What to Look for in your Billing Office

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Financial Disclosure

Donna McCune acknowledges a financial interest in the subject matter of this presentation as an employee of Corcoran Consulting Group.

Course Objective

- Recognize the most common errors made in the billing office
- Utilize industry benchmarks for comparison purposes
- Develop a strategy to minimize errors

Challenges Today

- High deductibles
- Verifying benefits and coverage
- Collecting at time of service
- Denial management
- Refunds
- What's to come

Then and Now

Then	Now
• Enroll a new doctor months in advance	• 60 Days
• Claims could be submitted up to 24 months after the DOS	• 12 months
• Long window for appealing claims	• 120 days
• Fee schedule was high	• Fee schedules reduced
• There were no Medicare Advantage plans	• 26% of Medicare beneficiaries are enrolled in an MA

Common Billing Office Errors

- Understand your contract
- Denial management
- Allocation of work
- Never say die, holding uncollectable balances
- No research of denials

Know What to Expect

- Make a master fee schedule for every contract
- Compare contracted rates against the EOB
- Appeal underpaid and wrongfully denied claims
- Only 78.5% of all claims process without error
  - Errors include partial payments without explanation
  - Underpayments
  - Overpayments
  - Erroneous denials

Source: 2007 Survey by National Healthcare Exchange Services on behalf of the American Medical Association

Educate Your Staff

- Your billing department can provide valuable training to your front desk.
- Does your staff understand your contracts?
- Do they know which ones need a referral or pre-authorization?
- Keep master insurance list with critical elements
  - Contracted?
  - Will not cover INTACS
  - Pre-certify all surgery
  - Drugs paid at invoice

Educate Your Staff

- Make sure claim write-offs are accurate
- Modifiers
- Diagnosis code linkage
- Frequency of exams and tests
- NCCI bundles
- National and Local Medicare Policies

Payment Entry

- Are you contracted? (see master list)
- Post denials for follow up and reporting
- Confirm auto-posting did not adjust under payments
- Did they pay your contracted amount?

Aging Buckets

Percent of Total A/R:	Healthy Range
0 - 30 Days	40% - 60%
31 - 60 Days	15% - 25%
61 - 90 Days	5% - 10%
91 - 120 Days	5% - 10%
Over 120 Days	10% - 25%

Case Study AR in Trouble

Date	0-30	31-60	61-90	90-120	120+	Total
Sep-13	$198,526.03	$59,460.42	$45,972.38	$35,181.30	$150,370.68	$489,510.81
	40.56%	12.15%	9.39%	7.19%	30.72%	
Benchmark	40-60%	15-25%	5-10%	5-10%	10-25%	

Case Study AR in Trouble

- No pre-bill capabilities
- Data entry by inexperienced untrained staff member
- No feedback to other staff when problem discovered
- Understaffed in Billing Department
- No logging of denials in PM

Claim Processing

- One of 3 things will happen to your claim
  1. Payment
  2. Denial
  3. Black hole

Common Billing Office Errors

- Understand your contract
- Denial management
- Allocation of work
- Never say die, holding uncollectable balances
- No research of denials

Common Billing Office Errors

- Write off denials without researching or appealing
- Or never writing off denials, posting errors and uncollected balances
- Not posting denials or documenting any work done on the claim in the PM

Denials

- Denials can be created at every level in the practice
  - No longer eligible
  - Wrong ID number
  - Wrong insurance
  - Wrong gender
  - Visit or surgery in post op time
  - Minor procedure on same day as office visit
  - No pre-certification
  - Claim untimely
  - Denial not appealed

Denial Management

- Is it a legitimate denial
- Can it be corrected on the phone
- Research same problem for other claims
- Notify staff who can prevent the denial
- Make sure your appeals address pertinent points
  - Medical necessity
  - Chart supports service
  - Use insurance companies policy in appeal

Optimize Collections

- Maximize the practice's ability to collect
  - Gather and confirm patient's insurance
  - Notify patients of your collection policy
  - Collect patient responsible balance at time of service
  - Follow procedure when patient's don't pay

Rate of Collectability

$1000 due from the Patient

- 30 days – $899.00 - 89.9%
- 60 days – $813.00 - 81.3%
- 90 days – $696.00 - 69.6%
- 6 months – $521.00 - 52.1%
- 1 year – $228.00 - 22.8%

Source: Commercial Collection Agency Association

Sample Collection Policy

Day 1	First Statement
Day 30	Second statement with note that informs patient that insurance has paid its portion
Day 60	Collection letter with demand for payment in 15 days
Day 75	Phone call
Day 90	Send to collection agency

Successful Case Study

- Practice sent multiple statements and dunning letters
- No phone call to patient
- Implemented tighter follow-up and one phone call
- Saw results within 3 months

