



Alaska Department of Health and Social Services
Division of Behavioral Health

“Getting to the Bottom Line”

***Maximizing Organizational
Revenue & Maintaining
Compliance***

***State of Alaska Division of
Behavioral Health***

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Agenda

- I. Maximizing Contract Revenue
- II. ABCs Of Accounts Receivable Management
- III. Auditing & Compliance



I. Maximizing Contract Revenue

Revenue Maximization

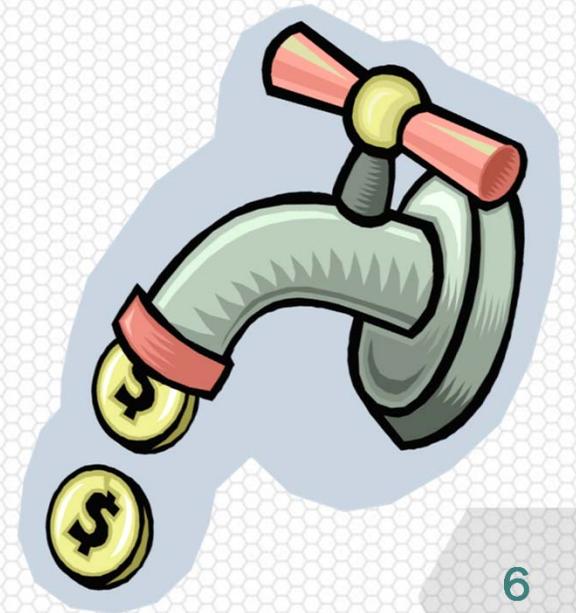
- Ensuring your organization efficiently captures, in cash, all of the revenues it deserves and only the revenues it deserves for the services you render!
- Cross-departmental proactive initiative
- Potentially lose 2-5% of revenue or more because of lost data, process inefficiencies, human error, etc.

Estimated Revenue Leakage In Select Service Industries

Industry	Estimated Leakage	Major Leakage Issues
Airlines	2-3%	Collection of Fees, Yield Management
Financial Services	1-2%	Little Leakage
Health care	5-10%	Payment Collection, A/R Aging, Charge Capture
Hospitality	1-2%	Little Leakage
Utilities	2-5%	Unbilled Meters, Outdated Systems

Revenue Leaks

- *Direct leaks* – when the full value of a service rendered is not collected
- *Opportunity leaks* – where process flaws or system inefficiencies stop an organization from capturing incremental revenue opportunities



Three Causes Of Revenue Leaks

1. Temporal causes

- Mergers and acquisitions
- Rapid adoption of technology
- Accelerated pace of service line development
- Rapidly shifting business environment and models

2. Susceptibilities

- Silo mentality of departments
- Cutting staff resources needed to maximize revenues
- Defensiveness of individuals
- Competing with other organizational priorities (RevMax is less “sexy”)
- Exceptions complex – some individuals’ jobs depend on processing exceptions/errors/etc.

3. Proximate causes

- Human errors – simple mistakes, interpretation errors, inability to follow rushed or complicated instructions
- Process flaws
- Technology not in place

Provider Agency's Fiscal Risk

- Providing unauthorized services
 - Invalid type of provider or not paneled
 - Units exceed those authorized
 - Service date outside the authorization dates
- Increased administrative costs / decreased reimbursement rates
 - Know your costs!
- HMOs denial of services which are authorized

Seven Key Strategies For Maximizing Revenues

1. Increase price
2. Increase capacity and productivity
3. Increase referral generation for services
4. Manage service authorizations
5. Develop additional services
6. Ensure proper coding and billing
7. Enhance collection on accounts receivable

Key Strategy #1: Increase Prices

- Increase prices for services delivered
- Negotiate higher contract rates
- Often difficult for behavioral health providers to make significant revenue gains here, but can be part of a comprehensive strategy
 - E.g., what if you were simply able to get \$5 more a visit for self-pay patients?

Key Strategy #2: Increase Capacity & Productivity

- Increase census
- Cancellation/no-show management
- Centralized scheduling and scheduling optimization
 - Do we have ambulatory appointments based on when clinicians want to work or when consumers want services?
- Use physician extenders for routine medication visits
- Performance-based compensation strategy

Key Strategy #3: Increase Referral Generation For Services

- Analyze referral patterns
- Survey referral sources for feedback
- Identify additional marketing and promotional activities



Key Strategy #4: Manage Service Authorizations

- Ensure service authorizations are obtained for all required services
 - Use technology as a tickler to warn staff in advance when service authorizations are going to expire!
- Increase number/type of services authorized

Key Strategy #5: Develop Additional Services

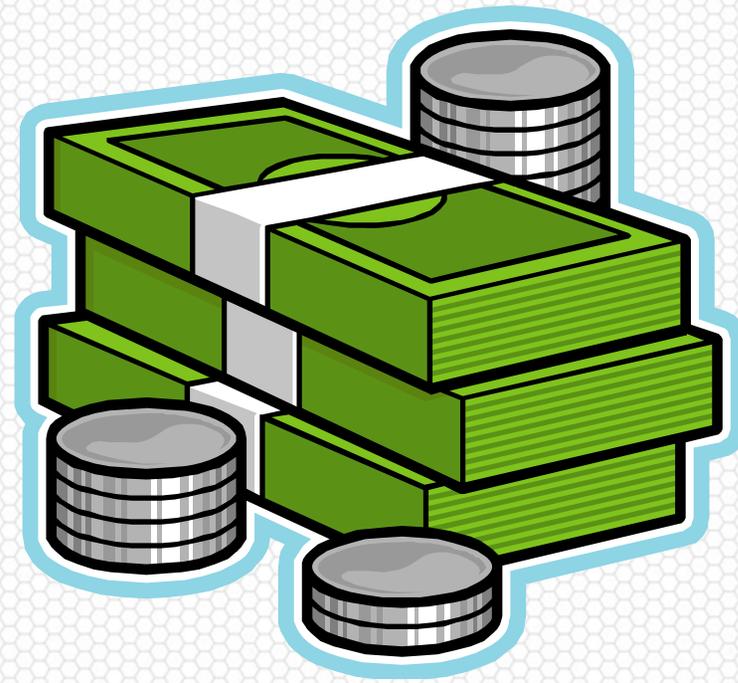
- Develop new services for current consumers
 - E.g., a child welfare provider obtaining a mental health clinic license so it can render the service rather than refer to it
 - What other services are your consumers receiving from other providers?
- Develop new services for your payers

Key Strategy #6: Ensure Proper Coding & Billing

- *This is a tricky issue* – making sure that you correctly code services to bill for the highest reimbursement that correctly describes the service rendered
 - Have to avoid “upcoding”
- Examples:
 - Appropriate bundling/unbundling services
 - Appropriate usage of diagnostic codes rather than simply therapy services
 - Appropriate use of evaluation and management codes

Key Strategy #7: Enhancing Accounts Receivable Collections

- This is the big ticket item for most providers!



Collections Pitfalls

- It is not unusual for behavioral health, child welfare, and social service providers to have collection rates of only 80% of net revenues!
- Effectively, this is a 20% bad debt ratio, meaning that an organization with \$1 million in annual net revenues is losing \$200,000 to bad debt expenses!

Bad Debt Expense Based On Collection Rate

Net Revenue	Collection Percentage	Bad Debt Expense
\$5,000,000	75%	\$1,250,000
\$5,000,000	80%	\$1,000,000
\$5,000,000	85%	\$750,000
\$5,000,000	90%	\$500,000
\$5,000,000	95%	\$250,000



Three Common Reasons For Bad Debt On Third-Party Claims

1. The clinician services are not covered by the payer (either due to credentials or lack of network membership)
2. The services are not authorized
3. The consumer no longer has benefits or coverage by the particular payer identified at the time of admission



