on date of service, non-covered benefit, exhausted benefit etc.

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

DENIAL REVIEW
REVENUE CYCLE MANAGEMENT

DENIAL REPORT/ 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
Expenses 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.

DENIALS
REVENUE CYCLE MANAGEMENT

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.

Timely Filing– Claims for covered services must be filed within 365 days from the date of service. Timely filing guidelines for Medicare/Medicaid crossover and third-party claims are 180 days from the Medicare or third-party payors payment date. Failure to do so results in a denial due to "Timely Filing". This also results in lost revenue and write-offs since members are not liable for denials due to timely filing.

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.

835 REPORT EXAMPLE

REVENUE CYCLE MANAGEMENT

Sample: 835-PLB CS Adjustment Report (Claim Level)

ED835R01 [redacted] 07/15/2010 Page : 1 of 1

835/PLB CS Adjustment Report

Transaction Receiver: 561561561

BATCH Level Information:

Payee ID	Check/EFT Number	Check/EFT Date	Total Check Amount	Good Claims Count	Good Claims Dollars	Bad Claims Count	Bad Claims Dollars	Total Batch Count
Batch								
6786786783	1002051930001069	07/03/2010	$77,210.55	1194	$76,625.00	5	$575.55	1199

Patient ID / Claim ID	Patient Acct # / Service Start	Patient Last Name / Service End	Patient First Name / Charged Amount	Paid Amount
Claim(s)				
YPP11122233301	235A45666	DOUGH	JOHN	
0105011005501	07/01/2010	07/01/2010	500.55	300.55
YPZ11122333301	235A45J678	LADY	LOVELY	
0105131005501	07/01/2010	07/01/2010	100.00	50.00
ZCS11123456701	235A451178	CHEEK	ROSIE	
0105141005501	07/01/2010	07/01/2010	75.00	25.00
YPH11223333301	AAA7878	MOUSER	MICKEY	
0105011005601	07/01/2010	07/01/2010	400.00	300.00
YPY11122342451	ZZZ235	SMITH	JOHN	
0105011005701	07/01/2010	07/01/2010	-250.00	-100.00

For additional information regarding these claims, please refer to the Explanation of Payment

This report is generated to assist in balancing provider accounts and should be used in conjunction with the HIPAA 835 Remittance.

[redacted]: - 835 Health Care Claim Payment/Advice v1

AGING REPORT EXAMPLE

REVENUE CYCLE MANAGEMENT

Insurance Aging Report

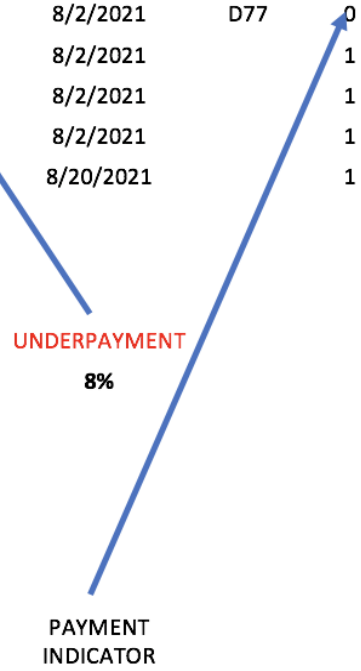
	$ 540,384.00	$ 396,673.00	$ 82,604.00	$ 34,231.00	$ 15,890.00	$ 540.00	$ 10,446.00
Carrier		**Current**	**Over 30**	**Over 60**	**Over 90**	**Over 120**	**Pending/Review**
Managed Care Organization A		$ 31,215.00	$ 11,230.00	$ 415.00	$ 95.00	$ 115.00	$ 2,352.00
Managed Care Organization B		$ 85,369.00	$ 65,215.00	$ 33,521.00	$ 12,541.00	$ 425.00	$ 6,584.00
Managed Care Organization C		$ 129,852.00	$ 4,589.00	$ 233.00	$ -	$ -	$ 658.00
Managed Care Organization D		$ 95,125.00	$ 1,254.00	$ -	$ 3,254.00	$ -	$ -
Managed Care Organization E		$ 55,112.00	$ 316.00	$ 62.00	$ -	$ -	$ 852.00