Successful Case Study

Date	0-30 Days	31-60 Days	61-90Days	Over 120+	Total
6/12/12	$40,160	$21,231	$13,519	$70,785	$155,668
9/4/12	$24,889	$10,036	$9,402	$48,396	$92,722

End of Month Reports

Date	Charges	Payments	Adjustments	Ratio
January-13	$389,751.94	$171,291.46	$177,852.27	44%
February-13	$322,964.14	$147,940.24	$167,559.74	46%
March-13	$398,691.00	$208,794.12	$227,397.57	52%

Payments divided by charges equals the gross collection ratio

Know When to Expect Payment

- Cash patients - the day of the service
- Medicare 14 days
- Blues about 20 days
- Medical Groups / IPAs 60 days

Tools for Monitoring – Days in AR

- Divide the entire month's receipts by 31 days = X
- Multiply your AR balance by your collection average = Y
- Divide Y by X = Days in AR
- Healthy Range is 35 to 50 Days
- Perform monthly

Days in AR

	PAYMENTS	X	AR BAL	COLL. AVG	Y	DAYS
January-13	$ 317,045.62	$ 10,227.28	$1,061,365.39	43%	$ 451,389.07	44
February-13	$ 360,097.72	$ 11,616.06	$1,159,579.84	45%	$ 519,375.97	45
March-13	$ 467,721.37	$ 15,087.79	$1,016,149.11	58%	$ 591,708.87	39
April-13	$ 415,544.49	$ 13,404.66	$991,737.16	52%	$ 515,676.53	38
May-13	$ 418,706.66	$ 13,506.67	$1,048,808.14	48%	$ 504,992.75	37
June-13	$ 406,007.78	$ 13,097.03	$983,743.73	52%	$ 514,963.70	39
July-13	$ 421,850.40	$ 13,608.08	$896,916.66	56%	$ 499,281.56	37
August-13	$ 396,069.38	$ 12,776.43	$858,535.94	47%	$ 401,866.11	31
September-13	$ 411,460.18	$ 13,272.91	$798,539.30	55%	$ 438,085.61	33

Common Billing Office Errors

- Understand your contract
- Denial management
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Common Billing Office Errors

- Allocation of work
  - Consider your payer mix
  - Look at the total number of claims to be researched
  - Consider breaking up patient collections among your billing staff

Billing Staffing Levels

- For each full time doctor, .75 full time equivalent biller
- One biller per $1.0 million - $1.25 million in collections.
- The addition of an ambulatory surgical center, optical, or heavy managed care contracts could require additional help

Common Billing Office Errors

- Understand your contract
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Common Billing Office Errors

- Never turn over accounts to collections and never write off bad debt
  - Skews your AR data
  - Causes staff to sort through uncollectable balances each month

Sample Small Balance Policy

- Small patient balances less $25.00 but greater than $5.00 will be billed twice.
- Small insurance balances $5.00 dollars or less will be written off at the end of the month.
- Credit balances on government program accounts (Medicare) will be refunded, regardless of the amount.
- Small credit balances for all others may be written off the system if the account balance is $5.00 dollars or less.

Common Billing Office Errors

- Understand your contract
- Denial management
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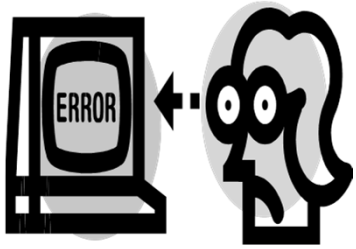
- Never say die, holding uncollectable balances
- No research of denials

Common Billing Office Errors

- No appeal, just refiles – indicators are EOBs coming back with “duplicate claim”
  - Happens when staff is unsure of what to do
  - Happens when the AR gets out of control
- Posting charges or payments get behind
  - Denials won’t be posted or worked
  - Claim status is not accurate in PM- causes extra work to research
  - Patient statements won’t be accurate

Common Errors



Common Billing Office Errors

- Incorrect modifiers
- Diagnosis code errors
- Misuse of waiver forms
- Policy issues
- Contractor errors

Modifiers

- Indicates both a professional and technical component
- More than one physician and/or location involved
- Increased or reduced service provided
- Only part of service performed
- An adjunctive service performed
- Bilateral
- Repeated
- Unusual events occurred

Source: AMA, CPT

Medicare Expected Frequency

- Modifier -24 2%
- Modifier -25 11%
- Modifier -57 1%
- Modifier -59 2%

- Based on Medicare paid claims for office visits (920xx, 992xx)
- Considers all ophthalmologists
- Subspecialists' utilization likely varies
- Requires supportive documentation

Source: CMS data (2012), 18 – Ophthalmology

Case Study

"Don't worry, I know how to get the claim paid, add a modifier!"