II. ABCs Of Accounts Receivable Management

Accounts Receivable Management

Admissions

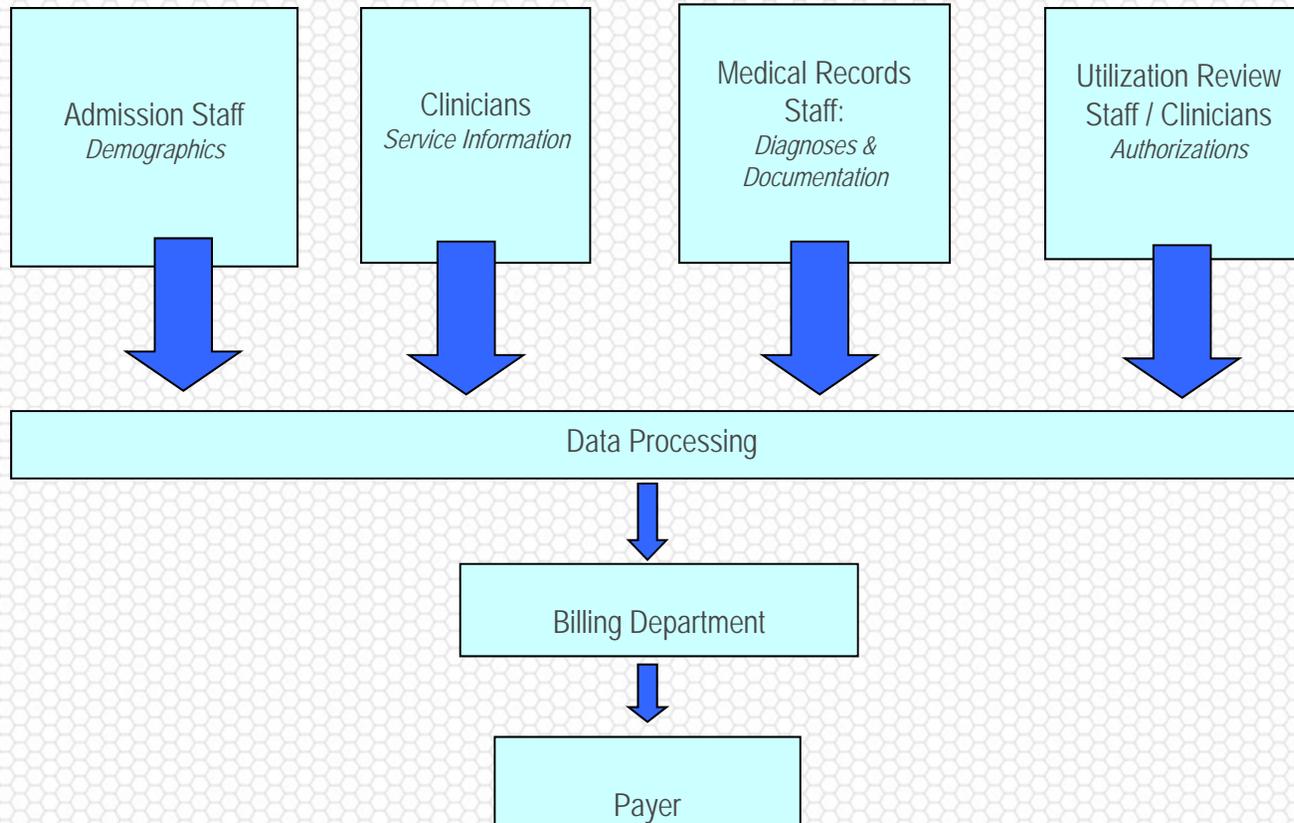
Billing

Collections

Admissions

Getting the “front end” right is probably the most important step in improving your agency collection rate

The Flow Of Billing Information



Service Registration

- Centralize accountability for accuracy and completeness of client demographic information
 - Benefits verification
 - Authorization
 - Required clinician credentials
 - Coordination of benefits
- Establish required data fields for client registration and perform QA on data entry for 100% of client registrations

Real Time Intake Process

- Utilize logical branching and abbreviated transactions for client flow
 - Transfer decisions “if-found” vs. “Not-found”
 - Initial appointment with “approved” staff
 - Log all contacts with date/time offered
 - Use temporary client numbering (#)
- Incorporate an administrative intake
 - Verify and enter all financial information prior to initial service
 - Print face sheet with all required elements: client data, authorization to receive treatment, etc.

Leverage Your EHR

- Set-up reports for common admission-related billing problems:
 - Missing data fields
 - Missing service authorizations
 - Missing diagnoses
- Use your EHR edit capabilities regarding payer benefits rules to the maximum extent possible
- Establish very tight security controls for which staff members can add new records to the payer table file

Clinician Credentialing

- Human resource staff have forms that gather all of the required billing data for clinical staff
- Primary source verification
- Assigning a single staff person with the responsibility for managing the clinician credential information, including:
 - Warning staff members when licenses or managed care network applications need to be renewed
 - Completing and tracking applications for network membership

Clinician Case Assignment

- Double-checking initial intake and case assignments
 - Ensure that consumers and clinicians have been matched appropriately
- Advertising to hire clinical staff with particular managed care network affiliations
 - When the networks are no longer accepting applications for new clinicians
 - When there is an insufficient number of staff to meet the demand for clinicians covered by that payer

Verify & Re-Verify Insurance Coverage

- Get it right from the start
 - Single point of accountability
 - Use forms that document all requirements
 - Double check 100% of client registrations for required fields
- Re-verify coverage for all consumers actively in care.
 - If automated eligibility information is available from the payer (i.e., Via telephone or eligibility downloads):
 - Re-verify coverage for every single date of service!
 - For other consumers,
 - Re-verify coverage every 30-60 days, based upon your organization's history with bad debt for loss of insurance coverage

Recruit Front Desk & Clinical Personnel As Part Of The Billing Team

- Actively solicit information about changes in insurance coverage and demographics:
 - Reception staff should be trained to identify changes in insurance coverage or employment
 - Clinicians should confirm the accuracy of insurance and demographic information every 30 -60 days
 - Signage and routine correspondence should alert consumers of the need to tell staff about changes in insurance coverage

Integrity Of Eligibility Data

- Initial Case Opening
 - Centralized versus decentralized
 - Use “eligibility verified” flag for intakes
 - Utilize second level review for opening new cases
- Ongoing Maintenance
 - Centralize only, period!
 - Close a case and close eligibility

Review Of Client Registration

- Consumer registration completeness – 100% of registrations should be reviewed for completeness by a different staff member than the one who originally entered the data
 - Preferably within 24 hours of registration
- The review can be done via computer or report
- Missing data should be obtained and error rates tracked for staff who enter registration data

Data Entry Quality Assurance Checks

- *Consumer coverage re-verification* – on a weekly basis, a random sample of admissions (usually 5 – 10% based upon volume) should have the insurance verification process re-checked
- If any errors in insurance verification are uncovered, 100% of the registrations should be re-checked for the given time period
- *Service entry QA* – ideally, if services are entered into the system in batch mode, your staff should do a batch total verification for all service entry
- *Payment entry & processing QA*- A batch totaling system should be in place for all data entry
 - 5% of the batches should be checked on a weekly basis

Billing

How Can We Streamline & Improve Our
Billing Processes?

Start With The Basics

- Maximize the use of fee computation functions
 - Simplify your service activity codes
 - Use fewer service codes – Never define codes based upon staff qualifications, client eligibility, clinical program, or duration
 - Use fewer rate schedules and more authorized service tables in the fund source file
- Billing starts with service entry!
 - Strive for service billing within 24hrs of provision
 - Setup a report to track “late service entry” to identify clinicians & locations whose services are entered more than seven days from date of service
- Most payers should be billed at least weekly to improve cash flow

Real Time Event Entry

(Or At Least 24 Hours)

Accountability – Accountability - Accountability

- Concurrent Documentation
 - Update employment contract to include: “Timely and accurate completion of required paperwork is a condition of continued employment”.

Leverage EHR Billing Edit Capabilities

- Payer table files
 - The goal is to set up all of the coding rules for each payer
- Start by ensuring that you record basic demographic data about the payer as follows:
 - Billing address for claims
 - Phone numbers for eligibility & claim status
 - Required billing forms
- Provider credentials
 - Develop a system of adding new clinicians, terminated and updating credentials

EHR Procedure Code Setup

- Procedure codes and service codes:
 - Service code names and unit lengths
 - Billing procedure codes by payer, clinician credential, location type, and date of service
 - Network provider fee screens by payer, clinician credential, location type, and date of service
 - Whether particular services are not covered based upon payer, clinician credential, location type, and date of service

EHR Service Edits Setup

- The following billing related edits should be setup in the system if possible:
 - Annual deductible
 - Annual dollar cap for behavioral health services
 - Whether service authorizations are required and when
 - What clinician credentials are covered
 - Whether a clinician provider number or license number is required on the claim form
 - Whether the employer name is required on the claim form
 - Whether a referring provider name or number is required on the claim form

EHR Provider Credentials

- Clinician credentials –common data elements and edits include the following:
 - Clinician demographic data
 - College degrees
 - Licenses and effective dates
 - Payer network affiliations and provider numbers

Charity Care As A “Payer”

- The objectives:
 - Separating charity care out from other payers in your accounts receivable so you know how much you are paying in-kind
 - Develop a mechanism for you to manage your charity care expenses
- How?
 - Set up charity care as a payer requiring authorization and set up an internal authorization process based upon clinical and budgetary goals

Tightly Manage Self Pay Accounts

- *Fee screen accuracy* – sliding scale fees and co-payment information must be accurately assessed and entered into the system
- *Service & payment entry accuracy* – you can't bill the consumer correctly if this information is incorrect
- *Fee collection at time of service* – this should be accomplished whenever possible

Self Pay Collection

- *Easy availability of self-pay balances* – ideally, this data is available:
 - On screen
 - On appointment schedules
 - On service tickets
- *Understandable and accurate self-pay statements*
 - Easy to read and understand
 - Should be mailed out on a monthly basis.
- *Clinician involvement* – payment for services is both a clinical and administrative issue
 - Clinicians should always know if a consumer has a self-pay balance and should address the issue in cases of delinquency

Collections

How hard are you chasing after unpaid service billing?

