Best Practices for Optimizing Cash Flow

Learn how managing billing processes and minimizing denials benefits your business - and your clients.

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The Leading Business Magazine for HME & Home Health Professionals

CHANGE HEALTHCARE

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Best Practices
for Optimizing Healthcare Cash Flow

- Understanding Process Improvement
- Understanding the Revenue Cycle:
  - Sales to Cash Collections
- Top Billing and Codes Issues
- 10 Tips for Better Revenue Cycle Management
- Q&A: Let's solve real-world examples of issues you face today
- PLUS: Tips to make a difference today!

How can patient and support care organizations remain patient-centric and optimize cash flow?

- Understanding the revenue cycle.
- How to identify issues in your company and set short-term and long-term goals to increase cash flow.
- How to optimize your revenue cycle from patient check-in to payment posting.
- How to engage patients early to collect required information and prevent front-end denials.
- How to train staff to discuss out-of-pocket costs with patients to set expectations and improve collections.
- How to manage rejections and denials to reduce delays in cash flow.
- How to increase revenue.
- TIPS TO MAKE A DIFFERENCE TODAY!

Factors Affecting Today's Healthcare Marketplace

Managing medical reimbursement is a complex, resource-intensive process that can be overwhelming to HMEs, DMEs, physician offices, homecare agencies, etc., which must remain focused on delivering a quality clinical experience above all else. Those companies in healthcare must remain laser-focused on delivering a quality clinical experience, regardless of the other business issues they face.

- Industry Regulation
- Government Legislation, Healthcare Reform, Affordable Care Act
- Insurance Companies: challenges and high deductible health plans
- Consolidation, Mergers, and Acquisitions
- Labor Shortages
- Provider Shortages
- Labor Costs
- Increased Equipment Costs
- Lack of Innovation
- Software and AI

Understanding Process Improvement

Understanding Process Improvement

"Today's problems come from yesterday's solutions." — *Peter Senge*

Process Focus

Why have a process focus?

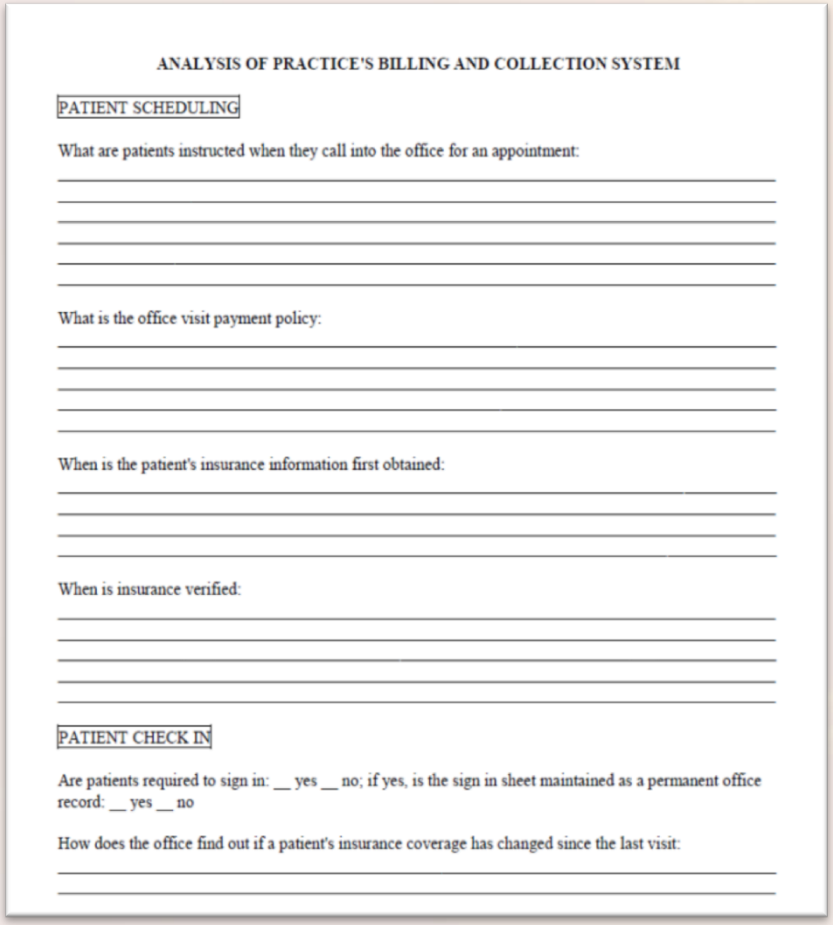
- So we can understand how and why work gets done.
- To characterize patient/physician/payer relationships.
- To manage for maximum patient/payer/staff satisfaction while utilizing minimum resources.
- To see the process from start to finish as it is ***currently*** being performed.
- Blame the process, ***not*** the people.

