Managing Accounts Receivable

MedTrust, LLC
LuAnn Jenkins, CPC, CPMA, CMRS, CFPC, CEMC

Disclaimer

This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational guide and should not be considered a legal/consulting opinion.

CPT is a registered trademark of the American Medical Association. Copyright 2009 - American Medical Association. All rights reserved.

Topics Of Discussion

- Prevention?
- Benchmarks
- Reports
- Fee Schedule maintenance
- Financial Policies
- Process
- Coding & Billing
Accounts Receivable

- The most important factor in managing the AR is prevention.
  - Take steps to get claims paid first time and do not touch the account again
  - Efficient and cost effective
  - Collecting from patients at time of service and following a strict collection policy on patient balances

REPORTS & BENCHMARKS

2014

Benchmarks – Measuring the AR

- A/R Age - Not more the 15% over 90 days
- Size of A/R
  - Size not more than 1 to 1.5 time average monthly charges
- Factors that can impact these benchmarks
  - Increased fees
  - Unusually high charges in a month
Insurance AR vs. Patient

- Measure both
  - Patient
  - Insurance
- Patient balances should be moved off AR if in collection, discharged from practice or considered non collectable.

Benchmarks

- Net Collection-Charges minus receipts and insurance contractual write-offs
  - 95% or higher
  - *Expect 5% bad debit on average*
  - *only if write-offs are actual contractual and do not include rejections/denials*

Benchmarks

- Days outstanding-how long do your charges stay on the A/R or how long does it take to get claims paid?
  - Total A/R divided by Average daily charges
  - 20-25 days
Benchmarks

- Gross Collection
  - Is a reflection of the fee schedule and *does not* provide a true measure of collection
  - If fee schedule is set too high this will be low
  - If fee schedule is set too low this will be high
  - Goal should be 40-60% depending on your fees and payer mix

Benchmarks

- Adjustment & Contractual write-off percentages
  - No set measurement
  - Dependent on:
    - Contractual agreements
    - Fee schedule
  - Important to track all adjustments versus contractual agreements

Scrubbing Claims

- Billing software edits
- Clearinghouse edits
  - Do they scrub for CCI edits
  - LCD errors
- Example: Payerpath Code Correct
Report Detail

- Tips
  - Run specific payers with ID#
  - Look for easy fixes
    - Incorrect number of digits for Medicaid ID
    - Incorrect alpha prefix for BCBSM
    - Railroad Medicare billed as Medicare
  - Run secondary claim report
    - Can you refile secondary claims electronically
    - Does your system pend/hold 2nd claims

Tertiary Claims

- Run report to check claims to 3rd payers
- Does your system send those electronically
- Do they need to be dropped to paper

Managing Pending Claim Reports

- Run >90 day report of open claims
  - Goal: no claims over 90 days
  - Work until under control***the focus on >60 days
- Run>60 day reports
  - This is the monthly report that will keep claims under control
Managing Pending Claim Reports

- Specific payers
  - BCBSM – Run >30 day report
    - Usually has a 7-10 turnaround on electronic claims so 30 days is old
  - Workers Comp -> 45 days
    - Michigan rules require payment in 30 days
    - Add 3% late fee on second submission if not paid in 30 days

- United Healthcare
  - Aetna *(any others you know have short time frames)
    - Have short claim submission timeframes
    - Run >30 day report monthly

---

2014 APPEALS
Michigan Prompt Pay
- Clean claims must be paid in 45 days
  - File against insurance company/not 3rd party administrator
- Simple interest rate of 12 percent per annum if not paid in 45 days
- Complaints are filed per claim
- Medicaid HMO
  - Electronic claims only

Department of Insurance Financial Services (DIFS)
**PENALTIES FOR LATE PAYMENT OF A CLEAN CLAIM:**
A clean claim that is not paid within 45 days shall bear simple interest at a rate of 12% per annum. The Director of DIFS may also impose a civil fine of not more than $1,000.00 for each violation not to exceed $10,000.00 in the aggregate for multiple violations.

