Monitor and Manage Payments from Third-Party Payers

March 29, 2018

Katie Saul:

Hi everybody, and thanks for joining us today. This is Katie Saul from the Title X Family Planning National Training Center, and I am happy to welcome you to today's webinar on Monitoring and Managing Payments From 3rd Party Payers.

A few things before we get started today. If you registered before 2:00 PM Eastern yesterday, you should have received a copy of the slides, and the reminder that was emailed to you yesterday. But just a note that we'll post the slides from today's webinar on fpntc.org. Along with a recording and transcript of the webinar, hopefully early next week.

We encourage all of you to use these resources. Especially when training your networks. We're including PowerPoint slides with talking points that can be used as a training tool as well.

We're going to answer questions today a couple of different ways. Throughout the presentation you can chat in a question at any time. And then we will read out those questions to our presenter at the end of the presentation. We're also going to take questions over the phone, 'cause we know that some of these billing questions can get a little complicated. We'll open up the phone lines at the end of the presentation as well, for Q&A. And we'll provide some instructions for that at the end.

We have two speakers today. Debbie Sullivan is a healthcare consultant with over 20 years of healthcare management experience. And she has extensive experience consulting on financial management in family planning settings. Debbie co-lead the financial management learning collaborative with Caitlin Hungate from the FPNTC. And Debbie also spent over 10 years as the Chief Operating Officer at Adagio Health, which is a Title X grantee in Pennsylvania.

For those of you who attended the first two webinars in this series, you will recognize Debbie's voice again. And I think many of you out in the network have worked with her over the years.

Caitlin who is also presenting today, is a project manager and a member of the FPNTC training, and technical assistance team. And Caitlin also co-lead the financial management learning collaborative with Debbie, which took place last year. So Caitlin, with that I'm going to turn it over to you.

Caitlin Hungate:

Thank you so much Katie. Hi everyone, and welcome to today's webinar focusing on monitoring and managing payments from third-party payers. This is the third financial management best practice outline in the Financial Management Change Package, a quality improvement guide to increase revenue, and this is available at fpntc.org. As Katie said, my name is Caitlin Hungate. I'm a member of the FPNTC's team, and I am joined by Debbie Sullivan today.

During today's webinar, we will be taking a closer look at strategies to help you monitor and manage payments from third-party payers.

Financial Management Best Practices

1. Bill the correct payer and optimal amount (archive available)
2. Monitor and manage client fee collections (archive available)
3. Monitor and manage payments from third-party payers

Link: https://www.fpntc.org/resources/financial-management-change-package

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The financial management change package draws from the literature and most current practice guidelines, to improve financial management. It includes the following three best practices, which we've addressed in our webinar series this month.

The first best practice, bill the correct payer and optimal amount. Best practice 2, monitor and manage client fee collections. And then today, monitor and manage payment from third-party payers. As you can see on the slide, the financial management change package is available on fpntc.org.

In order to increase revenue, it is important to consider all three best practices, and utilize a comprehensive approach that address each of these practices. We strongly encourage you to refer to the change package for more ideas about strategies and successes.

Financial Management Best Practice 3

Monitor and manage payments from third-party payers

FPNTC 3

Today we're focusing on collecting revenue or reimbursement from third-party payers, once the third-party payer has been billed. This best practice and relevant quality improvement strategies focus on third-party payer revenues.

Title X sites or agencies experience common missteps. Such as not identifying issues or trends related to third-party payers account receivables, or AR, and focusing on back end efforts rather than front end issues. There are other common missteps that we will cover today.

A Title X site or agency may consider implementing a quality improvement initiative, specific to this best practice if it is [inaudible 00:04:37] accounts receivable from third-party payers. If it's not aware of all third-party payer contract terms that impact revenue. If it is not measuring denials, or a site or agency's denials rate, that are higher than the industry best practice of 5%. If it is not monitoring AR aging, or AR aging buckets, that contains higher percentages higher than industry best practice.

Learning Objectives

By the end of the presentation, you should be able to:

- Describe the importance of monitoring and managing payments from third-party payers
- Identify at least one denial type that can be avoided by improving processes before filing a claim
- Identify one performance indicator sites can utilize to measure performance
- Describe one tool available to monitor denial rates

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There are four objectives for today's webinar. First to describe the importance of monitoring and managing payments from third-party payer. Secondly, for you to identify at least one denial type that can be avoided by improving processes before filing a claim. Third, to identify one performance indicator sites or agencies can utilize to measure performance. And fourth, to describe one tool available denial rates.

Now I'm going to turn it over to Debbie, who's going to dive into the rationale and go through the different strategies for this best practice.

Rationale for Monitoring and Managing Payments from TPPs

An important component of managing financial health

- To ensure you are receiving expected payments in a timely fashion
- To identify/resolve issues and trends that are slowing down the reimbursement process

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Debbie Sullivan:

Thanks Caitlin. Hi everyone, the monitoring and managing payments billed for services delivered is critical to maintaining financial viability. Particularly timely payments from third-party payers for services delivered. The monitoring practices and QI strategies discussed today will help you assure that your site or agency is receiving expected, timely payments. And that you can identify issues causing payments to be denied, delayed, or partially paid.

Suggested Performance Indicators

Net Collection Rate

- Can be broken out by:
  - Individual TPPs
- Industry benchmark is 95%

Denial Rate

- Can be calculated by:
  - Each payer
  - Denial reason categories
- Industry benchmark is 5%

Link: https://www.fpntc.org/resources/financial-management-performance-report-and-improvement-plan
Link: https://www.fpntc.org/resources/financial-dashboard

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There are several indicators you can use to monitor and manage your accounts receivable. We're going to start by talking about net collection rate. That reflects the rate of your site or agency's total collection of monies owed to you for services delivered. And it's typically calculated retrospectively. It is calculated by dividing dollars collected by dollars expected. And dollars expected will be those contracted rates you have with third-party payers. And that's for services provided during a specific time period.

You can use this indicator to assess net collection rate for all third-party payers together. Or drill down to the net collection rate for each third-party payer you contract with. Industry best practice is 95%.

Denial rate, another major, reflects the percentage of claims denied by third-party payers during a given time period. And it's calculated by taking the number of denied claims divided by the number of claims submitted. Denial rate can be further measured by each individual third-party payer. Or, by denial reason categories.