*process (pros'es) n. – A **repetitive and systematic** series of **steps or activities** where **inputs** are modified to achieve a value-added **output***

8 Elements of Process Improvement

1. Recognize the current state of the practice or facility.
2. Define what plans must be in place to improve each state.
3. Measure the systems that support the plans.
4. Analyze gaps (variance) in system performance benchmarks.
5. Improve system elements to achieve benchmarks.
6. Control system-level characteristics critical to improvement.
7. Standardize the systems that prove to be best in class.
8. Integrate these systems into the business framework.

How to Introduce Process Improvement



ANALYSIS OF PRACTICE'S BILLING AND COLLECTION SYSTEM

PATIENT SCHEDULING

What are patients instructed when they call into the office for an appointment:

What is the office visit payment policy:

When is the patient's insurance information first obtained:

When is insurance verified:

PATIENT CHECK IN

Are patients required to sign in: __ yes __ no; if yes, is the sign in sheet maintained as a permanent office record: __ yes __ no

How does the office find out if a patient's insurance coverage has changed since the last visit:

In-House vs Outsourcing

In House Pros:

- Price
- Knowledge of Environment
- Support of Findings

Outsourcing Pros:

- They Introduce Expertise:
- Science to Your Business
- Proven Methodology Total Practice Improvement (TPI), Lean, Kaizen, Six Sigma
- Metrics and Goals
- Work Process Mapping
- Value Stream Mapping
- Root Cause Analysis
- New Solutions i.e. Technology Optimization

Understanding the Revenue Cycle:

Sales to Cash Collections

The Revenue Cycle Business 101 Definition

The **revenue cycle** is a recurring set of business activities and related information processing operations associated with providing goods and services to customers and collecting cash in payment for those sales.

OR

The entire life of a patient account from creation to payment.

TIP to make a difference today!

BE REPETITIVE

BE CONSISTENT

The Revenue Cycle Business 101 Objective

The revenue cycle's primary objective is to provide the right product in the right place at the right time for the right price.

VS

A healthy revenue cycle should follow billing and collection best practices to ensure bills are submitted in accordance with payor requirements and all services provided are billed.

TIP to make a difference today!

CHANGE YOUR MINDSET To Optimize Cash Flow

Key Decisions: Revenue Cycle Business 101

- To what extent can and should products be customized to individual customers' needs and desires?
- How much inventory should be carried, and where should that inventory be located?
- How should merchandise be delivered to customers?
- What are the optimal prices for each product or service?
- Should credit be extended to customers?
- How much credit should be given to individual customers?
- What credit terms should be offered?
- How can customer payments be processed to maximize cash flow?

Key Decisions: Healthcare Revenue Cycle

- Staffing
- Workflow
- Front Desk, Check In, Registration, Intake
- Appointments and Scheduling
- Back Office, Delivery of Care
- Products and Services
- Price List
- Financial Policy
- Contracts
- Billing Process
- Technology
- Methods of Payment
- Check Out, Discharge

How Do Providers Make Money?

