Revenue Cycle Management:

The steps Title X agencies must take to get paid

Webinar 2:

Revenue Cycle Management:

After the Client Visit

August 7th, 2013

Family Planning
National Training Center
for Management and Systems Improvement

Intended Audience

Title X Grantee and sub-recipient staff who would like to implement a structure for managing revenue that will contribute to long-term sustainability of their clinic.

What is covered during each webinar:

Webinar 1 (July 24): Key components of the revenue cycle management process that should take place before the client's appointment and during the client's visit.

Webinar 2 (Today): Key components of the revenue cycle management process (billing and collections) that take place after the client is seen by the provider.

Webinar 3 (August 29): Negotiating fee schedules and executing contracts with third-party payers.

Training Objectives

- Describe the components of the revenue cycle management process that occur after the client visit;
- Apply the steps involved in coding, claims submission, and follow-up to ensure that reimbursement is received for the services provided;
- Identify the necessary resources for financial management in Title X agencies, based on clinic capacity; and
- Assess the agency's level of capacity to effectively carry out these components of revenue cycle management.

Polling Question

Who is participating in today's webinar?

a. **Local public health agency**
b. **State public health agency**
c. **Non-profit organization**
d. **Federal government agency**
e. **Other**

You can cast your vote in the Polling Panel of Webex!

Lou Ann Wilroy, Business Strategies Consultant

RT Welter & Associates

The Revenue Cycle

Source: Health Data Management: "*Revenue Cycle Management*" June 2008

Recap Webinar 1

- Pre-Visit: before the appointment
- Pre-Visit: once the client arrives
- Visit: checkout process
- Visit: charge capture and end of day procedures
- Collecting co-payments
- Collecting balances due
- The Sliding Fee Scale
- Providing confidential services

Case Scenario 1

- The agency's full charge for a visit is $125.
- The agency has a contractual agreement with Acme insurance to discount the charge to $100 and charge the client a $25 copay.
- A client insured by Acme is eligible for a 90% discount based on the Sliding Fee Scale (i.e. they only pay 10% on the Sliding Fee Scale).

1. How much does the agency collect from the client?
2. What charge amount is submitted to the insurance company?

Case Scenario 1: Answer

- **How much does the agency collect from the client?**
  - **$12.50**—the client can not be charged for more than what they owe on the Sliding Fee Scale (**10%** of the agency's full **$125** charge).
- **What charge is submitted to the insurance company?**
  - **$125**—the agency should submit the full charge to the insurance company, even though the obligation of the insurance company is to pay the discounted rate (**$100**) minus the copay to be collected by the agency (**$25**).

Case Scenario 2

- The full charge for a visit is $125.
- The agency has a contractual agreement with Acme insurance that they will discount the charge to $100 and charge the client a $25 copay.
- A client insured by Acme is eligible for a 50% discount based on the Sliding Fee Scale (i.e. they pay 50% on the Sliding Fee Scale).

1. How much does the agency collect from the client?
2. What charge amount is submitted to the insurance company?

Case Scenario 2: Answer

- **How much does the agency collect from the client?**
  - **$25**—the client can not be charged more than their copay
- **What amount is submitted to the insurance company?**
  - **$125**—the agency should submit the full charge to the insurance company, even thought the obligation of the insurance company is to pay the contractually discounted rate (**$100**) minus the copay to be collected by the agency (**$25**).

Case Scenario 2 (continued): Deductible!

- **You verified the client's benefit prior to their arrival and the insurance company informed you that the client hasn't met the deductible on their health insurance plan.**

1. What can you collect from the client?

Case Scenario 2 (continued): Deductible! Answer

- **What can you collect from the client?**
  - You can charge the client for a total of **$62.50** (including the copay).
  - The client never directly pays more than what they owe on the Sliding Fee Scale**.**
    - ✓ In this scenario, they pay **50%** on the Sliding Fee Scale of the **$125** full charge.
  - You file a claim with insurance company for the full fee of **$125**.

Case Scenario 3

- A client is above 250% FPL on the Sliding Fee Scale and is insured.
- Your full charge for the visit is $125.
- The contracted rate with the insurance company for the visit is $100.
- You verified benefits and found out that the client has not met the deductible and needs to pay for the visit.

1. What do you charge?

Case Scenario 3: Answer

- **What do you charge?**
  - The client should be charged **$100** (including the copay of **$25**).
  - File a claim with insurance company for **$125**.
  - Insured clients pay the contracted rate for services.
  - In the cases where the agency does not know whether the client has met their deductible, the insurance company should be billed and the agency should apply their collections policies to collect any balance due from the client.

Case Scenario 4

- A teen is covered through his parents' insurance and requests confidential services. He does not want an EOB to be sent home.
- He has a $25 copay and is willing to pay it.