Common denial reason categories include registration denials. Which would include such things as insurance verification is incorrect, or incorrect payer, or can't identify the client. And reasons such as that. Another category would be charge entry. And that's invalid procedure or diagnoses codes. Another category of denial reasons are the referrals or pre-authorizations are missing. Another category

would be medical necessity denial category. And another, credentialing. Those are some of the common categories you'll see discussed. Industry best practice is 5% as a denial rate.

At the bottom of the slide, we've linked to the financial management performance report and improvement plan, where you can enter your data and track your performance on these indicators. The second link to the dashboard includes citations for the industry best practices for net collection rate and denial rate, which we mentioned.

Suggested Performance Indicators

A/R Aging

- Can by measured /sorted by:
  - Site
  - TPP
  - Clinician

Link: https:// www.fpntc.org/resources/financial-management-performance-report-and-improvement-plan
Link: https://www.fpntc.org/resources/financial-dashboard

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Another suggested performance indicator for measuring and managing third-party payer payments is accounts receivable aging. AR aging refers to money owed to your agency for services provided. Distributing these monies by how old the money is. Dollar amounts outstanding are categorized by age from date of service in different age buckets. Which are typically 30 day increments of time. 0 to 30 days, 31 to 60, 61 to 90, 91 to 120, and 120 and above.

It is frequently used as an indicator of the ability to collect receivables when compared to benchmark percentages in each age bucket. These are four suggested way you can sort or measure AR aging.

You can do this by site if your agency has more than one service site. By third-party payer. Perhaps by clinician. Or by code. To name a few.

At the bottom of the slide are the same links that's mentioned in the previous slide. You can track your site's AR aging data in easy to use spreadsheets. And compare your performance to benchmark indicators that are included in the document.

Example of Impact

		Example 1 Reimbursement		Example 2 Reimbursement	
Monthly TPP charges	TPP contractual allowance (expected revenue)	%	$	%	$
$5,000	$4,000	95%	$3,800	50%	$2,500
A difference of $1,300 per month, and $15,600 per year					

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To demonstrate the importance of collecting third-party payer reimbursement, and the impact it has on an agency's or site's overall revenue. Let's look at this example of one agency's charges and expected revenue. In this example, the agency's monthly third-party payer charges are $5,000. And the expected revenue, based on contracted rates for the services, is $4,000. Example 1 in the middle of the page demonstrates when an agency collects 95% of the expected revenue. In that example they collect $3,800 per month. Example 2 demonstrates when this agency collects only 50% of the expected revenue. They collect $2,500 per month.

When we look at the revenue difference between these two collection rate levels, this equates to $15,600 annually. Or in other words, an annual revenue loss of $15,600 in example 2. That's monies that were due to the site for services they provided.

Setting Performance Indicator Goals

Approaches:

- Use industry benchmark
  - For example: 5% is an industry benchmark for claims **denial rate**
- Look at best practice among your clinics
- Review historical experience, state information, or peer data/experiences
- Reset or adjust as improvements are made

Link: https://www.fpntc.org/resources/financial-dashboard

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Measures really don't mean nothing if they are not compared to a goal or a benchmark. Those of you that have been part of the first two, know that there are multiple ways that you can set performance indicator. Some indicators have very clear industry benchmarks, like denial rate. And we've mentioned 5%.

Another way is to look amongst the sites in your network. For example, you can look at a site that has the lowest denial rate percentage, and use that percentage as your goal for your other site.

You can also use historical experience, or you can use state information. Such as State Medicaid managed care enrollment percentages, as a Medicare Managed Care Utilization benchmark for your organization. Or you can look at pear data, and perhaps use their peer mix data as your goal or benchmark.

And lastly, I just want to mention, you can always readjust those. Often sites will start and just do lower setting goals, and will not go to the ultimate goal just because it can encourage the staff to continue to improve. So, consider incrementally adjusting them as well.

Overview of Strategies for Best Practice 3

- Develop/implement detailed written policies
- Analyze accounts receivable (A/R) on a monthly basis
- Analyze denial rates and trends on a monthly basis
- Implement strategies to manage TPP contract terms and relationships

Link: https://www.fpntc.org/resources/financial-management-change-package

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Let's start by talking about the strategies to monitor and manage payment from third-party payers. The first strategies we're going to discuss today are develop and implement detailed written policies and procedures. Analyze accounts receivable monthly to identify and resolve issues. Analyze denial rates and trends monthly. Include by payer and by denial type, and resolve them. And lastly, the fourth. Implement strategies to manage third-party payer contract terms and relationships.

Develop Policies and Procedures

- Think about **frequency** or **approach** to reviewing and/or developing polices and procedures
- Items to address in agency's policies and procedures:
  - Scheduling process/front-end procedures
    - Gathering TPP insurance information
    - Prior authorization process
    - Insurance verification process
  - Client communications
  - Billing/collecting for TPP client fees
  - Claim submission process and time frame

FPNTC 11

Similar to the other best practices, the first strategy relates to your site or agency's policies and procedure. Related to payments from third-party payers. It's important to address the frequency at which your agency reviews exists policies, along with your approach to development them.

Think about how your agency details these policies and procedures, relevant to third-party payer billing and collection. A couple of topics you really need to make sure you include, and that are clear. One would be scheduling and front end procedure. Again, that gathering of the third-party payer insurance information accurately. Prior authorization for specific services when required by individual third-party payers. And verifying third-party payer coverage electronically. Either the night before services. And/or before the client is seen on the date of service. Depending on your agency's resources, and/or your system capability.

You also need to address client communications, directing them to bring in insurance information. Explaining the fees, including the copays and deductibles that will be the client's responsibility. Explaining to them the difference between service and billing confidentiality. You want to also make sure you have clear policies and procedures around billing and collecting for those third-party payer client fees. You also need a claim submission policy and procedure. Identifying a process and time period from the time of service to charge entry to claim submission. Typically these time periods shouldn't exceed 48 hours. Consider

developing scripts for staff. They can really help balance the customer service with the payment expectations.

Develop Policies and Procedures (cont.)