Appeal Timeframes
- Monitor payers
  - Medicare 120 days
  - Medicaid 120 days
  - BCBSM 30 days at each level
- COB issues allow for time from primary response
Appeals

- Appeal Policy
  - Minimum amount to appeal
  - Time frame expected
    - Monitor specific payers
    - Assign? By payer/provider

Methods

- Phone—slowest method
  - Some staff prefer?
- Email—documents response
  - Example: providersupport@michigan.gov
- Faxing—Make sure to document confirmation
- Online

Rebill?

- Do not rebill unless:
  - Corrected information
  - Confirmed that the claim was not received by the payer
- Unnecessary rebills create more work
  - Duplicates
  - Denials to work

2/18/2014
Front End Edits

- Know your software and clearinghouse reports
- Electronic Claims rarely “disappear”
- Most often it failed electronically
- Work front end edit reports

Review Thoroughly First

- Is it an insurance eligibility/COB issue?
  - May need to contact patient
  - Medicaid – buy in unit for Part B issues
  - BCBSM-COB form that can be submitted
  - Patient needs to be involved
    - Calling patients
    - Statements

Is it a Coding/modifier Issue?

- Is there a coverage policy issue
- Bundling issue
  - Check CCI, or edits followed by that payer
- Modifier?
  - Is it a Hospice issue
Billing Issues
- Incorrect use of units
- Format of claim
  - NDC#
  - Attachments
- Payer specific modifier issues
- Ordering/referring doctor
- Enrollment problem

 Corrections Online
- Research what payers will allow corrections through their web portals
  - Availity (Humana)
  - HAP
  - Aetna
  - United Healthcare Community Plan (Optum)

 Corrected Claims
- Refiling claims even with changes can be denied as duplicates
- Filing as a corrected claim electronically is accepted by some payer
  - Check software
  - Add original claim# and resubmission code
  - Box 22 on CMS 1500*
Appeal Steps

- Specific Form if required
  - Electronic claim status
    - BCBSM no longer accepting paper claim status
  - Online
  - Paper
- No form create a letter
  - Provider letterhead

Appeal

- Use complete information
  - Patient identifiers, demographics
  - Codes billed
  - Records/claim form
- Explain problem and what you want done
  - "please reprocess" is not enough

Appeal

- Explain what resources were used to support coding/billing (software, policies, manuals)
- Include documentation of other payer policy if supports your case
- Include all record documentation to support coding.
Examples:
- Timely Filing
  - Show proof of electronic file submission
  - Explain reasons for delay
    - COB for example
- Changing codes
  - Explain what code/modifier should have been used and why

Timely Filing
- BCBSM
  - 180 days
  - 2nd claims based on primary response
  - No exceptions
- Aetna
- UHC

Coding/Policy Reviews
- Higher level cases
- Request review by physician peer
  - Not nurse reviewer
- **Remember that medical necessity denials are related to policy
  - The diagnosis code or frequency did not follow policy
Medicare-Unprocessable-REFILE

- MA04-secondary claim missing COB info
- MA61-Patients insurance ID# invalid
- MA112-Incomplete/invalid rendering
- MA114-Invalid location
- N286-Missing/invalid referring provider

C-SNAP

- C-SNAP: https://www.medicareinfo.com
- Register/same day access
- Here's what C-SNAP can do for your office:
  - Eligibility
    - Effective date
    - If enrolled in Managed Care/name of carrier
    - If in home health Care
    - If in Hospice
    - Eligible Preventive services*
    - MSP information

C-SNAP

- C-SNAP: https://www.medicareinfo.com
- Here's what C-SNAP can do for your office:
  - Submit a new request for a redetermination/reopening or check the status on one previously submitted using C-SNAP.
  - Claim status data.
  - Detailed information about the payment of your previously processed claims.
  - Copies of EOBs
Medicare Appeal Steps