Internal

Provider productivity

Patient volume

Fees for services

External

Insurance claims (from private and govt. payers)

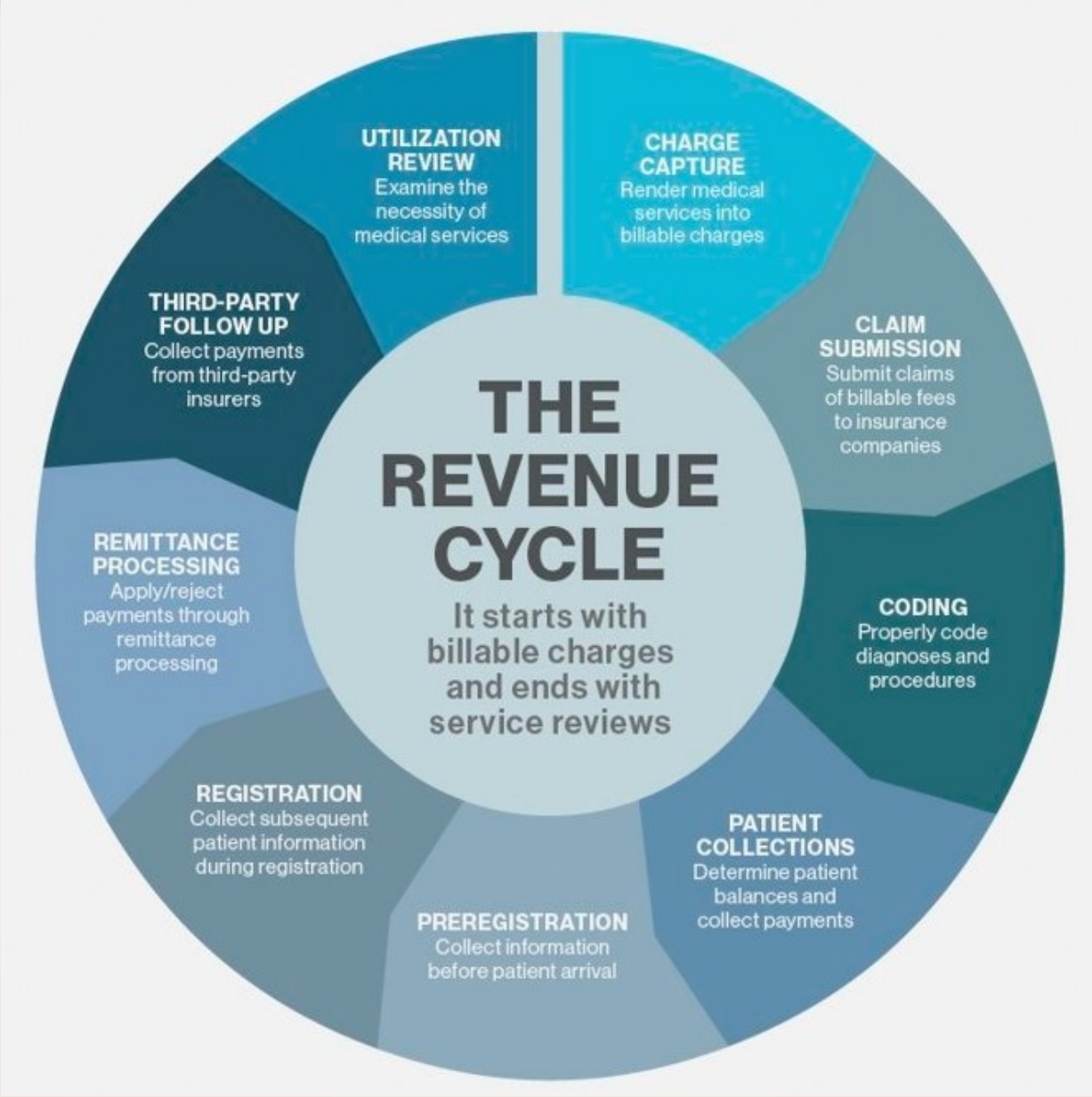
Certifications

Patient payments (deductibles, self pay)

Collections

How Do HMEs, DMEs, Physician Offices, and Homecare Agencies Make Money?