Follow-up, Follow-up, Follow-up!

- Fact: Accounts receivable follow-up & collection is the biggest problem for most organizations
- The standard you should seek to achieve is that your staff can account for the status of all claims that have aged 30 days since the last bill date

Know Your Trial Balance Rate

- Run a detailed aged trial balance for all claims over 45 days from the last bill date
 - Modify this report, if necessary, to ensure that it includes the following:
 - All claim transactions (billing dates, payments, adjustments, etc.)
 - Consumer and subscriber names and insurance information
 - Payer contact information
 - A/R notes regarding previous follow-up activities and dates

Take Action Immediately

- Typical actions after contacting a payer regarding an open claim:
 - Rebill the claim
 - Provide additional information for processing the claim
 - Balance billing the claim to the next payer
 - Billing the claim to self-pay
 - Coding the claim for bad debt write-off

Post Remittance Notices Timely

- Start by ensuring all A/R payments are posted in a timely manner:
 - What's the point of running an open A/R report if it is inaccurate because you haven't posted payments?
- Things to do:
 - Batch control systems for deposits & all correspondence
 - All deposits entered within 24 hours of receipt
 - All payments distributed within 48 hours of receipt
 - Data entry QA for payment distribution

Monitor Deposits Against Claims Balances

- Set-up a daily “undistributed receipts” report to monitor deposits that have not yet been applied to A/R
- Use electronic payment and remittance posting whenever possible to save time and money
- All payer correspondence should be batched with deposits and handled within the same time frame
 - Balance billing and denial processing should occur at the same time payments are posted
 - Other correspondence from payers should be processed within two business days

Document Well

- Ideally billing systems allow you to post A/R follow-up notes on individual client accounts and claims
- Bad debts should be approved and written off the A/R as soon as the claim has been identified as uncollectable

Billing & A/R Management Policies & Procedures

- Client registration policy and checklist
 - Including insurance verification requirements
- Daily insurance verification policy
 - For verification of continued insurance coverage
- Client demographic and insurance change policy
- Billing diagnosis policy
- Self-pay fee assessment and collection policy

Billing & A/R Management Policies & Procedures (cont.)

- Service authorization policy (initial and ongoing)
- No-show/late cancellation policy
- Appointment scheduling policy
- Service tracking policy
- Billing process policies
- Mail batch control policy
- Deposit and payment posting policy
- Correspondence processing policy

Billing & A/R Management Policies & Procedures (cont.)

- Credit balance and refund policy
- Collection and follow-up policy
- Bad debt write-off policy
- Self pay collection policy
- Month-end procedure policy
- Table maintenance policies for new insurances, clinicians, and service code files

Collection Percentage Reports

- Simply the percentage of the “net” A/R collected in a given time period
- Routinely run sorted by service month & payer category so you can track collection success over time
- Target should be 95% for ambulatory services & 98% for inpatient and residential care

Sample A/R By Payer

	A	B	C	D	E	F	G
1	ABC Mental Health						
2	FY15 AR Month of July						
3	Payer	Units	Charges	Adjustments	Revenue	Payments	Balance
4	Payer1	26	2,238.07	0.00	2,238.07	0.00	2,238.07
5	Payer2	548	4,814.26	0.00	4,814.26	0.00	4,814.26
6	Payer3	6	500.00	0.00	500.00	0.00	500.00
7	Payer4	3	166.47	0.00	166.47	0.00	166.47
8	Payer5	16	1,200.00	0.00	1,200.00	0.00	1,200.00
9	Payer6	2914	45,517.11	0.00	45,517.11	0.00	45,517.11
10	Payer7	7866	95,919.07	0.00	95,919.07	3,400.00	92,519.07
11	Payer8	106319	1,377,702.34	(114.00)	1,377,588.34	63,570.71	1,294,017.63
12	Payer9	107	5,411.00	0.00	5,411.00	0.00	5,411.00
13	Payer10	12474	62,370.00	(184.00)	62,186.00	5,931.00	56,255.00
14	Payer11	15	1,175.00	0.00	1,175.00	0.00	1,175.00
15	Payer12	3	166.47	0.00	166.47	0.00	166.47
16	Payer13	5	200.00	(130.00)	70.00	0.00	70.00
17	Payer14	752	7,067.50	0.00	7,067.50	0.00	7,067.50
18	Payer15	7	595.00	0.00	595.00	0.00	595.00
19	Payer16	1635	19,530.00	0.00	19,530.00	0.00	19,530.00
20		132696	\$ 1,624,572.29	\$ (428.00)	\$ 1,624,144.29	\$ 92,901.71	\$ 1,531,242.58
21							

Sample A/R By Payer & Service Month

	A	B	C	D	E	F	G	H	I
1	ABC Mental Health								
2	FY15 Revenue Summary								
3	Service Month	Payer	Units	Charges	Adjustments	Revenue	Payments	Balance	%Paid
4	01-Jul-14	Payer1	110191	\$ 1,477,203.00	\$ -	\$ 1,477,203.00	\$ 1,474,884.45	\$ 2,318.55	99.84%
5	01-Jul-14	Payer2	4938	\$ 66,763.22	\$ (296.66)	\$ 66,466.56	\$ 60,072.56	\$ 6,394.00	90.38%
6	01-Jul-14	Payer3	7403	\$ 86,500.94	\$ (144.79)	\$ 86,356.15	\$ 83,872.32	\$ 2,483.83	97.12%
7	01-Jul-14	Payer4	124	\$ 7,592.00	\$ -	\$ 7,592.00	\$ 7,592.00	\$ -	100.00%
8			122656	\$ 1,638,059.16	\$ (441.45)	\$ 1,637,617.71	\$ 1,626,421.33	\$ 11,196.38	99.32%
9									
10	01-Aug-14	Payer1	111196	\$ 1,496,675.10	\$ (82.45)	\$ 1,496,592.65	\$ 1,483,394.80	\$ 13,187.85	99.12%
11	01-Aug-14	Payer2	3952	\$ 63,079.96	\$ (227.00)	\$ 62,852.96	\$ 57,832.30	\$ 5,020.66	92.01%
12	01-Aug-14	Payer3	9203	\$ 129,935.53	\$ (463.94)	\$ 129,471.59	\$ 123,212.95	\$ 6,258.64	95.17%
13	01-Aug-14	Payer4	95	\$ 1,132.49	\$ -	\$ 1,132.49	\$ -	\$ 1,132.49	0.00%
14	01-Aug-14	Payer5	118	\$ 7,233.00	\$ -	\$ 7,233.00	\$ 7,233.00	\$ -	100.00%
15			124564	\$ 1,698,056.08	\$ (783.39)	\$ 1,697,272.69	\$ 1,671,673.05	\$ 25,599.64	98.49%
16									
17	01-Sep-14	Payer1	105952	\$ 1,471,569.12	\$ (66.93)	\$ 1,471,502.19	\$ 1,467,850.57	\$ 3,651.62	99.75%
18	01-Sep-14	Payer2	2098	\$ 38,424.80	\$ -	\$ 38,424.80	\$ 34,254.40	\$ 4,170.40	89.15%
19	01-Sep-14	Payer3	9415	\$ 133,115.90	\$ (45.19)	\$ 133,070.71	\$ 128,953.88	\$ 4,116.83	96.91%
20	01-Sep-14	Payer4	43	\$ 578.35	\$ -	\$ 578.35	\$ -	\$ 578.35	0.00%
21	01-Sep-14	Payer5	107	\$ 6,562.00	\$ -	\$ 6,562.00	\$ 6,562.00	\$ -	100.00%
22			\$ 117,615.00	\$ 1,650,250.17	\$ (112.12)	\$ 1,650,138.05	\$ 1,637,620.85	\$ 12,517.20	99.24%
23									
24	01-Oct-14	Payer1	107634	\$ 1,524,076.18	\$ (456.95)	\$ 1,523,619.23	\$ 1,513,108.51	\$ 10,510.72	99.31%
25	01-Oct-14	Payer2	1898	\$ 26,355.20	\$ -	\$ 26,355.20	\$ 24,861.60	\$ 1,493.60	94.33%
26	01-Oct-14	Payer3	8793	\$ 128,881.41	\$ (1,214.31)	\$ 127,667.10	\$ 125,205.65	\$ 2,461.45	98.07%
27	01-Oct-14	Payer4	83	\$ 4,929.00	\$ -	\$ 4,929.00	\$ 4,929.00	\$ -	100.00%
28			118408	\$ 1,684,241.79	\$ (1,671.26)	\$ 1,682,570.53	\$ 1,668,104.76	\$ 14,465.77	99.14%
29									
30		FY15 TOTAL	483243	\$ 6,670,607.20	\$ (3,008.22)	\$ 6,667,598.98	\$ 6,603,819.99	\$ 63,778.99	99.04%
31									