- Reopening*FORM or on CSNAP
  - Clerical errors/minor billing errors
  - Adding modifiers
  - Correcting units

Medicare Appeal Steps

- Redetermination (MAC)*FORM/CSNAP
- Reconsideration by a Qualified Independent Contractor (QIC) *FORM
- Hearing by an Administrative Law Judge (ALJ)
- Departmental Appeals Board (DAB)/Appeals Council
- Judicial Review in Federal District Court

BCBSM Appeal

- Call Provider Inquiry
- Claim status*/corrected claim
- Written Inquiry by area code
  - PO Box 2227 Detroit 48231-2227
    - (248,313,517,586,734,810,947,989)
  - PO Box 230589 GR 49523 (231 269 616)
- Contact Provider Consultant
BCBSM Appeal-claim disputes

- Next Level
  - Physicians Ombudsman Unit
  - Mail Code 2027
  - 600 E Lafayette Blvd
  - Detroit MI 48226-2998
- Informal conference
- Binding arbitration

Participation Agreement

- **3.7** PRACTITIONER will submit Clean Claims for all Covered Services to BCBSM within *one hundred eighty (180) days* of the date of service and only for services performed personally by PRACTITIONER or under his/her direct personal supervision.

Participation Agreement

- **3.8** PRACTITIONER at all times during the term of this Agreement shall:
  - a. Not waive Copayments and/or Deductibles that are the responsibility of the Member, except for hardship cases that are documented in the Member’s record or where reasonable collection efforts have failed.
Participation Agreement

- c. Notify BCBSM within thirty (30) days of changes in PRACTITIONER's business including changes in ownership, name, tax identification number, location, phone number, business structure, range of services offered and specialty. Prior notice of such changes does not guarantee continued participation under this Agreement.

Participation Agreement

- 3.12 PRACTITIONER shall not bill BCBSM for Covered Services rendered to themselves or immediate family Members (mother, father, sister, brother, spouse or child).

Participation Agreement

- IV. Recovery
  - BCBSM shall have the right to recover amounts paid for services not meeting applicable benefit criteria or which are not medically necessary as determined by BCBSM under Addendum 'A'. BCBSM shall have the right to recover amounts for services not meeting the applicable benefit, reimbursement or medical necessity criteria established by BCBSM, overpayments, services not documented in PRACTITIONER's records, any services not received by Member, non-Covered Services or for services furnished when PRACTITIONER's license was lapsed, restricted, revoked or suspended.
Participation Agreement

IV. Recovery

BCBSM will not utilize statistical sampling methodologies to extrapolate refund requests on medical necessity issues identified through sampling. BCBSM may extrapolate refund recoveries from statistically valid samples involving issues other than medical necessity. BCBSM shall have the right to initiate recovery of amounts paid for services up to eighteen (18) months from the date of payment or up to twenty-four (24) months from the date of payment as required by a (a) self-insured plan or (b) state or federal government plan. In instances of fraud, there will be no time limit on recoveries.

Medicaid CHAMPS

- Medicaid provider support
  - Providersupport@michigan.gov
  - providerenrollment@michigan.gov
- CHAMPS

Workers Compensation MICH

- www.michigan.gov/wca
  - Appeal form 104B
  - Late fees 3%
  - Notification of hearing for disputes
No Fault Auto

- Section 3107 (1) (a) of the Michigan No-Fault Act requires insurance companies to pay “allowable expenses,” which are defined as “all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person’s care, recovery or rehabilitation.”

Motorcycle Accidents

- The Injured Motorcyclist’s Entitlement to PIP Benefits
  - Although motorcyclists are not subject to the Michigan no-fault laws and are not required to purchase a no-fault policy, they may be entitled to no-fault benefits if their injury is caused by the operation or use of a “motor vehicle.” MCL 500.3105(1). Typically, this occurs when a motorcycle and a motor vehicle collide, although contact is not a requirement. As long as the motor vehicle was a significant factor in causing the motorcyclist’s injuries, benefits are typically collectible.