- More items to address:
  - Follow-up processes for pending claims, denials, and partial payments
  - Payment posting
  - Adjustment/write-off policies
  - Client acknowledgment of financial policies and procedures
- Training and observing team

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Some additional items that your policies and procedures should address include your approach to follow up on pending claims, denials, and partially paid claims. Identifying them, as well as expected follow up. Payment posting, and adjustment and write-off policies.

Write-off policies, it may be helpful to include specifics regarding the age of the account before it's written off. As well as include write-off codes that are meaningful to your organization. It's helpful to have at least two different write-off codes. Or two groupings of write-off codes.

The first, those which your agency was never expecting to receive revenue for in the first place. Such as a contractual write-off for example. And the second, those write-offs which represent lost revenue or bad debts. Such as a denial for a missing prior authorization. Important to obtain client acknowledgement of your policies and procedures, and to give clients a copy of their signed acknowledgment of them.

It is crucial that all these policies and procedures are clearly written and detailed, and the training occurs so they're implemented as you intend. Often policies and procedures are handed out, and new employees are given them for review. Certain elements can be misinterpreted or missed during this time. So, agencies should really take the time to review policies and procedures in person, and allow for discussion with and questions from the staff. And observe your staff members. If they perform the job function outlined in your agency's procedures.

And provide feedback. Bad habits can develop, so consider observing staff and providing them feedback periodically.

Manage A/R

Accounts receivable (A/R) is the amount of money that is **owed** to your agency for services provided and for which you billed

- **A/R management** involves running a variety of reports, analyzing data, and resolving A/R issues
- **Review A/R monthly**
- Identify information to **compile manually**, in the event of system or data extraction challenges

FPNTC 13

We're going to move on to the second strategy. We're going to be discussing accounts receivable for a few slides here.

Accounts receivable is the amount of money that is owed to your agency for services provided and billed for. Accounts receivable management involves running a variety of reports, analyzing data and resolving AR issues.

Reports have different names in each practice management, or electronic health records software program. But, most systems will be able to generate needed reports with information including date of service, date the claim was filed, filing error reports. Services billed and charges. Date and amount paid, date posted, adjustment types and amounts, and denials.

Most systems have the capability to run an incredible number of reports, and to abstract the data based on a variety of parameters. It can be overwhelming. To effectively manage your data, it is important to identify and establish which core reports and with what specific parameters, and with what frequency you're going to run them. And it should be based on what's most valuable to you to effectively manage your practice. Additional reports and data extraction can always occur when the core reports indicate further details might be helpful.

The financial management change package recommends agencies analyze accounts receivable on a monthly basis. And of course, while it's a best

practice to review overall AR monthly, it is important to review some specific data reports on a daily or weekly basis. How frequently and what type of report may depend on your agency's client volume, staffing, or other specifics regarding your agency's revenue cycle issues.

If your agency has system or data extraction challenges, utilize from your health record vendor. Or identify meaningful information that your agency can manually compile. Such as third-party payer charges, or third-party payer payments.

Utilize an A/R Aging Report

- An A/R aging report distributes what is due by how old the money owed is
- Allows high-level view/problem identification
- Measure expected (contract allowed amount) revenue vs. charges

FPNTC 14

An AR aging report is a good place to start to understand how much money your agency is owed. As previously mentioned an AR aging report is distributing that money by how old the money is that's owed to you. The AR aging report supports a high-level analysis to view and identify problems. Utilize an AR report available in electronic health record, or practice management software. Or create one. A homegrown tracking spreadsheet with the data from your system.

If possible, you might want to also consider setting up the report, or some version of the report, in your system to compare payments to expected or contractual amounts versus just comparing it to charges. So that your staff can easily determine when full payment versus partial payments are made. Extract monthly data and update or review this report monthly.

While it may be costly to have accounts receivable aging and other reports set up for you by your software vendor, or by contracting out for this technical support, these reports once they're established are a tremendous asset to managing your agency's accounts receivable.

Utilize an A/R Aging Report (cont.)

- Accessing detailed information that comprises **"bucket"** totals
- Data elements typically include:
  - Site
  - Encounter-level data
  - Procedure/service codes
  - Date of service
  - Dollars billed
  - Dollars expected
  - TPP
  - Clinician
  - Client ID information (patient number, birth date)
- Sorting data elements allows you to **identify issues or trends**

FPNTC 15

Most systems generate these AR reports that will compile the aged data in a manner that allows your agency to sort the receivables, not only by age but also by additional elements. These additional data elements typically include, site, encounter-level data, procedure or service codes, date of service, dollars billed, dollars expected, by third-party payer, or by clinician. And sorting by any one of these elements in addition to the age can help you identify new trends or new issues, such as a new denial on a specific code, or partial payments of a particular service. Or, a specific site or clinician denial pattern.

Manage TPP Contract Relationships

Why?

- Renegotiate rates; add new services
- Denials and/or coding issue resolution

Approaches to maintaining TPP relationships:

- Build data warehouse reports
- Share HEDIS/other measures
- Partner with TPPs to improve their outcomes
- Share client survey results
- Promptly answer their information requests

FPNTC 16

The third strategy I want to highlight is managing third-party payer contract relationships and contract terms. Ideally your agency has a documented process for managing third-party payer contract terms and relationships. A documented process and a policy form can provide direction on how to identify, negotiate, end or update contract terms. Such as service additions, or claim submission time frames, or rates with individual third-party payers. Having third-party payer contract relationships can be helpful when your site or agency needs to renegotiate rates, and/or wants to add new services. Secondly, these relationships will be helpful to manage claims or resolve coding issues.

Some suggestions to maintaining or developing third-party payer relationships include number one just communicating with the third-party payer on a regular basis. It's an important part of the strategy. Consider sharing information that's helpful or important to them. Not just your issues. Some ideas might be to build to your data warehouse and reports if needed, to provide third-party payers with meaningful or requested information. And this can help your agency easily access the necessary information for them. Of course, you may need assistance from your software vendor with this.

Report on HEDIS or other measures as compared to national benchmarks, or third-party payer benchmarks. Consider partnering with the third party payer to improve one of their outcomes in one of these measures that are

important to them.

Consider implementing a QI initiative focused on a HEDIS measure, or another measure that's substandard and provide feedback to the clinic staff regularly on third-party payer issues, and on required data measures versus benchmarks.