Encounter ID	Patient ID	Patient Name	MCO	Current	Over 30	Over 60	Over 90	Over 120	Pending/Review
20210715G0021	A17254	Allen Thompson	A	$ 345.00	$ 4,215.00				
20210713G0016	98764R23	Paul Sims	A		$ 3,315.00				
20210617G0016	A32140	Carrie Smith	C	$ 2,112.00	$ 305.00				$ 658.00
20210817G0017	A23984	Richard Price	C	$ 987.00	$ 1,262.00				
20210917G0018	JON43289	Timothy Jones	C	$ 987.00					
20211017G0124	09876K821	Kimberly Jenkins	B				$ 3,587.00		
20211005G0256	32158T326	Maria Garcia	C	$ 875.00					
20211005G0213	PRI125834	Terrence Prichaard	D				$ 3,254.00		
20211005G0175	156KT1236	Linda Hunt	C		$ 315.00				
20211006G0182	156BR9845	Soon Yung Pak	A			$ 415.00			
20211012G0177	575BN3514	Karen Simpson	C	$ 365.00					
20211016G0921	A85214	Gloria Sanchez	B		$ 3,214.00				$ 2,215.00
20211005G0179	WEL238547	Tara Wells	D	$ 3,256.00	$ 210.00				
20211017G0220	QUA32584	Dexter Qualls	E		$ 316.00				
20211017G0322	A62574	Troy Madison	C	$ 698.00					
20211017G0412	35871T652	Toni Williams	B				$ 287.00		
20211017G0023	A32158	Edward Offu	B				$ 365.00		

CLAIM RECONCILIATION EXAMPLE

REVENUE CYCLE MANAGEMENT

Claim #	Member Name	DOS	CLAIM TYPE	VENDOR NAME	NPI #	BILL AMOUNT	PAID AMOUNT	PAYMNET DATE	ADJ.	INDICATOR	CHECK #	LOB
98745632	SMITH, SAM	5/5/2021	M	GW HEALTH SYSTEM	9874563200	$1,258.38	$0.00	8/2/2021	D77	0	6491	200
12345678	DENA, RYAN	7/2/2021	M	MEDSTAR HEALTH SYSTEM	7894560025	$989.00	$123.12	8/2/2021		1	9871	200
85401269	GROVE, DYLAN	6/22/2021	ER	HOWARD UNIVERSITY HOSP	7419006325	$1,282.28	$625.45	8/2/2021		1	96321	100
25836974	SWIFT, TAMMY	6/8/2021	ER	HOWARD UNIVERSITY HOSP	2500836974	$1,485.24	$673.25	8/2/2021		1	96321	200
56479812	GREENW, TAYLOR	7/9/2021	ONA	PROVIDENCE HOSPITAL	8529631200	$867.00	$562.12	8/20/2021		1	78945	200



PAYMENT PERFORMANCE
REVENUE CYCLE MANAGEMENT

BILLING REVIEW CONTENT

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
- Others

Productivity by provider

- Identify non-compliant patients (HEDIS, EPSDT, Annual screenings) and test
- Key Performance Indicators (KPIs)

Appeals, if applicable

Note that cost-sharing does not apply to this patient population, as there is no cost-sharing requirement for services provided

KEY PERFORMANCE INDICATORS (KPIs)
REVENUE CYCLE

Key Performance Indicators (KPIs) are predetermined quantifiable measurements that reflect critical success factors for your practices. RC Industry Best Practice recommends that you measure monthly and use to track performances.