Ten Accounts Receivable Management Principles

1. Do it right the first time
2. Collect money due at the point of service
3. Eliminate lag times between service and billing
4. Manage claim rejections
5. Redesign bad processes
6. Encourage teamwork
7. Leverage technology
8. Share the data
9. Establish good internal control systems
10. Maintain appropriate staffing



III. Auditing & Compliance

Auditing & Compliance Introduction

- ACA provisions designed to increase program integrity in Medicaid and Medicare regarding provider participation, pending investigations of credible allegations of fraud, NCCI, RACs and home health
- Section 6401 of the ACA provides that a “provider of medical or other items or services or supplier within a particular industry sector or category” shall establish a compliance program as a condition of enrollment in Medicare, Medicaid, or the Children’s Health Insurance Program (CHIP)
- No new guidance from the OIG since September 2008:
<http://oig.hhs.gov/compliance/index.asp>

“It’s not a matter of IF, it’s a matter of WHEN....”

Audit Basics

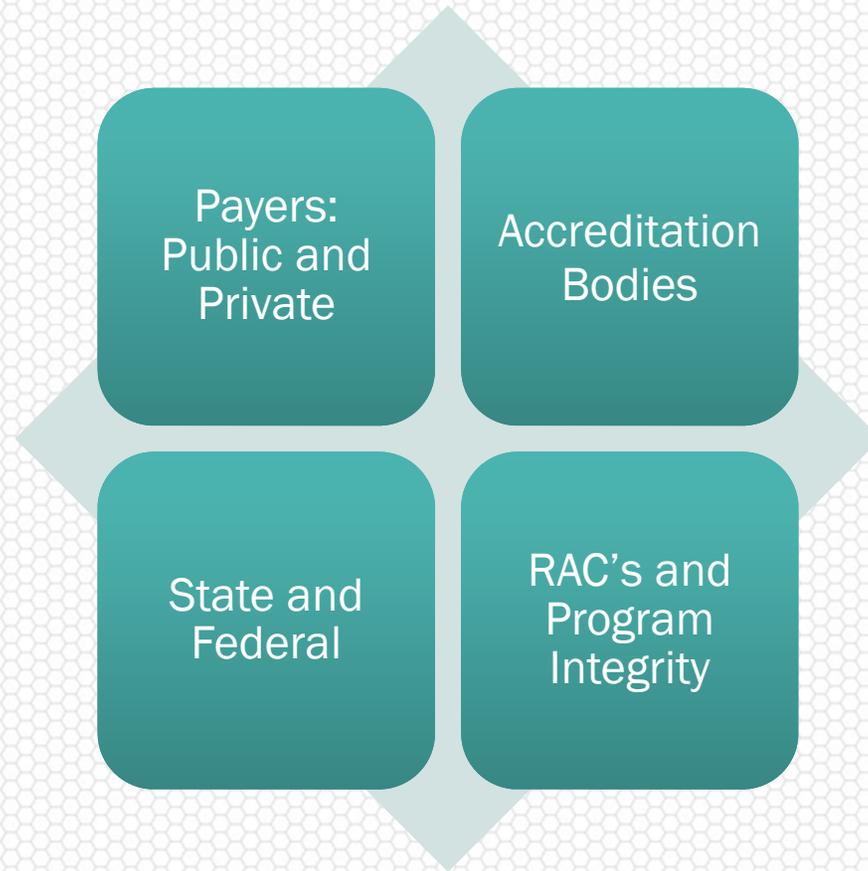
Ongoing Internal Audits

- Proactively Ensure Compliance
- Maintain Integrity
- Improve Processes

External Audits

- Enforce Compliance
- Fraud/Waste/Abuse
- State/Federal

Varieties Of Review



About Audits Thus Far

Audit firms reimbursed by contingency

Auditor experience/qualifications

Must auditors be licensed? (per State)

Policies are frequently misapplied/misinterpreted

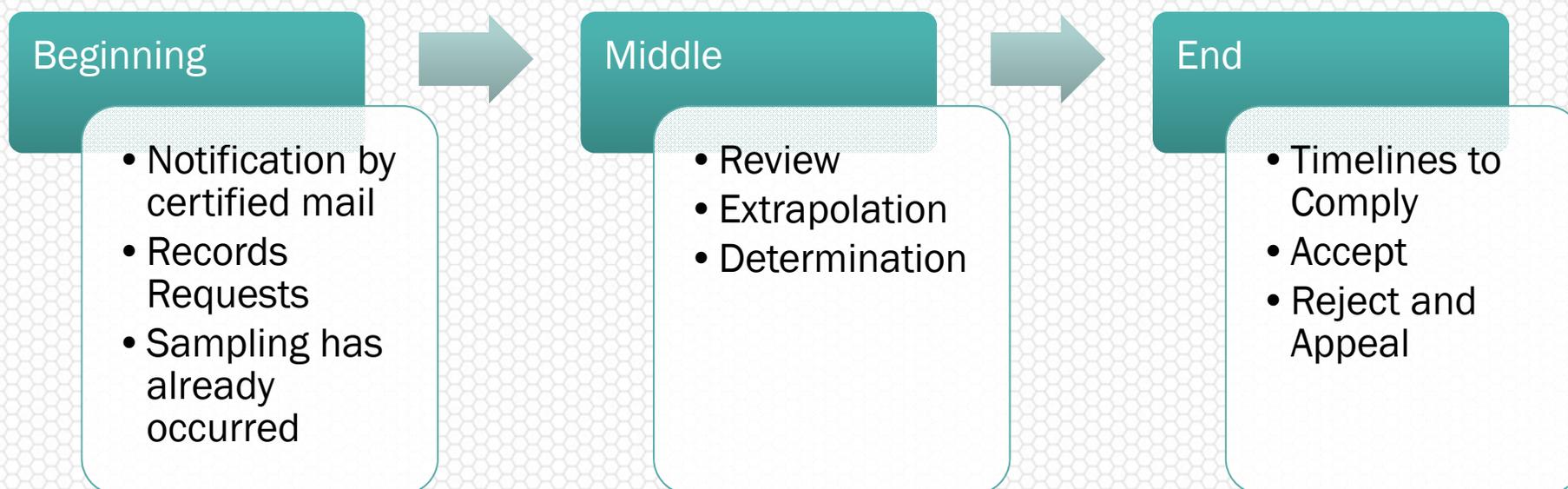
Pre-pay audits tend to have 0% accuracy—they CANNOT revoke contract based on this (check law)

Will misapply codes/wrong procedures

RAC & PI Audits: Creating Waves

- Recovery Audit Contractor, part of the ACA's Recovery Audit Program = It's the LAW
- Medicaid: Administered by State, RAC's required in each State by January 2012
- Looks for: overpayments, underpayments, and to recoup payments
- Vetting of Auditors questionable
- Auditor practice's questionable
- New Mexico, California, North Carolina and many other tragic results!