Share client survey results with the third-party payers. Consider utilizing their input to create or enhance your survey. And promptly answer all of their data requests or questions. When they call you for information, try to be prompt with answering that. And be tolerant if they're having an information technology issue, within reason. They're going to have issues just like you do as they do system upgrades, and they will appreciate you understanding.

And always, of course, be pleasant, helpful and knowledgeable when you correspond with them.

Monitor TPP Contract Terms

- Develop monitoring processes for contract terms to allow for prompt identification and resolution

  Remember: contract terms do not always translate to effective execution

- Be familiar with contract terms and changes, and educate team

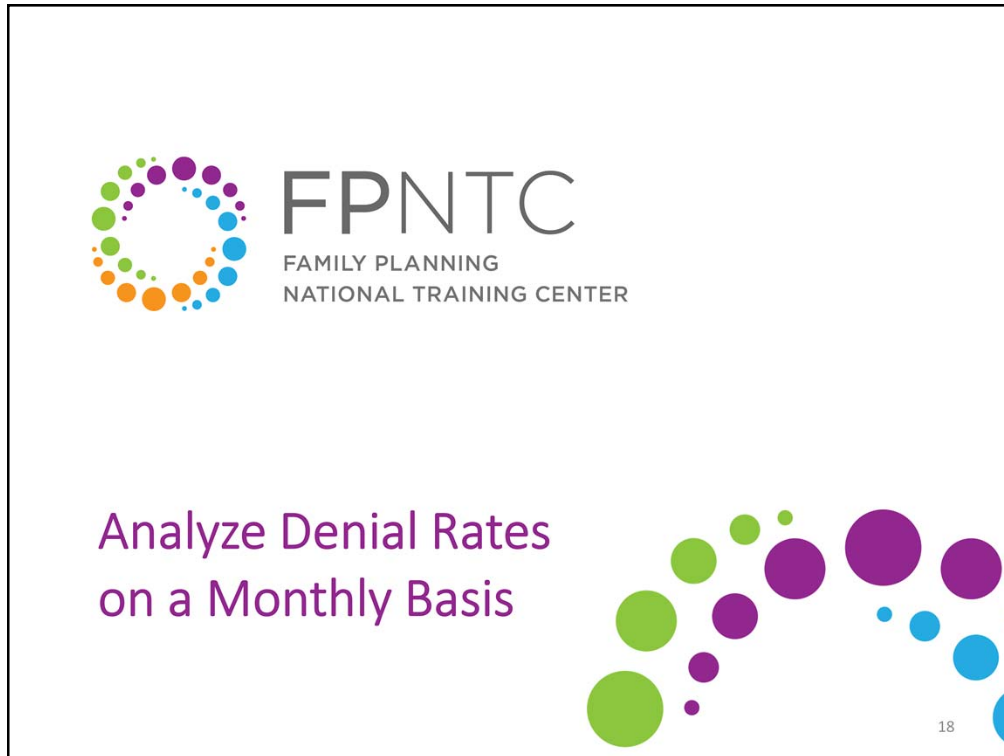
FPNTC 17

A few words on third-party payer contract terms. Developing a monitoring process enables your agency to identify and resolve issues promptly. Coding changes or issues may arise unexpectedly, and could lead to decreased or no payments. Remember just because you have a third-party payer contract, those contract terms don't always translate to effective execution of them. So, identify staff who might be responsible and familiar with those contract terms and changes.

And when establishing contract monitoring processes, think about frequency or events that might trigger a review. Suggestions include when adding services, or when prices for contraceptives go up, and/or on an annual basis. Consider using a contractual obligation tracking sheet. It's one tool that we've referenced, and I think included in resources in one of the prior webinars that you can use and keep track of contract elements.

Educate your team on contract element changes that impact them and their work. And example of this might be a service that gets added to the third-party payer contract that requires prior authorization.

I'm going to turn it back over to Caitlin for a moment.



Caitlin Hungate:

Thanks so much Debbie. And now we're going to focus on analyzing denial rates on a monthly basis. Before we dive into this particular strategy, we want to take a moment, and if you can all participate in this poll on this slide, and think about what challenges do you or your staff experience related to front end procedures.

And so go ahead and take a moment and select all that apply. That includes time, training, policy and procedure, data extraction, agency culture or client mindset. I see that a few results are coming in. And so we'll give a few more seconds, and then we'll share the results before we dive into the challenges around analyzing denial rates.

Okay. So thank you all for participating. It looks like the top two issues were time and training. Followed by agency culture and mindset. So, Debbie I'm going to turn it back over to you to talk through some of those challenges around denial rates.

Discussion of Challenges

- Time
- Training (knowledge of how/what to train)
- Policies and procedures that are not clear
- Data extraction issues
- Changing the culture of the agency/mindset of the client
- Other (type in answer)

FPNTC 19

Yes. Thanks Caitlin. Yeah, time can be a challenge. And in a busy clinic finding the time to do the follow up and to put together the contractual obligation tracking sheet, and get yourselves set up and your reports set up, that takes time.

The one thing that I say is that up front time investment, it saves you so much time in the future. So, taking the time to get yourself set up, and taking the time in everything from the front desk check in to getting your report and data extraction parameters set. Again, can be timely in the beginning, but it will eliminate so much of the denials and the correction work, which take much longer. So, I encourage you to take that time investment early on, and it will pay dividends in the long run.

In terms of training. I absolutely see this as one of the most critical pieces. Especially for smaller clinics, or organizations that don't have the know-how within them about managing accounts receivable and denials.

This is where I highly encourage you to utilize external resources. There's some great resources on the National Training Center's website, as well as NFPRHA. Just look externally, and make sure you're using all the resources that are available for you.

We've talked on the other two modules quite a bit about some of the other challenges, so I will refer you back to those to get some details on those two. So we can move on to the fourth strategy. And I want to dig in quite a bit to denials

management.

Denial Management

Denial is a refusal by a TPP to pay as a result of a clinician not adhering to the insurance's policies/procedures or pending receipt of additional information

- Analyze denial rates on a monthly basis
- Avoid denials
- Utilize reports to analyze denials
- Resolve unpaid or denied claims

FPNTC 20

Just to get us all on the same page, a denial is a refusal by a third-party payer to pay as a result of a clinician or a billing team member not adhering to the insurance company's policies and procedures. So, denial management is a significant component of accounts receivable management.