- Part-time or intermittent skilled nursing (SN) and home health aide services
- Occupational therapy, Speech-language pathology, Medical social services
- Routine and non-routine medical supplies
- Covered Drugs
- Branded Merchandise
- Medical services provided by an intern, resident-in-training of the hospital, NP, MA
- Home health services provided under arrangement at hospitals, Skilled Nursing Facilities (SNFs), or rehabilitation centers
- Subleasing


THE REVENUE CYCLE
It starts with billable charges and ends with service reviews
UTILIZATION REVIEW
Examine the necessity of medical services
CHARGE CAPTURE
Render medical services into billable charges
CLAIM SUBMISSION
Submit claims of billable fees to insurance companies
CODING
Properly code diagnoses and procedures
PATIENT COLLECTIONS
Determine patient balances and collect payments
PREREGISTRATION
Collect information before patient arrival
REGISTRATION
Collect subsequent patient information during registration
REMITTANCE PROCESSING
Apply/reject payments through remittance processing
THIRD-PARTY FOLLOW UP
Collect payments from third-party insurers

Top Billing and Coding Issues

What Are The Major Threats In The Revenue Cycle and The Controls Related To Those Threats?

There are many different leakage points in the revenue cycle but here are some of the most common:

- No Referral
- Documentation
- Registration, Coding or Billing Errors
- Unverified Insurance
- Underpaid Claims
- Denied Appeals

Major Threat COST of Denial Management

- According to the American Academy of Family Physicians (AAFP), the average practice has a claim denial rate between 5 and 10 percent.
- Most major private payers kept their claim line denial rates under the 5 percent marker, per the American Medical Association (AMA) report card.
  - Anthem had the highest claim line denials with 2.64 percent of claim lines,
  - Humana with 1.97 percent
  - Aetna with 1.5 percent
  - Cigna with 0.54 percent.
- 50 to 65 percent of denials are never re-worked.
- A study by the Medical Group Management Association (MGMA) found that the cost to rework a denied claim is approximately $25.
- Many practices had denials-resolution expenses at $30 per claim, while 38 percent experienced costs of $40 or more per claim.
  - If a practice has 30 denied claims per month, the annual cost to rework may quickly surpass $9,000.

Top Healthcare Billing and Coding Issues In-Patient and Outpatient Offices

Lack of Medical Necessity Established:

The claim will be denied because the payer does not deem the procedure for this diagnosis to be “a medical necessity.”

Incorrect Diagnosis:

Assigning a covered diagnosis does not mean you automatically can perform any procedure that exists for the covered diagnosis.

Documentation:

The medical record must justify why the procedure was necessary to treat the patient’s diagnosis.

Incorrect or Missing Claim Information:

Incorrect Date of Service. Incorrect carrier. Incorrect Place of Service. Inaccurate Referring Physician Information. Incorrect NPI. Incorrect Tax ID. No Provider Name. No Insurance Information On File.

Top Healthcare Billing and Coding Issues In-Patient and Outpatient Offices

The Claim Is Missing A Modifier Or Has An Incomplete Or Invalid Modifier:

Misuse and abuse of modifiers (particularly modifiers 22, 25, and 59) is under the Office of Inspector General (OIG) scrutiny, and can result in significant penalties.

Beneficiary Eligibility — Claims often are denied for eligibility because:

The beneficiary number is invalid on the claim.

The beneficiary is not eligible to receive benefits.

The beneficiary's claims must be filed to another insurance plan.

Out of Network Penalties.

Non Contracted Facility.

Top Billing and Coding Issues Homecare Agencies

Lack of Medical Necessity Established:

The claim will be denied because the payer does not deem the procedure for this diagnosis to be “a medical necessity.”

No Plan of Care or Certification:

- No plan of care established and approved by a physician.
- This reason for denial is often cited when there is a care plan. Always use page numbers on your documentation. All pages MUST be included.
- Provider plan of care is present but did not include the physician’s signed certification or recertification and dated.