RAC Process



Mathematical Extrapolation:

Auditor determines you owe X based on a sampling of your claims (usually around 100-150). “THEREFORE, we extrapolate that the recoupment amount is going to be XXX” based on that sample size

RAC/PI Audit Findings: A Sample

NPI # on claim must correspond to signature on Line 53

“Authorization Required” when NO authorization was required

Obtaining a prior authorization does NOT equate medical necessity

Consent for treatment must be clearly and blatantly documented

Start/Stop/documentation non-negotiable for timed codes

Hand-signatures then typing in dates

Poor handwriting/demarking staff credentials is no excuse

What is your policy and procedure for e-signatures? E-signatures get dinged

Our Experience Tells Us...

You will NOT agree with the
audit findings

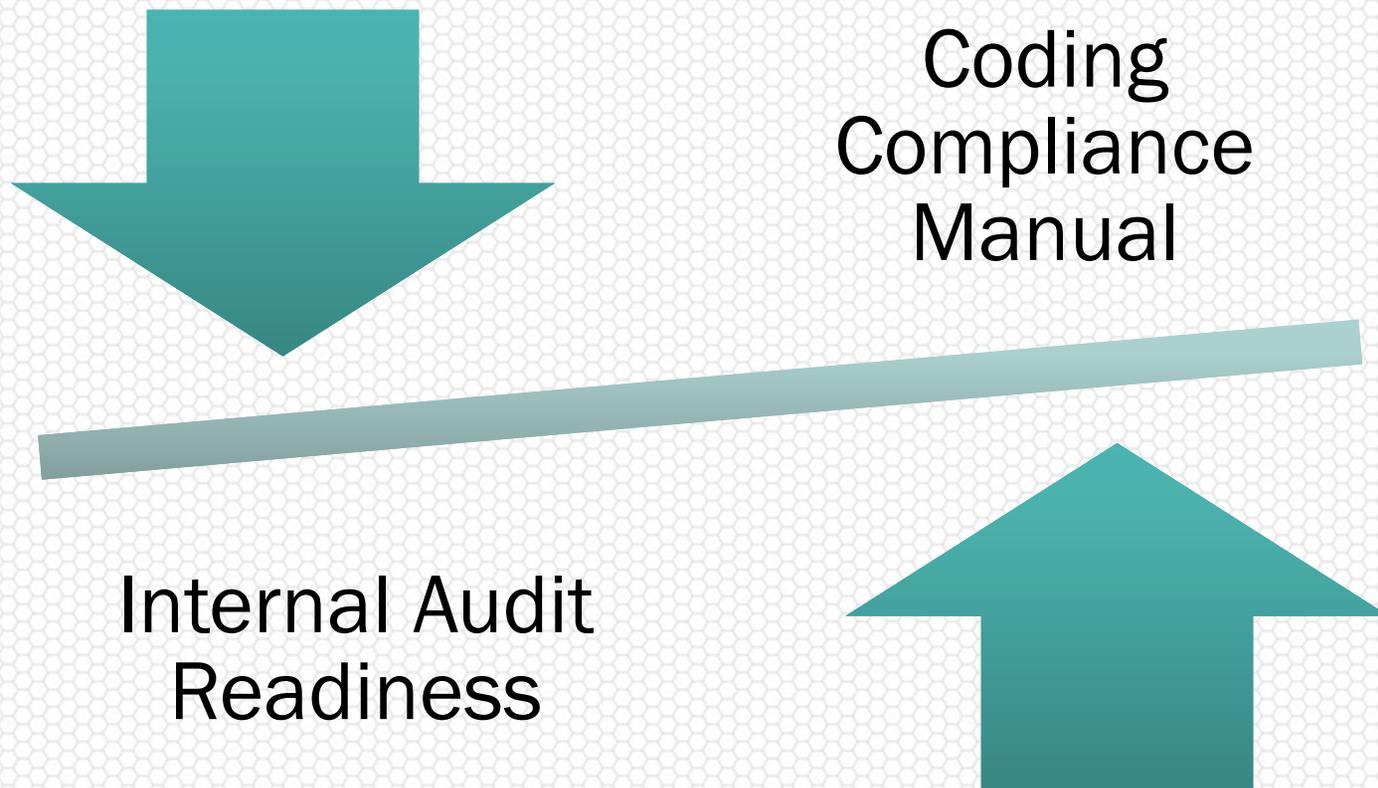
Obtain legal counsel and
Appeal

Know Your
Rights

Arm yourself with State
law, regulations, contracts,
statutes

Be very aware of Appeal
deadlines!

Two Areas Of Preparedness



Internal Audit
Readiness

Coding
Compliance
Manual

The Importance Of Internal Audits

What Is An Internal Audit?

“Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organization’s operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.”

Performed by professionals with an in-depth understanding of the business culture, systems, and processes, the internal audit activity provides assurance that internal controls in place are adequate to mitigate the risks, governance processes are effective and efficient, and organizational goals and objectives are met.”

Why We Should Internally Audit

- Increased scrutiny already, only to get worse with ICD-10 coding changes too
- Monitor organizational compliance and areas of needed education
- Demonstrates ongoing due diligence
- Risk management
- Significant clinical documentation changes will require staff to increase specificity in a way not ever done before
- Prepares for external audits

Strategic Positioning: Another Great Reason To Internally Audit

Best Practice

**Quality and
Process
Improvement**

**Consumer
Confidence**

Internal Audit Types & Components

- Contract compliance
- Access to care
- Anti-Kickback
- Medical Necessity
- Whistleblower
- Coding
- HIPAA
- And more...
- Identify a sample period
- Pull data
- Request documentation
- Conduct the audit
- Meet with staff
- Review findings
- Write report
- Develop a Corrective Action Plan (CAP)

Internal Audit: Sample Hit List

Clinical/Medical, Technical & Quality of Care Review Items:

1. Does the service meet the necessity criteria?
2. Diagnoses and services are supported in evaluation?
3. Does the documentation support the service(s) provided?
4. Is the documentation complete, legible, include all the appropriate signatures?
5. Are the appropriate consents to care on file?
6. Treatment plan development and updates completed (if applicable)?
7. Prior authorization required? Approval on file?
8. Overlapping/same-day services
9. Interactive complexity sessions documented appropriately?
10. Crisis and collateral visits
11. Was the activity billed (or not billed) correctly?
12. Coordination of benefits for primary/secondary/tertiary coverage

The Internal Audit CAP

- Understand and be able to identify payer rules, service definitions, and consumer benefits
- Be intimately familiar with State, Federal and other defined regulations including Medicaid guidelines: Understand ill-defined areas and potential impact
- Define your CAP performance guidelines
 - Easy to understand
 - Specific, measurable and achievable
 - Address progress toward specific goals
 - Identify individual accountable for outcome
- Continuous Quality Improvement (CQI)

Internal Audit: CQI Process

- Review & update policy and procedures periodically
- Align with Coding / Compliance Manual
- Update as payer regulations, definitions, procedures, contracts, etc. change
- Accounts Receivable Management
 - Billing Cycle
 - Coordination of Benefits
 - Payment and Refund Processing
 - Automated and Manual Process Reviews
- Develop and utilize audit review tools, checklists, scoring sheets