Denials represent revenue due to an agency or site for services delivered. They are typically caused by claim errors, and many of these errors will result in payment when they're corrected.

Some suggested strategies to manage denials include number one analyzing denial rates and trends on a monthly basis. Number two, my favorite, avoiding denials. We'll review this in the next few slides before going into details about these other strategies.

Number three, utilizing reports to analyze denials. And four, resolving unpaid or denied claims. And setting aside time weekly to follow up on these.

Denial Types to Avoid Before Filing a Claim

- Registration denials
  - Examples: not eligible on date of service, insurance verification, incorrect payer, cannot identify client, DOB
  - Strategy: implement insurance verification processes
- Credentialing denials
  - Example: clinician not credentialed
  - Strategy: maintain credentials
- Timely filing denials
  - Example: untimely filing, unresolved registration issues
  - Strategy: bill weekly; monitor reports

FPNTC 21

Denials management begins before the service is rendered and the claim is filed. Attention to processes before the client visit, or the claim is submitted eliminates the majority of denials. It's important to denial reason type, and determine needed process changes to minimize that particular denial type in the future.

An agency can avoid these common denial types with efforts before filing. Registration denials. Again, these include denial types such as not eligible on date of service, insurance verification issue, incorrect payer, cannot identify client and/or date of birth. So a bunch of different names for the same type of category, that denial, registration.

Strategies to minimize or avoid registration denials. Again, can't stress enough, gathering that accurate third-party payer insurance information and client information, and use an electronic verification system that checks client eligibility on the date of service. Run a not eligible on date of service report, if your agency system has one, on a weekly basis is another check after the electronic verification. Poor or non-existent eligibility verification causes denials. It's going to delay you getting reimbursed, and it's going to require re-work of the claim. All which are very timely. Also, consider saving the electronic verifications for potential future adjudication issues.

Another type of denial. Credentialing denials. That's when your

clinician isn't credentialed with the specific third-party payer. Strategies include assuring they're all credentialed. And you can utilize a credentialing tracking tool. Which is just like an Excel spreadsheet, and I think we've referenced that in the past and have an example of one. You can also use an outside credentialing agency. And then in some cases you might be credentialing through CAQH or the national database, the Council for Affordability Quality Healthcare. Some different strategies on following up on credentialing.

A third one is timely filing denials. And that might sound like an after the fact issue. I can tell you that many of the denials of this type are caused by unresolved registration issues. Some strategies to avoid this really include ensuring agency's billing for services on a weekly basis. And to avoid missing submission of data from a client encounter, you can run a report such as a kept appointment, no charge. Might have a different name in your system. But this type of report identifies clients that have been checked in, checked out, and have no associated charges.

You can run an incomplete claims file report. Again, it might be called something a little different in your system. To identify all encounters and associated charges, including those that can't be billed because of missing information. Such as a diagnosis code. Identify and correct these claims weekly.

As previously mentioned, also remember to identify time periods from time of service to charge entry to claim submission. And try to make sure that, that doesn't exceed 48 hours, and assure that this is happening for your organization.

Denial Types to Avoid Before Filing a Claim (cont.)

- Prior authorization denials
  - Examples: missing referrals, prior authorization
  - Strategy: identify services requiring prior authorization
- Medical necessity/charge entry denials
  - Examples: diagnosis coding error, invalid procedure
  - Strategy: chart audits, scrubbing software
- Bundled/non-covered denials
  - Example: missing modifiers
  - Strategy: manage contract terms, scrubbing software

FPNTC 22

Additional types of denials to avoid by managing front end processes include prior authorization denials. Again, you're missing that referral or that prior authorization. Strategies to avoid these include identifying the services that require prior authorization. And make sure that you have a prior authorization process. Utilize that contractual obligation tracking sheet to identify third-party payers and services where prior authorization is required, and keep a copy at the front desk.

Medical necessity, charge entry denials. Strategies for those are to implement chart audits regularly. Utilize scrubbing software and/or submit your claims through a clearinghouse. Similarly, with the bundled or non-covered service denials, you want to make sure that you are managing those contract terms when you have a third-party payer that has some specifics around how to bill. Add that to the contractual obligation tracking sheet. And again, utilize scrubbing software, or submit through a clearinghouse.

Most of your packages, most of your electronic health record and practice management systems do have some opportunity to utilize scrubbing software and/or submit through a clearinghouse. And if not, there are organizations that do just those services.

But remember, getting clean claims submitted in a timely fashion is going to save a ton of time managing denials. And obviously it gets the money to you in the most efficient fashion.

Analyze Denial Rates on Monthly Basis

- Can help identify issues/processes that are affecting revenue and cash flow

When denials occur, analyze rates and trends by:

- Denied dollars by payer
- Number of claims by payer
- Denial reason category
  - For example: registration, charge entry, credentialing, preauthorization

FPNTC 23

Okay, we're going to move on.

Implementing the previous strategies may eliminate most of your agency's denials. But, you're still going to have a few denials to address. Analyzing denial rates can help your agency identify specific issues or processes that need improvement. Once rectified the revenue and cash flow will likely improve.

A low denial rate indicates a healthier cash flow, and less billing staff work and rework of claims. Industry average is 5% to 10%. And a best practice is less than 5%.

Analyzing denial rates and trends can be measured by several approaches. The first, denied dollars by payer. Another is number of claims by payer. And then a third, denial reasons by category. We just discussed some of those categories. Including registration, or credentialing, etc.

Each third-party payer, again they use their own terminology to define denial types. So grouping together similar reason is a helpful start to identifying problem areas most efficiently.

Determine which reasons are problematic. In other words, high number of denials in certain categories. And address the underlying reason, which is some process that needs to be refined.

Utilize Reports to Analyze Denials

Sample reports:

- Denied claims
  - Look for similar issues and resolve multiple claim issues simultaneously
- Client charge/activity file
  - Look at claim/client-specific details and note denial reason
- Electronic remittance advice
  - Look at explanations for clinicians' claims payments

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Another approach to denials management is utilizing reports and/or third-party payer websites to investigate denials. Suggested reports include a denied claim report. Review it thoroughly first, looking for similar issues so that you can resolve multiple claim issues at the same time, rather than reviewing it one by one.