Top Billing and Coding Issues

Home Medical Equipment (HME) or Durable Medical Equipment (DME)(DMEPOS)

4 HHA VS 20 DME

Reason Code	Administrative/Other *(For Transmission via esMD)*
HH0XA	The file is corrupt and/or cannot be read
HH0XB	The submission was sent to the incorrect review contractor
HH0XC	A virus was found
HH0XD	Other

Reason Code	Administrative *(For Transmission via esMD)*
GEX01	The file is corrupt and/or cannot be read
GEX02	The submission was sent to the incorrect review contractor
GEX03	A virus was found
GEX04	Other
GEX05	The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable.
GEX06	The documentation submitted is incomplete
GEX07	This submission is an unsolicited response
GEX08	The documentation submitted cannot be matched to a case/claim
GEX09	This is a duplicate of a previously submitted transaction
GEX10	The date(s) of service on the cover sheet received is missing or invalid.
GEX11	The NPI on the cover sheet received is missing or invalid.
GEX12	The state where services were provided is missing or invalid on the cover sheet received.
GEX13	The Medicare ID on the cover sheet received is missing or invalid.
GEX14	The billed amount on the cover sheet received is missing or invalid.
GEX15	The contact phone number on the cover sheet received is missing or invalid.
GEX16	The Beneficiary name on the cover sheet received is missing or invalid
GEX17	The Claim number on the cover sheet received is missing or invalid
GEX18	The ACN on the coversheet received is missing or invalid

Top Billing and Coding Issues Homecare Agencies

More Visits Than Deemed Reasonable and Necessary

- Skilled nurse visits not covered because documentation indicated more visits were provided than were reasonable and necessary.
- Visits may be denied that do not affect payment but will affect the overall charge denial rate.

Face to Face Encounter Requirements Are Not Me

- No Face to Face encounter documented.
- The Physician who signed the certification is not the physician they have on record being the patient's physician.

Top Billing and Coding Issues

Home Medical Equipment (HME) or Durable Medical Equipment (DME)(DMEPOS)

- Subsequent Need
- Detailed Written Orders
- Dispensing Order Statements
- Refill Requirement Statements
- Proof of Delivery Statement
- Medical Records Statements
- Utilization Records
- ABN Statements
- DIF Statements

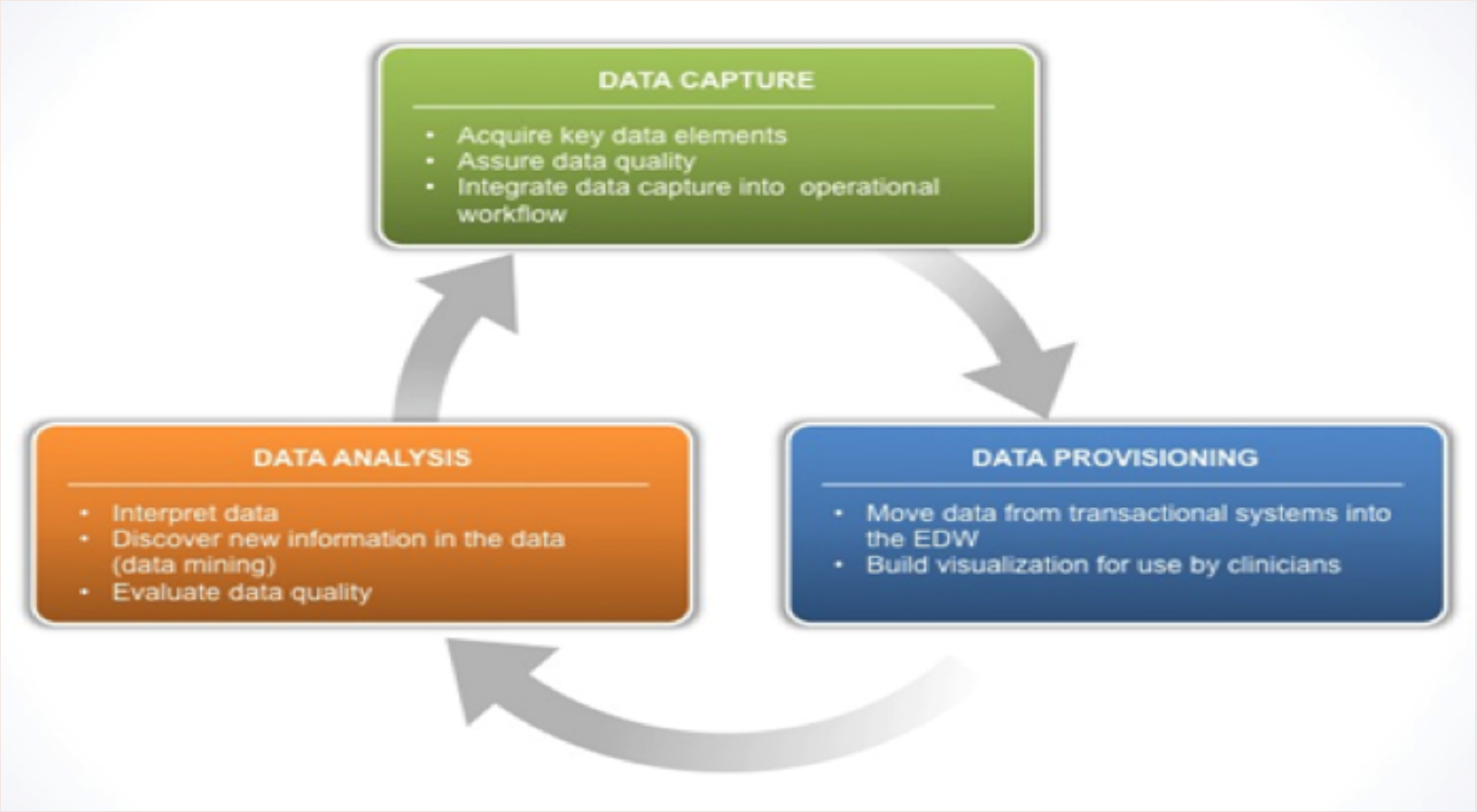
10 TIPS for Better Revenue Cycle Management