Internal Audit Tools

Software
Programs

Outside
Parties

Manual
Processes

What We Know About Audits

Paybacks/Problems Can Be Preventable/Defensible

Clinical Documentation

Medical Necessity

Internal Audits & Prevention Are In YOUR Control

Leadership Support & Enforcement

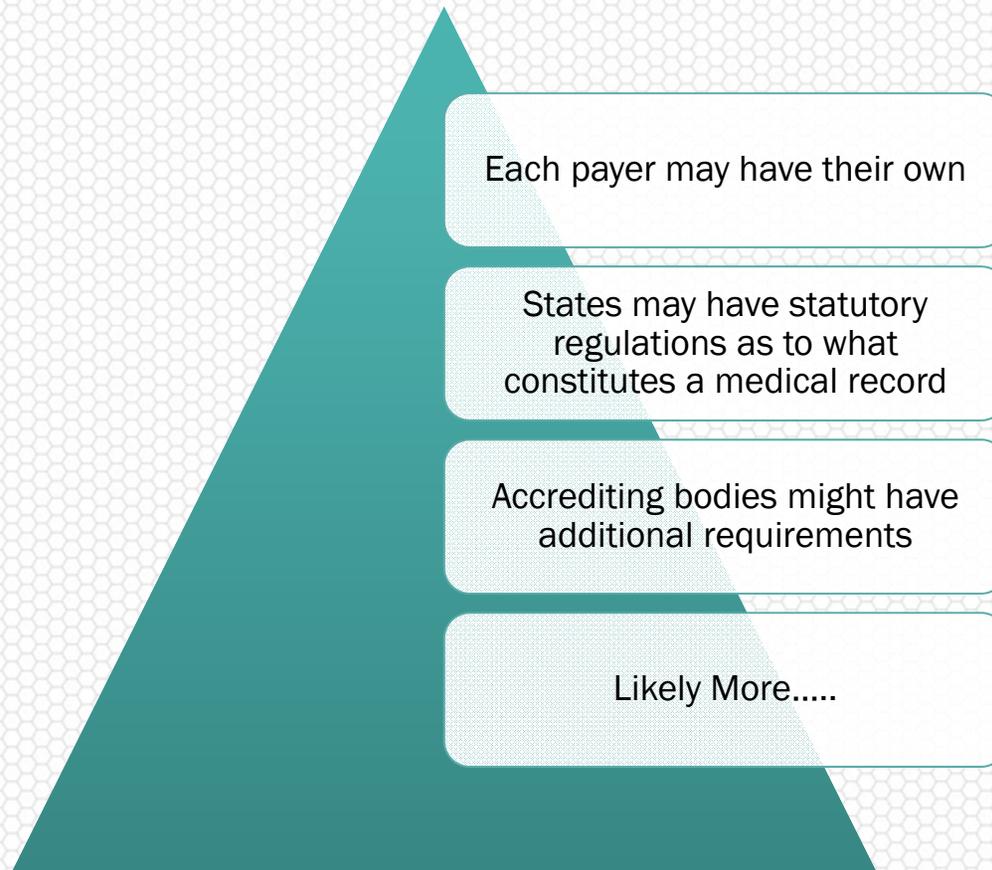
Manage Risk: Prevent Refunds & Paybacks By Being Proactive

- *Address Concerns*: Unhappy workers, competitors, and patients
- *Review Documentation*: Missing notes, plans, the golden thread
- *Know Medical Necessity*: Does your staff know what is required to meet the guidelines for this?
- *Modifiers*: Overuse can prompt a red flag
- *Identify Billing Patterns*: Waiving of fees/co-pays, deductibles, up-coding, inconsistent billing, unbundling, etc.
- *E&M Billing*: Overuse of high-level coding may be a red flag
- *Static Templates*: Watch out for overuse or dependence of check boxes and lists
 - This is an area auditors frequently comment about lack of individualized treatment planning

Payers & Medical Necessity

- Even though professional services are paid based on the procedure code, according to the CMS Comprehensive Error Rate Program, “Medical necessity is the overarching criterion for selection of a procedure and/or service”
- The diagnosis codes support medical necessity and are used for medical review, auditing, and coverage
- Example: Magellan has a 131 page-PDF defining every aspect of medical necessity

So Many Clinical Documentation Guidelines!



Clinical Documentation Tips

Incorporate scales:

- Mild, Moderate, Severe
- Persistent, Intermittent
- Beck Scales, PHQ9
- Subjective Scales

Consider changes in documentation capture processes to facilitate improvements

- Enhance prompts in EHR systems
- Revise forms used to capture examination findings

Educate clinical staff about findings from the review and the documentation elements needed to support ICD-10-CM codes

- Use specific examples
- Emphasize the value of more concise data capture for high-quality data

Review the potential revenue impacts if non-specific or inaccurate diagnoses are utilized

- Payment is driven primarily by medical necessity which is dependent upon the diagnoses reported on claims.

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred

Be careful of EHR Templates

CDI: Clinical Documentation Improvement Program

The purpose of a CDI program is to initiate concurrent and, as appropriate, retrospective reviews of patient health records for conflicting, incomplete, or nonspecific provider documentation

The goal of these reviews is to identify clinical indicators to ensure that the diagnoses and procedures are supported by ICD-10-CM codes

Someone is monitoring and implementing a program

Developing Your Coding Compliance Manual

Compliance Program Overview

- Code of conduct that produce a clear commitment to compliance
- Appoint high-level individuals to oversee compliance
- Effective staff training programs
- Ongoing internal monitoring systems to uncover potential problems and encourage reporting without fear of retaliation
- Open lines of communication
- Disciplinary systems for noncompliance
- Reasonable steps to respond and correct

Compliance Program: Regulation & Guidance

- Federal and State Regulations:
 - According to CFR 42 (Code of Federal Regulations), it is required that all providers of mental health services verify that every (single) service provided is accurately documented, signed, and billed appropriately
- Seven compliance program elements in CMS's guidance proposal per ACA:
 1. Written policies and procedures
 2. Compliance officer, compliance committee, and high-level oversight
 3. Effective training and education
 4. Effective lines of communication
 5. Well-publicized disciplinary standards
 6. Effective system for routine monitoring and auditing
 7. Prompt response to compliance issues

Compliance Program: Effectiveness

- What does an “effective” compliance program mean according to CMS?:
 - Organization devotes “adequate resources”
 - Standards of conduct are easy to read and comprehend
 - Compliance officer is a full-time employee with knowledge and experience of regulatory standards
 - CEO/President and senior management are engaged in the compliance program
 - Organizational culture of compliance
 - Routine audit and monitoring in operational as well as programmatic
 - Measurement and tracking
 - P&P to control, identify and report fraud, waste and abuse

Coding Compliance Program & Manual Elements

- Strikes a balance between being general and specific
- Minimally covers certain areas that are ill-defined
- Included in staff education, training, and onboarding
- Identifies areas of risk and risk mitigation
- Defines collaboration between:
 - Billing
 - QI/QA Departments
 - IT Departments
 - Clinical leadership
 - Executive leadership
 - Middle management
 - Participation at every level of the organization!

Do You Have A Coding Compliance Manual?

- Whether your billing is internal or outsourced: Coding Compliance Plan/Manual, Policies and Procedures **MUST** be in place
- Reviewed and updated annually, no exceptions
- These documents are *discoverable*
- Due diligence: time, resources, and personnel prevent ongoing monitoring

“An ounce of prevention....”

Coding Compliance Manual Contents

Coding Compliance Manual Intro

- Uniform Policy Statement and Commitment to Accurate Coding
- Parties Responsible for Coding
- Reporting Requirement by Agencies
- Procedures for Inaccurate Code Assignment/Claim Rejections
- Sources Used for Coding (CPT, HCPS, ICD, etc.)

General Issues and Reporting Procedures

- Identification of any payer-specific requirements related to code assignments
- Internal Communication
- External Communications
- Procedures for correction of inaccurate code assignments in the client record, health information system or to agencies where the codes have been reported

Compliance Program

- Statement of Purpose and Program Defined
- Follows OIG Standards
- Committee members/personnel responsible
- Communication Procedures
- Defined audit plan for code accuracy and consistency review and corrective action plan for identified problems

Coding Compliance Manual Contents

Clinical Documentation

- Definitions
- Principals and Elements of A Medical Record
- Treatment Plan and Progress Notes
- Medical Necessity
- Procedures to use when documentation is not clear or when clinical staff cannot remember

Outline of Provider Types

- MD, Psychologist, APRN, PA, etc.
- Use State Definitions/Regulations
- Include Scope of Practice

Guidelines: Coding & Reporting Diagnoses

- Use of ICD-10, CPT, HCPCS
- May include crosswalks (ICD-DSM), other documentation
- Place of Service Codes, Modifiers, etc.
- Procedure for Inaccurate Code Assignment

Coding Compliance Manual Contents

HIPAA Component

- Policies and Procedures
- ePHI, BAA's
- Security/Mobile Devices/Laptops
- Privacy and Security
- Technology (mobile devices, equipment disposal, laptops, etc.)

References

- Statement of adherence to:
 - OIG
 - CMS
 - State and Federal Regulations
 - Standards of Practice
 - Accreditation Compliance

Itemization Of Clinical Services

- Service Code and Brief Description
- Time, Provider Types, Place of Service
- Mode of Delivery, Limitations
- Service Description Expanded
- Minimum Documentation Requirements
- Coding Guidelines (carrier/state/federal/payer rules), modifiers applicable, etc.)