Client charge activity file reports. You're looking at claim or client specific details. And make sure to note and understand the denial reason. An electronic remittance advice or an ERA, it's an electronic data interchange version of an EOB, and it provides details about the claim payments. And if the claim is denied it provides explanation.

After your agency has investigated all information, and if the corrective action is clear, your staff should carry it out and resubmit the claim.

Resolve Unpaid or Denied Claims

- Call claims representative, ask specific questions
  Foster a good relationship with insurer contact
- Document findings to minimize future denials of the type investigated
  Provide feedback regarding errors and corrections
- Claims may have more than one denial reason and may require multiple corrections to be paid

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As part of denials management, your agency should always try to first resolve the unpaid or denied claim. But if you can't resolve a claim on your own, then call a claims representative and ask specific questions. For example, this may be necessary when documentation from a third-party payer isn't clear regarding a rejected claim. Or, your agency isn't sure how to correct a claim for resubmission. Fostering that good relationship with the insurer contacts can help this process.

Document your findings to minimize future denials of this type. And this can be done in that contractual obligations tracking sheet. Make sure you provide feedback to clinicians and other staff on findings. Such as the wrong lab got used, or provided certain services that weren't covered, or it got billed too late, etc.

Remember, claims can have more than one denial reason, and may require multiple corrections before get paid.

If your agency has several sites or clinics, another approach to resolving unpaid or denied claims, is to share issues and solutions with each other during conference calls.

Possible QI Initiatives and Measures

Denial Rate–by reason category

(identified "prior authorization required" as an issue)

Front desk and contract management processes

- Observe/retrain staff on prior authorization processes
- Identify TPPs and services that contractually require prior authorization and add to contractual obligations tracking sheet. Review with team
  - – Measure this denial type by TPP

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Let's discuss a possible QI initiative Title X sites or agencies can focus on related to denial rates. As a reminder, it is first important to monitor indicators against benchmarks to identify issues. By monitoring indicators against benchmarks, you can identify areas where performance can be improved.

Earlier we discussed measuring net collection rate, and denial rates, and AR aging as measures related to the best practice of monitoring and managing payments from third-party payers. Any one of these, when less than your benchmark, could lead you to investigate and to develop focused, targeted improvement plans, and corresponding specific areas to improve your revenue.

So, if a denial rate by reason measure is unfavorable when compared to the benchmark for the denial category prior authorization required, consider which of these possible tasks may be impactful based on your current practice assessment.

One, observe or retrain your staff on prior authorization process. If it's established.

Two, if a policy and procedure on this topic isn't established, then develop one with staff input and train on it and implement it.

Or three, does your staff know which third-party payers require prior authorization, and for which services? If not, consider how you're going to

document this information. Again, think about possibly using a tracking sheet, and then continue to measure denials in this category.

If you're a multi-site organization, monitor this by site, and retrain where and as needed. You may monitor this by third-party payer, and uncover an issue with a specific third-party payer regarding prior authorizations that would need to be addressed as well.

Possible QI Initiative and Measures

A/R Aging– measured by site

(Identified percentage in 120+ age bucket as an issue)

Payment processes

- Review denials to assess if this is causing an A/R aging issue; observe/retrain staff on claim submission and A/R follow- up policies; review policies and procedures
  - Further sort/analyze A/R by site, by TPP, by clinician, or by code to further identify and/or follow up on issues
  - Denials rates

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Let's talk through one more possible QI initiative related to this best practice.

When third-party payer, accounts receivable aging dollars, and corresponding percentage are unfavorable as compared to the benchmark in the 120 day plus bucket, consider which of these possible tasks may be impactful. You might want to look at denial measures as well, and they might help identify if denials are causing this AR aging issue.

Follow up with specific plan. Training for specific site or clinician, or follow up with a specific third-party payer. And/or other denial solutions we just spent time reviewing. If denial issues are identified.

Another area to review is claims pending submission. While this is a front end process, again if registration errors are not corrected in a timely fashion, then claims cannot be submitted to the third-party payer due to missing information, that may lead to an increase in AR aging in the older bucket.

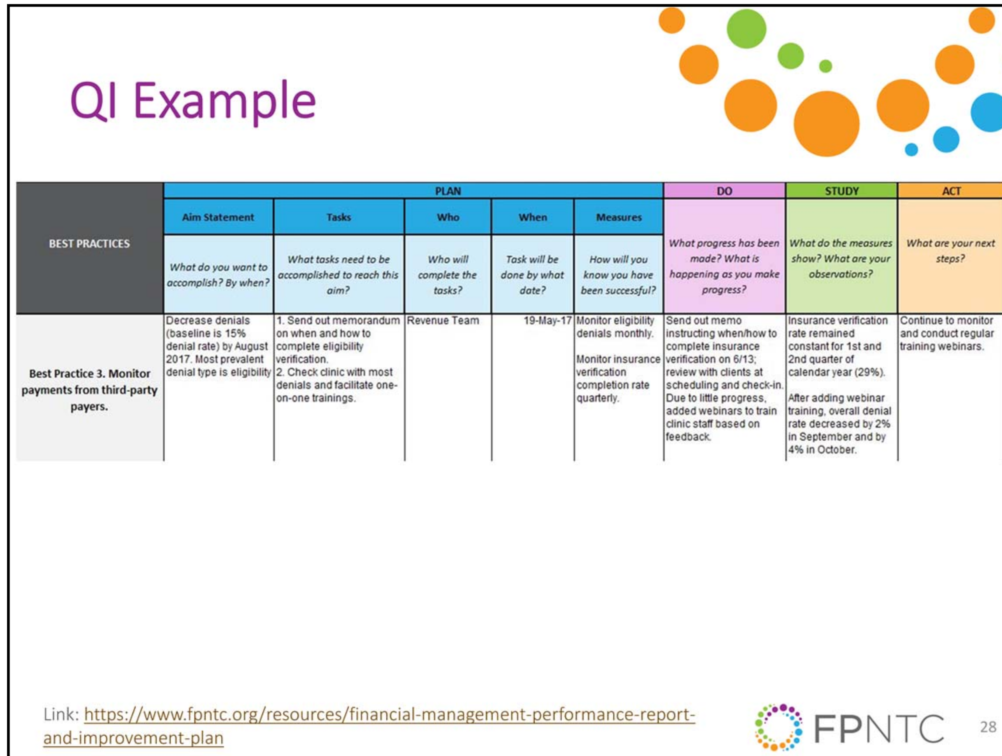
So review policies and procedures, and consider if there's any need to modify current practices, or consider observing and retraining staff when needed in these AR policies. Including how to address unpaid or partially paid claims. How to follow up on those registration errors, denials management, and/or payment

posting.