Industry Standard:	**Other useful indicators:**
• Days in Accounts Receivable (AR) • Net Collection Rate • % of AR greater than 90 days • % of AR greater than 120 days • Denial Rate • Credit Balance % of AR • Time of Service Collection % • Charge Lag	• % of claims billed electronically • Payment Posting lag • % of write off for eligibility • % of write off for timely filing • % of write off for authorizations

REV UP DC Coaches can assist in implementing based on RC Industry Best Practices.

VIGNETTE REVIEW

REVENUE CYCLE

COACHES TO DISCUSS PRACTICE ENGAGEMENT

CONCLUSION
REVENUE CYCLE MANAGEMENT

REVENUE CYCLE FOUNDATIONS RECAP

- **Registration** – validate demographics with current address, phone number and insurance
- **Eligibility** – verify active coverage for all dates of service (2 months)
- **Authorization** – obtain authorization for ordered services with supporting documentation
- **Credentialing** – confidential formal review of provider qualifications when applying for panel/contract with payor
- **Claim submission** – include member demographics, provider ID/Vendor name, address, NPI#, Tax ID#, billable ICD – 10, CPT codes and authorizations, diagnosis codes and Provider signature
- **Denials Management** – Review of suspended and denied claims or bill lines, for reconsideration or appeal and coaching
- **A/R Follow-up** – review of payment files (835) for errors, payment discrepancies and underpayments
- **Reimbursement/Reconciliation** – review of posted payments, adjustments applied reconciliation and check dates for Provider performance

Post - Assessment:

1.) What is the primary reason to focus on Billing?
- a.) Verify Member Eligibility
- b.) Proper reimbursement for services rendered
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2.) Which of the following is NOT an example of a Denials report?
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3.) Reimbursement of services rendered are received on:
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QUESTIONS?

Thank you for attending today's Billing Forum education session. Please complete the Revenue Cycle Billing Forum Satisfaction Survey, which will be sent to you via email. Once you have completed the Satisfaction Survey, you will receive:

1. The Revenue Cycle Quick Reference Guide
2. The Revenue Cycle Billing Forum presentation slides
3. The Revenue Cycle Billing Forum session recording

Questions? Contact us at RevUpDC@integratedcaredc.org

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

ADDENDUM

TIPS REVENUE CYCLE MANAGEMENT

Tips of the Week #1-8

Tips #1– 8

1. **Registration:** Take this opportunity to update the patient's account with current information to maintain an efficient billing process.
2. **Eligibility**: Obtaining current eligibility adds efficiency to the revenue cycle process.
3. **Authorization**: Always request an authorization for services and dates of services that require one per plan guidelines for appropriate reimbursement.
4. **Fraud, Waste and Abuse:** See something say something. Use the link below for additional information:

   http://surl.li/bnuyo
5. **Claims submission**: Claims should be processed timely to recoup proper reimbursement.
6. **Denial Management**: Establish a Denial Management Team within your Billing/Claims department. RCM SOP recommends a weekly review to identify risks timely. This will eliminate write-offs, aging A/R, and improve the Auto Adjudication/clean claims rate.
7. **Accounts Receivable**: Verifying proper payments and reviewing denials timely will assist t he Revenue cycle/Accounting Team post of proper reimbursement.
8. **Reimbursement/Reconciliation:** An Established Reconciliation/Reimbursement process ensures accurate and error-free payment posting.

Revenue Cycle Management for Practice Transformation
REV UP DC

VIGNETTE #1
REVENUE CYCLE

The introduction of the Rev – Up DC has been a welcomed initiative for several Behavioral Health Practices. This practice had the burden of fast tracking to learn specific workflows and procedures of a Residential/SUD Provider due to new hires. During the initial meeting we addressed the current state of each area based on the Revenue cycle flow.

Those areas included Registration, Eligibility, Authorizations, Credentialing, Claims, Denials Management, and reconciliation.

The team did not hold back on the need for assistance and welcomed our assistance.