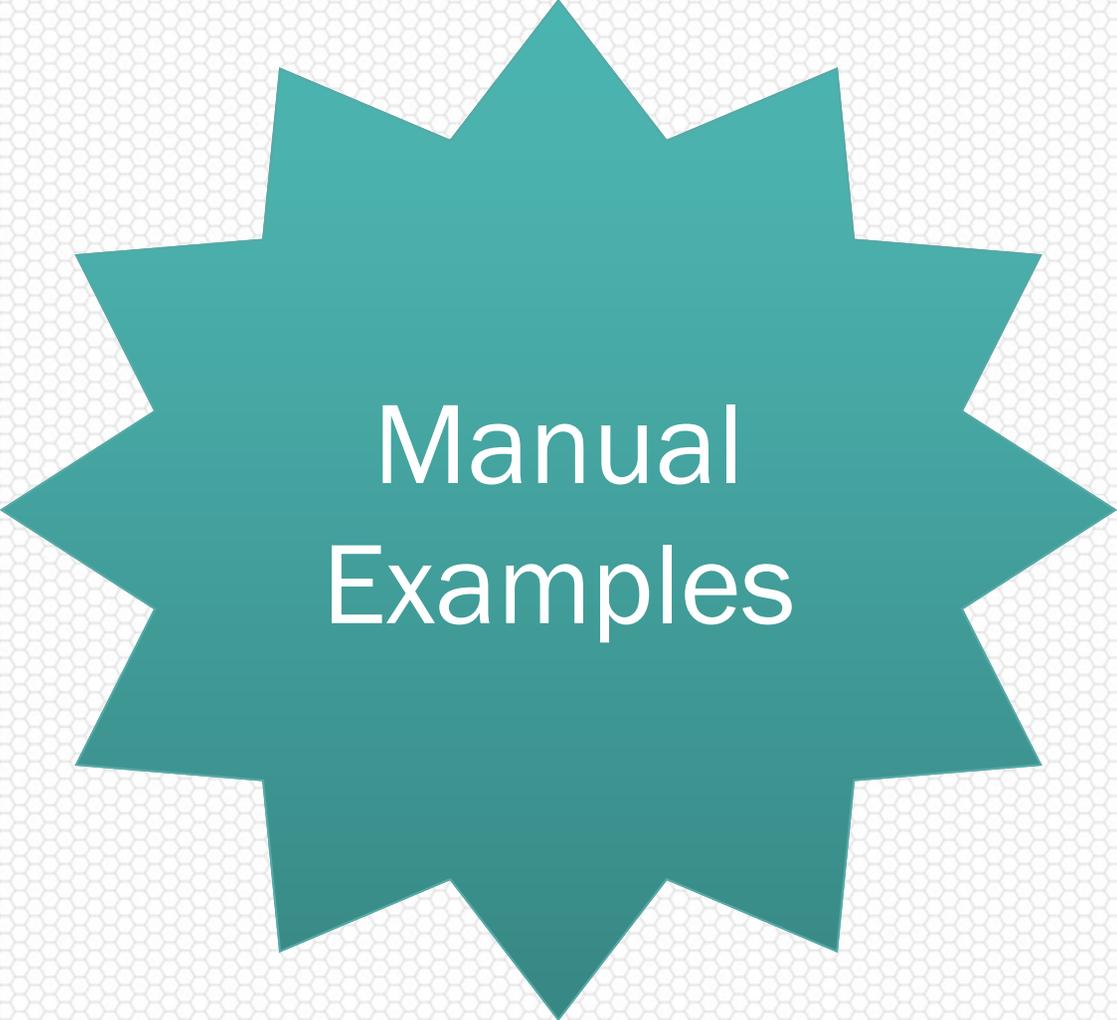
Coding Compliance Manual Contents

Claim Rejection Procedures Due To Codes

- Clarify that codes will not be assigned, modified or excluded for the purpose of maximizing reimbursement or avoiding reduced payment
- Specify that codes will not be changed or amended for the sole purpose of having the service covered by Medicaid or other insurance

Other

- Policy statement that code assignments must be supported by complete and appropriate client record documentation including the specific reason for an encounter (e.g., specific diagnoses as well as symptoms, problems or reasons for the encounter) and any conditions treated (e.g., physician order for services, reason a service was ordered, test results)

A large teal starburst shape with multiple points, centered on the page. The background of the entire slide is a light gray pattern of small, repeating hexagons.

Manual Examples

Billing & Claims

All ICD-10, CPT® and HCPCS codes claimed for reimbursement for submission to Medicare or other third party payers must be accurate and correctly identify the services provided/ordered by the physician or other authorized person. Providers are responsible for ensuring the completeness and accuracy of the documentation submitted for the services ordered and performed and the supporting diagnoses. Responsibility for completeness and accurate coding and/or billing of the services and diagnoses submitted on all claims for reimbursement rests solely on the provider of the service.

This guidance addresses only the most common situations that may arise and it is not intended to be all-inclusive. Appropriate communication regarding Coding Compliance situations will depend on the facts and circumstances surrounding the issues.

Selection of CPT® or HCPCS Codes

Providers should ensure that the CPT® or HCPCS codes coded and to bill Medicare or other third party payers accurately reflect the services that were ordered and performed as described in the documentation provided. When there are questions as to the code selection, the provider must clarify the matter.

All additional documentation provided to clarify code reporting must fall within the appropriate definition of medical record documentation provided (e.g., a signed and dated amendment to the provider's note in a patient's medical record).

Providers will ensure to report current service codes, CPT® and HCPCS codes are updated annually, semi-annually, and quarterly in accordance with AMA and CMS CPT®/HCPCS code guidelines. All staff coding and reporting services will maintain training on the updated CPT®/HCPCS codes and guidelines.

Selection of ICD-10-CM Codes

All staff performing coding and billing are required to follow the Official ICD-10-CM Coding Guidelines as approved by the cooperating parties of the ICD-10-CM Coordination and Maintenance Committee (AHA, CMS, NCHS and AHIMA) to select the appropriate diagnoses codes for the reporting of each encounter.

Case Management (CM) Services

Case Management (CM) Services assists patients in gaining access to needed medical, social, educational and other services, these services can be provided by a licensed/qualified non-physician practitioner or physician. Case management services include service planning and program linkage; referral recommendations; monitoring and follow up; client advocacy; and crisis management.

Care Coordination

CPT®/HCPCS Procedure Code	T1016
Description	Case management, each 15 minutes
Time	Each 15 minutes
Provider Type	<ul style="list-style-type: none"> - MD/DO/MP - Licensed EdD/PhD/PsyD/MP - PA/APRN/RxN - LAC/LCSW/LSW/LMFT/LPC
Place of Service	Office – 11 Inpatient – see pages 24 – 25
Mode of Delivery	N/A
Interaction / Relevant Limitations	N/A
Service Description	Minimum Documentation Requirements
<p>Case management assigns the administration of care for an outpatient individual with a mental illness to a single person (or team); this includes coordinating all necessary medical and mental health care, along with associated supportive services.</p> <p>Other core functions include outreach to engage clients in services, assessing individual needs, arranging requisite support services, monitoring medication and use of services, and advocating for client rights and entitlements.</p>	<ul style="list-style-type: none"> • Date of service • Start and end time • Patient demographic information • All contacts with and on behalf of patient • Nature and extent of service • Date and place of service delivery • Mode of contact (telephone or face-to-face) • Issues addressed (adult living skills, family, income/ support, legal, medication, educational, housing, interpersonal, medical/dental, vocational, other basic resources) • Type of activity (assessment, service planning, referral, monitoring and follow-up)

SAMPLE BILLING AND COLLECTIONS POLICIES AND PROCEDURES MANUAL
TABLE OF CONTENTS
 from HRSA

SECTION 1 INTRODUCTION

- A. Program/Clinic Description
 - i. Vision, mission, scope of services, future plans
- B. Organization Chart – Detailed Structure of Billing and Collections Staff
- C. Job Descriptions of Billing and Collections Staff

SECTION 2 BILLING OVERVIEW

- A. Requirements for Completing a CMS-1500 and UB-04
 - Medicare
 - State-specific Medical Assistance
 - State-specific S-CHIP
 - Blue Cross Blue Shield
 - HMO
 - Worker's Compensation
 - Other Commercial Payers
- B. Billing Flow Chart(s)
 - By Clinic
 - By Program
- C. EDI explanation and options? Remittances and claims examples

SECTION 3 FINANCIAL POLICIES –

- A. Financial Policy
 - Payment due date(s)
 - Acceptable form(s) of payment
 - Responsibility for completion of explanation of patient responsibility
 - ~~➤ Define written agreement with patients for patients with payment plans and when to initiate.~~
 - Patient responsibility for payment if prior authorization is not obtained (if applicable)
- B. General Cash Controls – Front Office
 - General procedure
 - Procedure(s) for payment at time of visit
 - Procedure(s) for payments by mail
- C. Procedures for Payments by Mail
 - Opening/separating mail

- Logging correspondence
- Date stamping correspondence/stamping checks/photocopying
- Making deposits