Review and analyze additional and more detailed information by further sorting your AR data to hone in on your issue. Let's say you are sub-recipient with multiple service sites. Perhaps you will analyze AR aging by site. And does one specific site stand out?

As previously mentioned, other ways to analyze AR aging data, might be to look at it by third-party payer, procedure, or clinician.

Turn it back over to you Caitlin.



BEST PRACTICES	PLAN					DO	STUDY	ACT
	Aim Statement	Tasks	Who	When	Measures			
	What do you want to accomplish? By when?	*What tasks need to be accomplished to reach this aim?*	*Who will complete the tasks?*	*Task will be done by what date?*	*How will you know you have been successful?*	*What progress has been made? What is happening as you make progress?*	*What do the measures show? What are your observations?*	*What are your next steps?*
Best Practice 3. Monitor payments from third-party payers.	Decrease denials (baseline is 15% denial rate) by August 2017. Most prevalent denial type is eligibility	1. Send out memorandum on when and how to complete eligibility verification. 2. Check clinic with most denials and facilitate one-on-one trainings.	Revenue Team	19-May-17	Monitor eligibility denials monthly. Monitor insurance verification completion rate quarterly.	Send out memo instructing when/how to complete insurance verification on 6/13; review with clients at scheduling and check-in. Due to little progress, added webinars to train clinic staff based on feedback.	Insurance verification rate remained constant for 1st and 2nd quarter of calendar year (29%). After adding webinar training, overall denial rate decreased by 2% in September and by 4% in October.	Continue to monitor and conduct regular training webinars.

Thanks so much Debbie. Now we wanted to dive into an example of a quality improvement example using the financial management performance report and improvement plan, which comes from the financial management learning collaborative. And how a grantee organized their quality improvement efforts around this best practice. Using their Plan-Do-Study-Act, or PDSA model.

In this example, the grantee focused on decreasing denials. Which is the Aim statement, and apologies since it's a little hard to see on the screen.

So grantees, sub-recipients, and service sites or agencies on the call today, you can use this tool to organize your own quality improvement efforts related to monitoring and managing payments from third-party payers.

Again, this tool can be found on FPNTC. And we've linked to the resource page on the slide.

The aim of this initiative was to decrease denials by August 2017, and they wanted to decrease the baseline, the baseline was at 15%. The grantee further identified eligibility denials, as Debbie talked about specific denial type. This was the most prevalent denial type for their grantee network.

The quality improvement team comprised of the revenue team, identified two different tasks to decrease denials. First, by sending out a memorandum to all of it's network sites describing when and how to complete an

eligibility verification. And secondly, to check in with clinics with the most denials and provide individualized training to those clinics.

The quality improvement team monitored eligibility denials on a monthly basis, and monitored insurance verification completion rates quarterly. So that you can see in the measures column.

The grantee sent the memo out to the sites instructing them when and how to complete the insurance verification. And the site reviewed the policy with clients as scheduling future visits. As well as when clients checked in.

Due to little progress in this particular denial, the eligibility denials rates, the quality improvement team added additional webinars to train individual clinic sites.

So they did that, checked in to see what was working and what was not working.

The insurance verification rate, and that you can see. It's going to be documented in the study part of this example. It remained constant for the first and second quarter of the calendar year, which is around 29%.

And after adding the individualized training webinars, the overall denial rate decreased by 2% in September of 2017, and then by 4% in October.

So this quality improvement team decided to continue to monitor these two measures and conduct regular training webinars with clinic teams.

This is just one way of a grantee of how they implemented a quality improvement initiative that addresses this best practice to monitor and manage payments from third-party payers. There are many strategies, including the ones we've presented today, that sites or agencies can utilize in their own setting. We encourage webinar participants to also refer back to the financial management change package for additional details and examples of how others have implemented strategies.

Resources

- Financial Management Change Package
- Financial Management Performance Report and Improvement Plan
- A/R Management Tool
- Financial Dashboard
- Contractual Obligations Tracking Sheet

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There's several resources available on fpntc.org to support implementing this best practice. The first one that we've mentioned throughout the webinar, and this whole series, is the Financial Management Change Package.

The second one, which as on the last slide I showed you one of the tabs in the resource, is the Financial Management Performance Report and Improvement Plan. It's an Excel spreadsheet, and you can document your Plan-Do-Study-Act quality improvement initiatives. As well as document the specific measures and indicators related to this best practice.

Three additional resources include an AR Management Tool, the Financial Dashboard that Debbie talked about that includes the industry best practice for many of these indicators, and a Contractual Obligations Tracking Sheet.

Please note the Contractual Obligations Tracking Sheet is from a project that has ended, and the website will be up only until the end of August of this year, of 2018.

We encourage you to review the training packages on fpntc.org related to financial management, including third-party billing, where you may find additional resources, or archived webinars, or other tools to support you and your network or sites or agencies in implementing quality improvement initiative.

And now we want to turn it over to questions. And we want to hear from you. And I'm going to turn it over to Katie to help us facilitate this Q&A. But I see that there's some through the chat.

Katie Saul: Oh, Caitlin it looks like we lost audio. But that's okay 'cause we are ready to take questions. We have a couple of questions via chat, which we're going to read out and answer first. But, as I mentioned at the start of the webinar, we're also going to take questions over the phone. Melissa could you just give the participants some instructions on how to queue up on the phone line?

Melissa: Thank you. If you would like to ask a question, please signal by pressing *1 on your telephone keypad.

If you're on a speaker phone, please make sure your mute function is turned off, so that your signal can reach our equipment.