During the coaching sessions we discovered resource issues, such as people operating in areas that did not reflect, their skill set. Team members working without appropriate user access to systems or training that would allow them to work more efficiently instead of depending on others to complete their assigned tasks.

VIGNETTE #1
REVENUE CYCLE (CONT'D.)

The practice also required assistance with accessing their reports (835, 837) and interpretation of those reports.

As a result, one to one meetings were scheduled with DBH (Provider Relations, Claims Team and Authorization) to identify training(s), user access for residential authorizations, claim reports and address their current barriers. Since the team was engaged in the Rev-up sessions, they made themselves available for a weekly standing meeting.

As their coach, I made myself available between meetings to discuss any new findings or issues that required immediate attention.

The Clinical Team was able to gain access to systems, attend training sessions and used reference materials made available by Rev-Up such as Residential workflows and tools from the respective MCOs to assist in day-to-day process flows.

VIGNETTE #1
REVENUE CYCLE (CONT'D.)

By reviewing reports, we were able to uncover missing modifiers, inappropriate codes and claims with plan payor issues (470 local dollars).

The A/R reports were used for one-to-one coaching along with reference materials to address errors and resubmittals. Monthly A/R reports were made available for timely reviews. The process alone reduced denials yet created a cross walk for new claims and system wide corrections. The Practice hire 4 new resources to provide efficiency with day to day operations and clinical support.

The Claims Rep now reviews their remittance advice weekly for potential submittals and the Monthly A/R report for process improvements. As a result, a folder was developed called "Behavioral Health Resource Materials".

While this is an ongoing process improvement initiative to ensure their readiness, the practice has made significant strides from our initial session. The Practice now meets bi-weekly and remain invested in their performance.

VIGNETTE #2
REVENUE CYCLE

Many behavioral health practices have welcomed the introduction of the Rev - Up DC. Creating and implementing policies to create an efficient back-office operation and build infrastructure was a challenge for this practice.

The practice also needed assistance in hiring additional staff. Furthermore, credentialing assistance was needed with the MCOs.

My role as the assigned Coach was to review the DBH Business and Administrative Operations Best Practices Manual and Appendices and provide them with the resources relevant to their needs.

In response to the resources provided, the practice was able to develop and implement policies within the organization. In addition, they welcomed a LICSW to the team. The practice was able to benefit from the tools and credentialing requirements offered throughout our involvement. A process for credentialing for all of the MCOs was initiated in July by the practice and is currently in progress.

VIGNETTE #3
REVENUE CYCLE

This assigned Behavioral Health practice is relatively small, averaging just about 12-20 patients per week for Substance Abuse Disorder treatment. Provider assessment revealed that due to volume/income, staff members were multi-tasking particularly there were no trained staff handling revenue cycle functions. The Clinical Director was also over the staff handling billing and clinicians were involved in coding etc.

The practice was also billing sporadically and receiving explanations of payment and denials required to do AR reconciliation on a quarterly basis.

With the assistance of DBH, the frequency was increased to monthly (i.e. the receipt of Electronic Remittance Advice 835 files). We met and coached the practice on how to read this file, interpret the denial and or payment adjustment codes so that necessary appeals/resubmission of claims can be done promptly.

VIGNETTE #3
REVENUE CYCLE (CON'T)

Most of the denials were due to procedure code and place of service code incompatibility. This resulted in the **denials** rate dropping from 15% to 5% immediately. The practice would like to increase staffing to improve efficiency of revenue cycle but can't afford to right now. They hope to expand services and capacity in the short term.

The practice was also coached on the necessity to verify eligibility of patients prior to service and obtaining necessary authorizations. They currently rely on DBH to have done this prior to patient referral to the practice. This is a crucial step once the MCOs' take over.

Most noteworthy, this practice currently does not have an Electronic Health Record system. They are awaiting a grant from DBH/DHCF which is expected soon per DHCF. WellCentric will continue to work with this practice to ensure that the transition to MCOs will be smooth and anticipated growth will be sustainable.