Medically Unlikely Edits (MUEs)

- Table on CMS website
- Updated quarterly
- Example – 67820 *Correction of trichiasis; epilation, by forceps only*

HCPCS/CPT Code	Practitioner Services MUE Values
67820	1

Source: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

Claim Example

- Epilation on both left and right lower eyelids
- Claim is paid; does not "violate" the MUE limit of "1"

21 1. 374.05 (Trichiasis of eyelid without entropion)					
24a	24b	24d	24e	24f	24g
mm/dd/yyyy	11	67820-50 (Epilation)	1	$$$	1

Claim Example

- Epilation on both left and right lower eyelids
- Claim is denied; “violates” the DOS MUE limit of “1”

21 1. 374.05 (Trichiasis of eyelid without entropion)					
24a	24b	24d	24e	24f	24g
mm/dd/yyyy	11	67820-RT (Epilation)	1	$$$	1
mm/dd/yyyy	11	67820-LT (Epilation)	1	$$$	1

Avoiding Modifier Errors

- Physician and staff training on proper modifier use
- Establish policy regarding who appends modifiers
- Conduct reviews specifically for appropriate modifier use
- Monitor utilization of modifiers

Common Billing Office Errors

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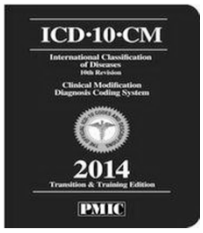

Case Study

- Billing office receives call from technician / MD
- Provides “list” of covered diagnosis codes for a particular test
- Technician / MD append one of the “covered” diagnoses to ensure payment
- Billing office works only from list of approved codes and never checks the chart to confirm condition exists

Compare and Contrast

ICD-9

- 17 Chapters
- 14,000 codes
- 3-5 digits
- First digit is numeric or alpha (E or V)
- Digits 2-5 are numeric

ICD-10

- 21 Chapters
- ~ 69,000 codes
- 3-7 digits
- Digit 1 is alpha
- Digit 2 is numeric
- Digits 3-7 are alpha or numeric (alpha digits are not case sensitive)

General Guidelines

- Diagnosis codes are to be used and reported to the highest number of characters available. [1]
- Signs and symptoms are acceptable when a definitive diagnosis has not been established by the provider. [1]
- Do not code diagnoses documented as “probable”, “suspected”, “questionable”, “rule out”, or “working diagnosis” or other similar terms indicating uncertainty. [2]

Sources: 1. ICD-10 Official Guidelines, Sect 1 B. General coding guidelines (pg 19)
2. ICD-10 Official Guidelines; Sect 4 H. Uncertain diagnosis (pg 73)

General Guidelines

- Multiple codes may be required for a single condition that affects multiple body systems. [1]
- Principal diagnosis should be based on the condition that prompted the visit and was the primary focus of treatment. [2]
- Code all documented conditions that coexist at the time of the visit, and require or affect patient care treatment or management. [3]
- Do not code conditions that were previously treated and no longer exist.[3]

Sources: 1. ICD-10 Official Guidelines, Sect 1 B. General coding guidelines (pg 19)
2. Terminology (pg 3)
3. ICD-10 Official Guidelines; Sect 4

Avoiding Errors

- Physician and staff training on assigning correct diagnosis codes
- Physicians should "link" diagnosis codes
- Patient inquiries require chart review of chief complaint and finding
- Establish policies regarding changing diagnosis codes
- Prepare for ICD-10

Common Billing Office Errors

- Incorrect modifiers
- Diagnosis code errors
- Misuse of waiver forms
- Policy issues
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Case Study – ABN

MD discusses performing an anterior segment OCT (92132) for the diagnosis of glaucoma suspect. The patient is informed that this may not be covered by Medicare as their Medicare contractor does not include this diagnosis code as a covered indication for this test on their LCD. The patient signs a universal ABN that has been customized by the practice for any beneficiary who is financially responsible for an item or service.

Is this reasonable?

Advance Beneficiary Notice of Noncoverage (ABN)

- Notice that Medicare will probably deny reimbursement
- Mandated by HIPAA
- Document reason why item is not covered
- Give signed copy of ABN to patient
- (*recommended*) Collect full fee from patient

Source: CMS-R-131 (03/11)

Advance Beneficiary Notice of Noncoverage (ABN)

- Option 1. I want the _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment…I can appeal to Medicare…
- Option 2. I want the _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal to Medicare…
- Option 3. I don't want the _____ listed above. I understand with this choice I am not responsible for payment…I cannot appeal to Medicare…

When is an ABN required?

- Get an Advance Beneficiary Notice (ABN) when
  - Beneficiary is financially responsible
  - Not covered…
    - No eligible diagnosis
    - Normal findings
    - Screening
    - Standing orders for a test
    - DME noncovered items

When is an ABN *NOT* required?