Medical Providers & the Michigan No-Fault Law

- When the Michigan Legislature enacted the No-Fault Automobile Insurance Act in 1973, it did not draft a statute that utilizes managed-care concepts, as have other states that enacted a no-fault system. On the contrary, the Michigan No-Fault Act is purely a fee-for-services system obligating a no-fault insurer to pay all “allowable expenses” as defined in the statute.
Denial of Claims based on Fee Schedules

- Sometimes, the no-fault insurance company supports its denial of the claim by referring to certain fee schedules that are utilized in Workers’ Compensation cases or utilized to determine what benefits are payable under health insurance policies or governmental benefit programs.
- The Court of Appeals has clearly held that it is improper for a no-fault insurance company to use fee schedules to determine the extent to which medical expenses are compensable under Subsection 3107(1)(a) of the statute. See Munson Med Ctr v Auto Club Ins Ass’n, 218 Mich App 375 (1996) and Mercy Mt Clemens Corp v Auto Club Ins Ass’n, 219 Mich App 46 (1996).

Collection

- To avoid this situation, the Michigan Insurance Commissioner has issued Bulletin 92-03, which requires no-fault insurance companies to protect the patient from any collection efforts undertaken by the medical provider and to inform the provider that the dispute is solely between the insurer and the provider and does not involve the patient.

Bulletin 92-03

- However, it remains doubtful whether this bulletin can legally cut off the right of a medical provider to sue a patient to recover the balance that remains unpaid after an audit. Therefore, patients and providers should pay close attention to whether any portion of their medical expenses are being denied because of a no-fault insurance company audit. If this is happening, patients and providers should consult with legal counsel to determine what legal rights they may have regarding the unpaid amount.
Managing Fee Schedules

- Don’t leave money on the table
- Review fee schedules annually
- Monitor payer allowed amounts (Paying 100%? Look at fee)
- Gross Collection over 70%?
  - Fees may be too low
- Do not set fees based on cash patients
- Use Payer fees or RVUs as basis

Contracts

- Michigan has limited opportunities to negotiate*ask before signing
- But be sure to review contracts
- Items to look at
  - Time frames (*submission & appeal)
  - Payment policies
    - Multiple surgeries
    - Assistant surgery
    - Pre authorization requirements
Overall Financial Success of the Practice

- Depends on good policies that are enforced
  - Need provider support***
- Written and provided to patients and staff
- Posted in the office

Financial Policy-Cash Drawer

- Balance cash drawers every night!!
- Account for all payments collected
- Take funds out of drawer; deposit or lock up
- Require staff to give receipts to all patients
- Post sign telling patient they should always receive a receipt

Financial Policy-Billing patients

- Standard is 2 statements; one collection letter
- Assess a “billing” fee on the 2nd statement for administrative costs.
  - Don’t call it a late fee*
- Use collection agency or assign staff to make calls
  - May also add a collection fee*

*Patient must be aware (signed financial policy)
Financial Policy—Cash patients

- Cash patients
  - Use financial need form to prove income levels
  - Set office policy to give "financial need" adjustments (for example: 2.5 x national poverty level)
  - It is legal to provide free service to patients in need (per Medicare)

Compliance Concerns

- Discount policies
  - Waiver of copay/deductible is not allowed for Medicare unless financial need is documented
  - Most commercial contracts also require providers to collect patient copay/deductibles per provider contract
  - Discount can be given to cash patients
  - *Do not down code to lower fees

Collect up Front

- Cash patients should expect to pay at time of service
- Consider collecting prior to patient being seen for cash patients, set co-pays and previous balances
- Cash patient—set a fee schedule such as the BCBSM allowed amount for example.
Affordable Care Act (ACA)

“The Affordable Care Act created a 90-day grace period before insurers can drop policy holders who fall behind on premiums. So, delinquents who obtain tax-subsidized health insurance through an Obamacare health insurance exchange have three months to settle up their bills prior to their policy being canceled.”