1. What do you do?

Case Scenario 4: Answer

- **What do you do?**
  - Unless you have a specific agreement with the insurance company to suppress the EOB, you can not bill insurance.
  - If you are not billing the insurance company, any donation or payment you collect, would not be considered a copay. The copay is a contractual agreement with the insurance company for a portion of their contracted rate.
  - You can ask the client if they can pay based on the Sliding Fee Scale.
  - If the client can not pay, then you still provide services.

Summary of All Scenarios

- Client pays the LOWER of what she/he owes on the Sliding Fee Scale OR the copay.
- Client does NOT pay MORE than what she/he owes on the Sliding Fee Scale (even insured clients).
- When clients request confidential services, agencies should have collection policies that are consistent with Title X rules and applied equally to all clients.

Questions/Discussion

Revenue Cycle Management:

After the Client Visit

- Coding and Documentation
- Billing/Claims Submission
- Collections and Claims Follow-Up
- Accounts Receivable
- Outsourcing Revenue Cycle Management

Coding and Documentation

What is medical coding?

- ***The transformation of services, diagnoses, and supplies into alphanumeric codes***

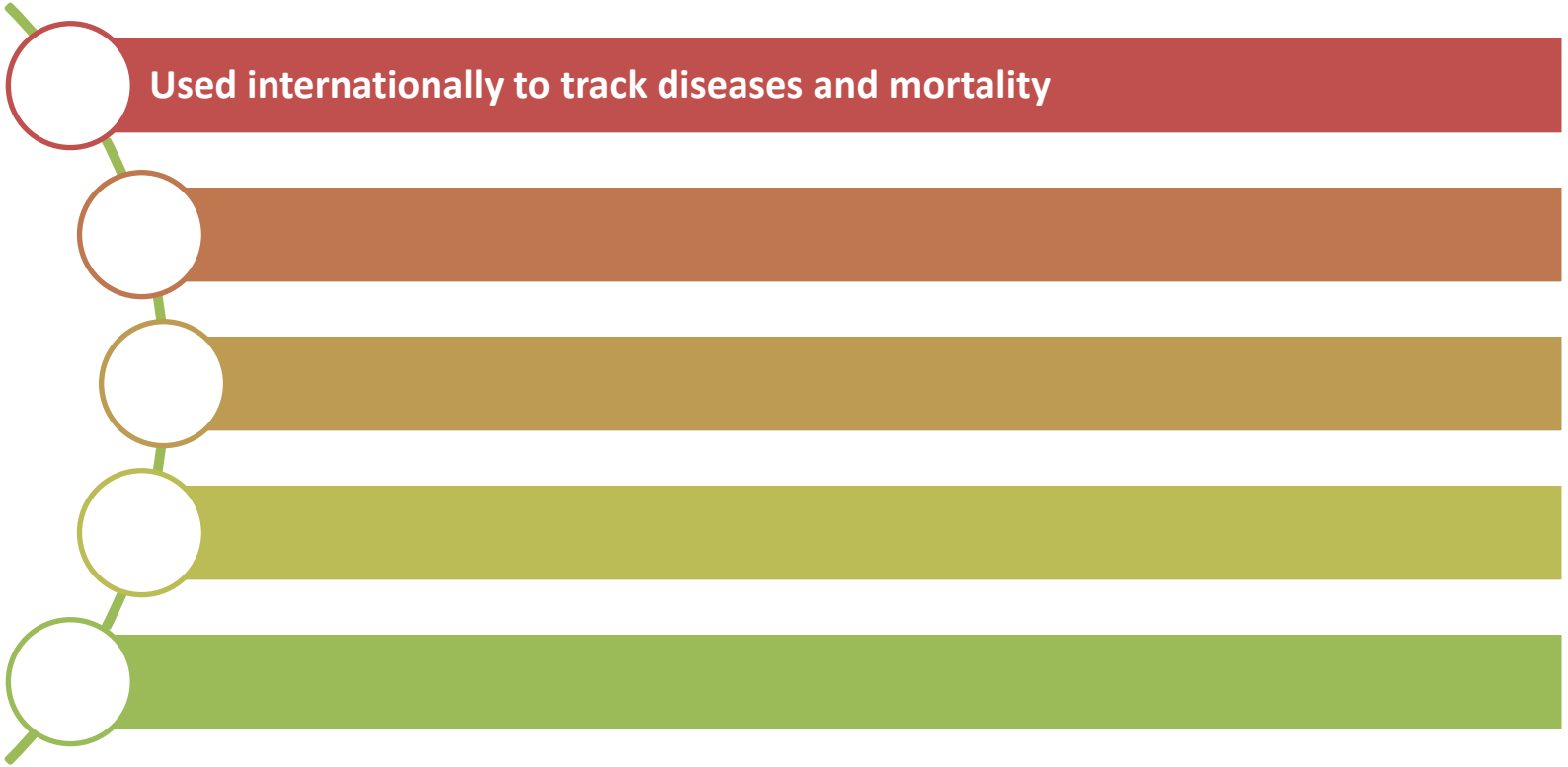
Three primary code sets:

- **CPT®**
- **ICD-9 (ICD-10 in 2014)**
- **HCPCS Level II**

Coding: CPT-4® (Current Procedure Terminology)

- Developed by the American Medical Association in 1966
- Five character, alphanumeric codes
- Updated annually, effective January 1 each year
- Provides a uniform language to describe services
- Effective means of reliable communication
- Used to report services to payers for reimbursement
- Used as a basis for payment
- Used for data collection
- Includes Evaluation/Management (E/M) Codes

Coding: ICD-9-CM (International Classification of Diseases)



Coding: ICD-10-Clinical Modification (CM)

- **Replaces ICD-9 effective October 1, 2014**
- **Improves ability to:**
  - Measure health care services
  - Increase sensitivity when refining grouping and reimbursement methodologies
  - Conduct public health surveillance

Coding: Number of Codes Comparison

	Diagnoses	Procedures
ICD-9-CM	14,315	3,838
ICD-10-CM	69,099	71,957

Coding: HCPCS

(Healthcare Common Procedure Coding System)

- **CPT codes used by Medicare and Medicaid**
- **HCPCS Level I: standard CPT codes**
- **HCPCS Level II: medical supplies, durable medical goods, and non-physician services provided outside the physician practice**
  - Includes: ambulance, durable medical equipment, prosthetics, orthotics, supplies, outpatient hospital care, chemotherapy drugs
  - Family Planning Examples:
    - ✓ J 1055 Depo-Provera, J 7307 Implanon
    - ✓ J 7300 ParaGard, J 7302 Mirena
    - ✓ J 0696 Injection, Ceftriaxone sodium

Coding: Evaluation and Management (E/M) Codes

- Office visit codes
- Five digits, starting with “99”
- 99201-99205: new patients
- 99211-99215: established patients
- 99241-99245: office consultations
- 99354-99360: prolonged services

Coding: E/M Codes

- **80% of claims in family planning are for E/M services**
- **Key Components of E/M Documentation:**
  - History
  - Exam
  - Medical Decision-Making

Coding: Top Ten E/M Coding Errors

1. Upcoding
2. Downcoding
3. No chief complaint
4. Unclear assessment
5. Documentation not signed
6. Test billed but not ordered
7. Documentation of medications is unclear
8. Incorrect diagnosis
9. Documentation missing
10. Illegible

Coding: Documentation Basics

- If it isn't documented, it didn't happen
-
-
-

Agency Capacity Assessment Checklist

- ✓ Access to current ICD-9 and CPT coding resources
- ✓ Strategy for training providers and staff on ICD-10
- ✓ Coding audits and education/updates for providers and staff at least annually

Questions/Discussion

Polling Question

My agency currently utilizes a clearinghouse for claims submission:

a. **Yes**

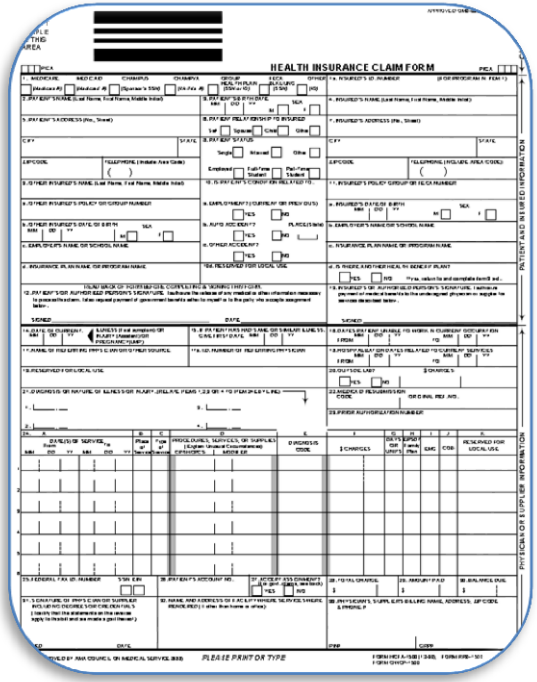
b. **No**

c. **I don't know**

You can cast your vote in the Polling Panel of Webex!