SECTION 4 PATIENT INFORMATION POLICIES

- A. Appointment Scheduling
 - Established schedule with physician(s) and other patient care providers
 - Scheduling for new patient vs. established patients
 - Schedule patients 15-30 minutes before time to see provider to allow for registration time
- B. Collection of Patient Information
 - Describe data collection process, including method(s), timing and responsibility
 - Describe data verification process, including method(s), timing and responsibility
 - Establish written checklist that defines each registration task for:
 - a. First patient visits
 - b. Follow-up visits
 - c. Walk-in patients
- C. Information to Collect and Disseminate
 - Collect from patient:
 - a. Patient name, address, phone number(s)
 - b. Insurance information – Insurance company, address, member number, group number, guarantor, effective date, phone number, co-pay, mental health benefit, prescription benefit
 - c. Referring provider or agency
 - Share with patient:
 - a. Payment and billing policies
 - b. No-show and cancellation policies
 - c. Need to bring insurance card and payment to scheduled visit
- D. Qualifying/Application Process for Uninsured Patients
- E. Standard Preregistration Procedures
- F. Physician Responsibilities For Patient Information/ Financial Requirements

SECTION 5 BILLING PROCEDURES

- A. Encounter Form Development and Management
 - Annual review and update process, including diagnosis/procedure codes
 - Completion of encounter form
 - Flow chart of handling of encounter form
- B. Timing of Encounter Form Review and Billing
 - Gathering of encounter forms
 - Time limit on form processing and data entry –
 - Charge capture process
 - Charge verification/accuracy
 - Coding process
 - Reconciliation process - patients seen vs. encounter forms generated
 - Procedure for "finding" lost/missed charges
 - Frequency of billing (daily, 2x/week, etc.)
- C. Bill Tracking
 - Policy for tracking bills submitted to insurers
 - Procedure for unprocessed claims
 - Frequency of follow-up
- D. Payment Due From Patient
 - Who to collect payment from
 - When to collect payment
 - Estimating amount of payment
 - Procedure for collecting payments when payment not made at time of visit
- E. Payment Processing
 - Check processing
 - Bank deposits and reconciliation
 - Payment posting to billing system
 - Reconciliation of daily deposits
 - Job descriptions and assignment of duties

SECTION 6 COLLECTION FOLLOW-UP

- A. Denial Management Procedures
 - Identification of unpaid/denied services, including remittance advice reviews
 - Research and correction process
 - Time requirement for processing denials
 - Payer contact list
 - Frequency of re-bills to payers

- B. Bad Debt/Uncollectable Account Write-off Policy
 - Frequency of review
 - Small balance write-off policy
 - Number and frequency of patient statements sent before write-off
 - Procedure and approval process for account write-off
 - Clearly identified staff authorized to write-off accounts
- C. Patient Communication
 - Collection letters and dunning levels (make sure patient understands that payment is expected throughout process)
 - Collection policy signage in clinic and waiting areas
 - Collection policy statements in patient brochures
- D. Use of Insurance Information Sheets or Index Cards
 - Procedures on insurance follow-up
 - Summary matrix of insurance company coverage policies and billing Requirements

SECTION 7 USE OF OUTSIDE AGENCIES FOR COLLECTION

- A. Use of Collection Agencies
 - Board policy defining when to use
 - Frequency of account write-off and transfer
 - Collection agency collection policies
 - Collection agency analysis reporting
- B. Use of Small Claims Court
- C. Use of Attorneys for Collection

SECTION 8 MEASURING OVERALL EFFECTIVENESS

- A. Tools and Statistics Useful in Determining Success.
 - Patient account statistical report
 - Financial performance measures; definition of:
 - a. Gross collection ratio
 - b. Accounts receivable ratio
 - c. Days in receivable
- B. Reporting
 - Collection activity
 - Weekly activity
 - Total accounts receivable by patient, by payer and by provider

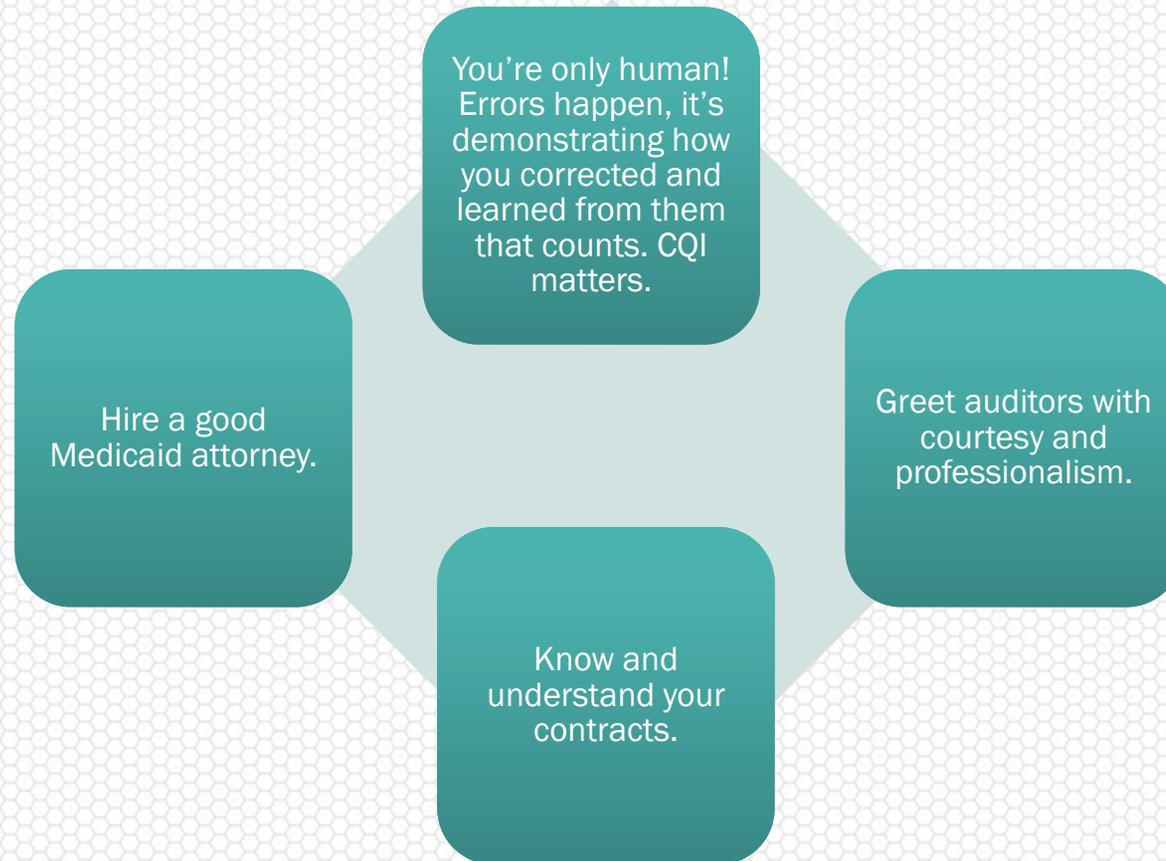
Audit Readiness

- Anticipate and expect audits
- Decide: Certified coders or leave it to the clinicians?
- Increasing coding and documentation knowledge
- Staff education and ongoing training
- Provider communication: updates, policies, what constitutes proper documentation
- Implement claims tracking and review program
- Implement compliance program
- Utilize self-audit tools

Preparedness Checklist

- ✓ Culture of excellence and commitment to compliance
- ✓ Compliance program and manual
- ✓ Audit and compliance committee
- ✓ Internal audit program
- ✓ Documented corrective action and due diligence
- ✓ Have standardized method for coding quality performance
- ✓ Utilize benchmarking to improve coding accuracy
- ✓ Educate, educate, educate!
- ✓ Know your rights and the law
- ✓ Appeals processes and timelines

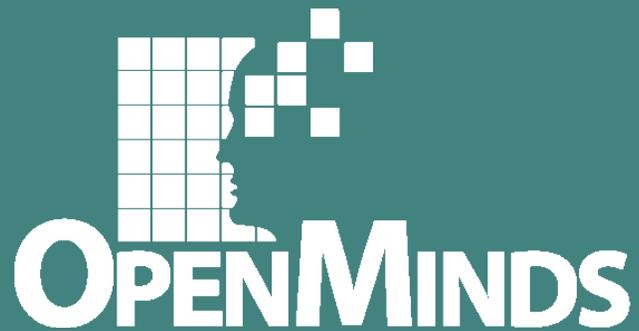
Parting Advice





Questions & Discussion

The market intelligence to navigate.
The management expertise to succeed.



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