ACA ????

Insurance companies must pay claims through the first 30 days of delinquency.

31st until the 90th day of non-payment, insurance companies will no longer be responsible for the payment of claims.

It will be up to doctors, hospitals, and any other healthcare provider to collect fees for their services directly from patients!

Check Eligibility EVERY TIME

Websites should show “pending” when the policy premiums have not been paid

??Request premium payment proof?
**Surgery Offices**
- Meet with patient
- Review insurance
- Discuss payment arrangements for deductibles and copays prior to surgery

---

**Banking Responsibilities**
- Multiple staff involved
  - Opening mail
  - Posting checks
  - Depositing checks
- Do not have the same person handling all these steps
- Theft is easier than you think

---

**Banking Options**
- Consider using banking services that allow scanning and depositing of checks from the office (*Remote Capture*)
- Sign up for all *EFT's* that are available from payers (less checks to handle)
- Consider online patient payment options
Posting Options

- Practice Management system should provide automatic posting (ERA)
  - Enroll for as many as possible
- Saves time (multiple page EOBS are posted in seconds)
- Errored claims or claims not posted are reported
- Still review EOBS for payment issue

Payer Websites

- Paper EOBS discontinued by many payers
- Save PDF from sites
- Website provide access
  - CSNAP WPS Medicare
  - WebDenis BC, BCN
  - HAP
  - Medicaid HMOs

Technology

- Scanning
  - Develop a shared drive to store scanned files
  - Staff can access and view
    - EOBS, hardcopy claims and attachments
  - Posting via a scanned document
  - Scan documents
**Red Flag Rule* Not Implemented**

- But is a good policy!
- Prevents medical insurance fraud
  - Using another person’s card
  - Presenting old insurance cards that are no longer in effect
- Verifying with picture ID***
- Always checking eligibility
- Train staff to recognize suspicious situations

---

**Role of the Front Desk**

- Critical staff
  - “Garbage in garbage out”
  - "No time"
- Full schedule does not mean you are getting paid for everything!
- Taking time to confirm insurance, coverage copays/deductibles will pay off!

---

**Technology *******

- Dual Screens or large screens
  - Staff can have multiple applications open to verify information in patient account (address, phone, insurance)
  - While checking payer/or other software for eligibility, copays/deductibles
- Headsets for phones
- Website access
Authorizations

- Critical that proper authorizations are in place
- Check prior to visit
- Many payers no longer retroactively authorize
- If patient still wants to be seen; have a signed form acknowledging that patient agrees (per visit)

Compliance Concern: Overpayment Policy

- Identifying credit balances
- Immediate refunds
- Contacting insurance companies for takebacks
- Monitor

60-Day Rule

- February 13, 2012, CMS issued long-awaited guidance under the Patient Protection and Affordable Care Act (PPACA)
- Requires providers to report and refund known overpayments by the later of 60 days from the date the overpayment is "identified".
Collecting from Patients

- Advance Beneficiary Form (ABN)
  - Using current Medicare form
  - Policy in place-bill with modifier GA
  - Staff trained on use
- Non Medicare patients
  - Use a similar form when charging patient for non covered services (even Medicaid)

Coding vs. Billing

- What is the difference between coding and billing?
- How to use payer policies to avoid denials
- What tools are available with your software and clearinghouse
- How to develop compliance office coding/billing policies and procedures
- Resources that will help your practice
Coding Versus Billing

- Coding includes
  - CPT-procedures
  - ICD-9
  - HCPC Level II
- Describes services provided and documented in the medical record

Clean Claims

- Goal should be to submit claims correctly the first time
- Take time to review
  - Eligibility and demographics
  - Coding
  - Linking
  - Bundling
- Cost effective/efficient

Capturing Charges

- Audit Code/Charge Entry For:
  - Missed charges-encounter marked but not entered
  - Missed services-encounter not marked
    - *Clinical staff not tracking services
  - Co-pays collected
Billing is Based on Payer Rules