Billing: Claims Submission

- Claims are submitted on the CMS 1500 form
- Make sure all required information is complete
- Technology should be in place to pre-populate claim forms
- Consider submitting claims through a clearinghouse via secure, encrypted data transmission



Billing: The Claims Clearinghouse

- Standardizes claim information and submits to payers
- Prevents errors and allows you to catch and correct errors within minutes rather than days or weeks
- Fewer claims are delayed or rejected
- Reduces reimbursement time to under ten days
- Submits electronic claims in batch all at once, rather than submitting separately to each individual payer
- Provides a single location to manage all claims

Billing: The Claims Clearinghouse

How do I know I need one?

- Does your agency bill (or plan to soon bill) electronically?
- Does your agency bill a number of health plans...or just one?
- Is your staff experienced at electronic billing?
- What is your claim volume?

Agency Capacity Assessment Checklist

- ✓ Staffing structure and expertise to support claims submission
- ✓ Technology to carry out electronic claims submission
- ✓ Access to clearinghouse services

Questions/Discussion

Collections: Claims Follow-up

- **Payment should be received within 10-15 days**
- **Reasons for delay**
  - Never received
  - Denied
  - Pending additional information

Denial Management: Appeals

- Set a dollar amount for claims to be appealed
- Review the denial reason
- Submit the appeal within 7 days of receiving the denial notice
- Ask the client for assistance
- Review the conditions of your contract with the payer

Collections: Accounts Receivable

- **Accounts Receivable = money owed to the clinic**
- **Account Aging:**
  - 0-30 days
  - 31-60 days: greater chance of receiving payment
  - 61 – 90 days: top priority
  - Over 90 days: chance of receiving payment decreases significantly

Collections: From Clients

- Monthly billing: send statements to all clients at the same time each month
- Cycle billing: send groups of statements every few days or weekly
- Generate statements from practice management software or outsource
- “1, 2, 3 strikes, you’re out”
- Follow debt collection laws and observe professional guidelines

Revenue Cycle Management Performance Measures

Questions/Discussion

Data Management: Build it or Buy it? Options for Outsourcing

- Eligibility verification
- Clearinghouse services (claims submission)
- Claims follow-up
- Patient statement services

Decision-Making Factors: When to Outsource

Number of providers	Average days in Accounts Receivable (AR)
Number of billing personnel	Accounts Receivable ratio
Total monthly salary and benefits for billing personnel	Total revenue billed monthly
Number of coding personnel	Total revenue collected monthly
Total monthly salary and benefits for coding personnel	Practice management system
Total monthly salary and benefits for management personnel	Electronic claims submission capability
Number of claims filed monthly	Adequate hardware
Average cost per claim	Experienced staff with coding and billing expertise

Costs for Outsourcing

- **Clearinghouse:**
  - Set up fee plus flat fee per provider per month: $50-$250
  - Per claim fee based on average daily claim volume with volume discounts: <$1.00/claim
- **Outsourced billing:**
  - Price per claim: $5-10 per claim
  - Percentage of collections: 7-9%
- **Patient statements:** 7-9% of collections

Outsourced Billing Comparison: Primary Care Practice With Three Physicians

	In House	Outsourced
Billing department costs	$118,000	$4,000
Software and hardware costs	$7,500	$500
Direct claim processing costs	$3,600	$122,500
Software and hardware costs	$5,500	$2,000
% of billings collected	60%	70%
Collections	$1,370,900	$1,623,000
Collections costs	$129,100	$127,000
Collections, net of costs	**$1,241,800**	**$1,496,000**

Agency Capacity Assessment Checklist

- ✓ Staffing structure and expertise to support claims follow-up
- ✓ Technology/software to track accounts receivable and collections process
- ✓ Finance/accounting expertise

Questions/Discussion

Revenue Cycle Management: Webinar 3

Contracting with Payers

August 29th, 2013

2-3:30 PM EST

Session Description:

This webinar is the final in a three-part series focused on revenue cycle management at a Title X clinic. To receive reimbursement, health care agencies and providers must participate in commercial and public health plans. Participants will learn about the payer contracting process, including how to identify which health plans to work with, which services are billable to payers, and what to look for in a contract. In addition, the webinar will cover fee schedule development and guide Title X agencies to set reasonable and customary fees for the services they provide.

Audience Poll:

I thought this webinar was …

- Too long
- Too short
- Just right

You can cast your vote in the Polling Panel of Webex!

Upcoming NTC Training Activities

- **STI Series, Part 2: STI Update Q&A (Clinicians)**

Webinar, 8/8/13

- **Integrating Male Reproductive Health Services: Lessons From the Field**

Webinar, 8/21/13

- **National Family Planning Clinical Symposium**

Kansas City, MO, 9/11/13 – 9/14/13

Thank You!

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