A voice prompt on the phone line will indicate when your line is open. Again, please press *1 if you have a question on the phone.

Katie Saul:

Okay. In the meantime, we have a couple of questions. One from Angie that says, "Do you have any guidelines on the website or from Debbie that

explains how to transfer third-party payment EOB info manually into Patagonia? We have a contract with a third-party payer, but the payments to our clinic do not post automatically into Patagonia, and payments have to be posted manually, which allows or creates a patient responsibility balance issue." Debbie, any thoughts?

Debbie Sullivan:

Sure, sure. So, for those of you that have electronic posting set up and running beautifully, you probably cringe thinking about the problem that that all creates. But, in reality I can't address this in specifics because I don't know the ins and outs of every health record and practice management system. But indeed, having electronic posting set up to post the payment, write off automatically the contractual adjustment, and have that balance transferred to the patient, or the secondary payer. That is a best practice. Again, that involves typically working with your vendor and knowing what the system capabilities are. If it's not occurring for you, I would highly suggest that you call Patagonia, or you have a contact there. Or get in touch with one of your peers that works with Patagonia, and see how they're handling this. But again, a best practice in this area, is to utilize your system's electronic posting capabilities. And hopefully having that automatic write-off of at least the contractual amount, and the balance getting transferred to a secondary payer. Some of the systems also then accommodate sliding that balance if it's going to a patient.

But, it's understanding what your system's capabilities are, and if you, again, call your vendor, and/or talk to someone else in the Title X network that you know that uses it, and see how they're handling it. But that's a nightmare, so Angie, I think that would be an important thing to follow up on.

Katie Saul:

Okay. Thanks Debbie. One other question that we have in chat is from Kathy. "Can you explain the difference between a third-party payer and other types of providers?"

Debbie Sullivan:

Okay. When we say third-party payer, what we are referring to are all the different organizations that you have contracts with, that are going to provide you revenue for services that you're performing for your patients. In particular, it includes medical assistance, medical assistance managed care organizations, if they exist in your state. Or private insurance types, like Aetna or United. When we say TPP or third-party payer, we're talking about those entities that are providing you revenue, other than the patient or the grant. Those entities that are providing

revenue for services you're providing. Again, your patient is contracted with those organizations to be covered for the services, and then you are contracted with them to get paid when you deliver the services.

That would be totally different from a provider. When we say provider, we're typically referring to the physician, to the nurse practitioner. Again, the third-party payer is paying for it, and the providers are the one delivering the services. And the providers I mentioned briefly are credentialed to provide the services through the third-party payer. That's just saying that they have all ... They've completed medical school, or nurse practitioner school, that they have their continuing ed credits, all the things that you need to stay current with your license. And that stuff is all validated, and that's how they get credentialed with a third-party payer. That can happen either through a national data bank, or through a third-party payer specific credentialing way. I hope I explained that, if not please vocally speak up and let me know if I can answer it better or differently.

Katie Saul: Okay. Thanks Debbie. And as a reminder to participants, I believe if you press *1, you can ask a question over the phone as well. For now, that's it for the chat questions, although we'll take more if we still have some time. But, Melissa, do we have any questions in the queue on the phone?

Melissa:

Yes, we'll take a question. Caller, go ahead.

Anne:

Hello. Hi. Hello? Can you hear me?

Melissa:

Yeah.

Katie Saul:

Yes, we can.

Anne:

Hi. Yes, this is Anne, and I had a question. How do we copy off the certificates for the courses that we have attended?

Katie Saul:

I can answer that. This is Katie. I was going to address that at the end, so-

Anne:

Oh, okay.

Katie Saul:

... if you'll just sit tight for just a couple more minutes, I'm going to give some instructions about that, 'cause we're in the middle of changing that process. So-

Anne:

Okay. Thank you so much.

Katie Saul:

... hold tight. Let's see if we have any other questions for Debbie, and then we'll get to that. Thanks.

Anne:

Okay.

Debbie Sullivan:

Good question.

Anne:

Thank you.

Katie Saul:

Okay. Melissa, any other questions?

Melissa:

No further questions on the phone.

Katie Saul:

Okay. Well, I wanted to say thank you to both Debbie and Caitlin for all

three webinars, including today's. This has been a series, as we mentioned, that's been based on our financial management learning collaborative. We've got lots of resources online as Caitlin has mentioned both today and on other sessions, so we encourage you to look at those. You can search for them in the search bar on our website, or you can look at the third-party billing training package on the website, and that's another way that we have them organized.

And, of course, you can contact us at any time at the training center with questions, and we'd be happy to answer them for you.

A couple of notes about the certificates and the evaluation because we got a couple of questions about that, as well as the slides.

We hope to post the slides for today's webinar, the transcript, the recording, as well as slides with talking points that you all can use as a training tool. We hope to post those sometime next week. We've been a little bit slower to post the ones from these sessions, but those will be up on FPNTC in the next few days, we hope. So, please keep an eye out for those.

As far as the certificate of participation go, we understand that this has been an issue. And those of us at the FPNTC have been trying to figure out the best way to resolve this. We are in the process of integrating our participant evaluation in the webinar with our training account system on fpntc.org. At the end of the webinar today, you'll see the evaluation pop up. If you want to receive a certificate, you have to be logged into fpntc.org when you complete that evaluation.

And while we're in the middle of this transition, we do understand that when you go to log into FPNTC to your training account, you lose the evaluation link, and that's why we're in sort of limbo here. We're going to email that evaluation link to all participants directly following this webinar. I think you should receive it just after 3:00 PM Eastern. So that, if for some reason when logging into fpntc.org you lose that link, you can get it directly from your email.

Again, as long as you're logged in to your training account on

fpntc.org, and you complete that evaluation. That should go straight into your evaluation report, and you'll be able to get that certificate of completion.

We know that on the last couple, or maybe on the last webinars, we were transitioning to this system, there was a bit of a glitch. So, we're hoping that this, in the meantime, allows you all to get the certificate.

But, as always, if you have any questions, please don't hesitate to email us and we'll make sure you get what you need.

I think that is it for today, so keep an eye out on FPNTC. All of these resources will get posted, including the slides. So, just stay tuned, and for now, thanks to everybody for joining us today. And that concludes the webinar.