- Medicare policy provides specific billing instructions
  - Bundling rules
  - Modifier guidance
  - Fee schedules
  - Medically necessary ICD codes

Billing is Based on Payer Rules

- BCBSM policy provides specific billing instructions
  - Bundling rules
  - Modifier guidance
  - Fee schedules
  - Medically necessary ICD codes

Policies NCD & LCD

- Primary authority for all coverage provisions and subsequent policies is the Social Security Act (the Act).
- Contractors use Medicare policies in the form of regulations, National Coverage Determinations (NCD) to interpret provisions
- Local Coverage Determinations (LCD)s apply the provisions of the Act; "reasonable and necessary" information only
LCDs-The key to coding/billing correctly

- Codes describing what is covered and what is not covered can be part of the LCD.
- HCPCs codes
- ICD-9-CM codes for which the service is covered
- ICD-9 codes for which the service is not considered reasonable and necessary, etc.
- Will contain both Professional & Facility

WPS Medicare
www.wpsmedicare.com

- Policy/Coverage
  - Local Policies
    - Injection List (high dollar drugs)
  - National Policies
  - Lab policies-CMS website
    www.cms.gov/mcd/indexes.asp

Example: LCD for Vitamin B 12 Injections (L30145)

- ICD-9 Codes that Support Medical Necessity.
  - 266.2 OTHER B-COMPLEX DEFICIENCIES
  - 268.0 PERNOCIOUS ANEMIA
  - 268.1 OTHER VITAMIN B12 DEFICIENCY ANEMIA
  - 281.3 OTHER SPECIFIED MEYALOBLASTIC NEC
  - 564.2 POSTGASTRIC SURGERY SYNDROMES
  - 579.3 OTHER AND UNSPECIFIED POSTSURGICAL NONABSORPTION
  - V07.39 NEED FOR OTHER PROPHYLACTIC CHEMOTHERAPY
  - V45.3 POSTSURGICAL INTESTINAL BYPASS OR ANASTOMOSIS STATUS
  - V45.75 ACQUIRED ABSENCE OF ORGAN STOMACH
  - V58.49 OTHER SPECIFIED AFTERCARE FOLLOWING SURGERY
  - V58.69 LONG-TERM (CURRENT) USE OF OTHER MEDICATION
National Correct Coding Initiatives Edits

  - Overview
  - Hospital Outpatient PPS and Therapy NCCI
  - Medically Unlikely Edits
  - NCCI Edits - Physicians
  - NCCI Edits – Hospital PPS
  - NCCI Transmittals

National Correct Coding Initiatives (CCI)Edits

- Purpose - to prevent improper payment when incorrect code combinations are reported
  - Column One/Column Two Correct Coding Edits
  - Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual
  - *Updated Quarterly*

Medically Unlikely Edits (MUE)

- MUE is a unit of service (UOS) edit for a HCPCS/CPT codes
- Single provider/single pt same date
- Some MUE values are not published
  - Confidential information for use by CMS and CMS contractors only
Freedom of Information Requests
- Medicare Fee Schedule Database

Medicare Learning Network
- Educational products informational services
  - program policy changes/information to properly bill the Medicare program

Training & Education
- Document training
- Ongoing training for all employees and providers
- Teleconferences, web based
- Organizations
  - AAPC, MMBA, MSMS
Summary

- Create an environment where AR is top priority not last on the list.
- Develop good financial policies
- Monitor benchmarks
- Audit denials/adjustments

Resources

- www.medicareinfo.com (CSNAP)
- www.elizabethwoodcock.com – tools/data/stats to help access office
- http://www.ftc.gov/os/statutes/fdcpajump.shtm Fair Debit Practices
- www.appealoterson.com – sites with form examples

More resources

- https://www.medicalreferenceengine.com/mre/ - coding, billing search tool
  - Health plan policy search
MedTrust LLC

- Thank You