- No Advance Beneficiary Notice (ABN) required when
  - Item or service is statutorily (by law) non-covered
  - Not covered by statute…
    - Refractions
    - Routine eye exams
    - Most refractive surgery
    - Cosmetic surgery
    - Non-covered portion of deluxe IOLs
    - Eyeglasses or CLs outside of benefit

Form Completion

- Add your name, address, phone to the header
- Can *customize* "Items or Services", "Reason Medicare May Not Pay" and "Estimated Cost" boxes
- Use blue or black ink, white paper
- Must be one page, single-side, reverse side blank

Form Completion *(continued)*

- Fill in beneficiary's name and your ID number (*i.e.*, account #) at top of form
- Do not use patient's Medicare # on the form
- Complete the "Items or Services" section with proposed service
- Complete "Reason Medicare May Not Pay" with reason why denial expected
- Use language beneficiary understands
- "Estimated Cost" field required

Form Completion *(continued)*

- ABN must be signed before items or services provided
- Beneficiary must personally choose option to sign
- Patient must sign and date form
- Legible copy must be provided to the patient

Claim Filing

- Option 1 – Claim must be filed
- Option 2 – Claim filing optional
- Utilize appropriate modifiers

Modifiers

- GA – Waiver of liability statement issued as required by payer policy
- GX – Notice of liability issued, voluntary under payer policy
- GY – Not a covered service

Source: MedLearn Matters JA6563, Feb 2010

Avoiding Errors

- Ensure proper version of ABN is in use
- Follow detailed instruction set for completion of ABN
- Utilize appropriate modifiers when waivers are used and claims are filed
- Educate on when ABNs are utilized

Common Billing Office Errors

- Incorrect modifiers
- Diagnosis code errors
- Misuse of waiver forms
- Policy issues
- Contractor errors

Coverage Policies Vary

- Medicare's policies are not universal
- Local policies differ from place to place
- Policies change from time to time
- Basis for coverage vary

Criteria for Cataract Surgery

- The patient has impairment of visual function due to cataract(s) resulting in:
- Decreased ability to carry out activities of daily living such as reading, viewing television, driving or meeting occupational or vocational expectations.
- Snellen visual acuity of 20/40 or worse. Not all patients with visual acuity of 20/40 or worse require cataract surgery because:
  - They are able to satisfactorily carry out their activities of daily living with changes in eyeglasses, lighting or other non-operative means.
  - The operative risk is not commensurate with the potential benefit to the patient.
  - Other eye disease such as macular degeneration or diabetic retinopathy rather than cataract is the limiting factor of visual function.
  - The patient has posterior segment disease requiring surgical or laser intervention and where the cataract is an impairment to visualization.

Source: Novitas LCD L32690

Criteria for Cataract Surgery – Draft

- Medicare coverage for cataract extraction with Intraocular Lens implant (IOL) is based on services that are reasonable and medically necessary for the treatment of beneficiaries who have a cataract. Cataract patients must have an impairment of visual function due to cataract(s) resulting in the decreased ability to carry out activities of daily living such as reading, viewing television, driving or meeting occupational or vocational expectations, with further annotation of the following bulleted indications:
- The patient has been educated about the risks and benefits of cataract surgery and the alternative to surgery, and has provided informed consent.
- The patient has undergone a standardized formal measure of his visual functional status, the results of which suggest that the patient's visual functional status can be improved commensurate with the risk of surgery by undergoing cataract extraction with IOL implant. Such testing can be performed with standardized measurement tools such as the Activities of Daily Vision Scale or the VF-14 questionnaire, or other standardized tools that indicate impairment of visual functional status amenable to improvement with cataract surgery.

Source: Novitas LCD L32690

Avoiding Errors

- Monitor payers' websites frequently
- Sign up for email notifications with MAC
- Consider participating in comment periods on draft policies

Common Billing Office Errors

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Example

ID:268

TITLE: Incorrect Denials of Claims for bevacizumab (i.e., Avastin™) for Ophthalmologic indications

BUSINESS TYPE IMPACTED:Part B

DATE RESOLVED:

We request that you not resubmit your claims. Instead, please watch for E-mail Updates and the Latest Production Alerts section of our Web site for additional information on the status of this issue.

Source: NGS Medicare 2014

Adjust and Prevent

- All practice employees have the ability to positively or negatively impact collections
- Post charges and payments daily
- Submit clean claims
- Verify insurance eligibility
- Collect patient responsible balances at time of service
- Fix transmission errors daily
- Payment posting – utilize electronic posting

Adjust and Prevent

- Work denials as soon as they arrive
- Use event driven billing for your patient statements
- Use of ABNs when appropriate
- Internal auditing and modify your process when its not working
- Training and continual monitoring
- Use the resources
- Develop policies and procedures specifically addressing billing office activity

More help…

For additional assistance or confidential consultation, please contact us at:

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or

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