TIP #1	You Can't Manage What You Can't Measure.
Tip #2	Manage the Billing and Collection PROCESS Daily, Weekly, Monthly, Quarterly, Annually. Then Repeat!
Tip #3	Don't Buy a CHEAP Healthcare Management System. You Get What You Pay For.
Tip #4	Hire The Right People and Put them in the Right Place!
Tip #5	Train, Train, and Then Train Some More; When Done With That, COMMUNICATE, Then Train Some More!
Tip #6	Engage Patients In the Process.
Tip #7	Set Your Benchmarks.
Tip #8	Optimize Patient Collection Practices.
Tip #9	Is Really Tip #1: Optimize the Provider Experience.
Tip #10	Hold Everyone ACCOUNTABLE!

TIP # 1

You can’t manage what you can’t measure

“You don't know where you're going until you know where you've been.”



Invest in Meaningful Analytics

- **Stage 1: Data Capture** You data is impacted by the way people, processes, and devices produce and capture data. An analyst is responsible for the data's appropriateness (capture the right stuff), discreteness (capture it in the right format), and ease of data extraction (is the data easily accessible).

- **Stage 2: Data Provisioning** Capture data from multiple source systems throughout the organization to produce meaningful insights. For example, EMR data, Billing data, Cost data, Patient Satisfaction.

- **Stage 3: Data Analysis** The appropriate data has been captured, pulled into a single place, and tied together. Data Quality and Presentation.

TIP: Aggregating data manually, using Excel, is time consuming and error prone. Incorporate NEW technology solutions like Enterprise Data Warehouse (EDW).

Types Of Reports To Run:

Basic Management Report
- For the Facility/Practice By Individual
- Provider/Physician/Employee
- On a Comparative Basis

Activities Reports - Clinical, Sales, Inventory

Accounts Receivable

What to Measure

- **Gross Collection Percentage**
- **Net Collection Percentage**
- **Days in A/R**
- **A/R Ratio**
- **A/R in excess of 90 days old**
- **Year over year comparison**
- **Charges by Payor**
- **Revenue by Payor**
- **Payor Revenue by Physician**
- **Referring Physician by Physician**
- **Clinical Encounters by type**
- **Clinical Encounters by Payee**
- **E/M coding comparisons**

- How long does it take to get paid by payors.
- Percent of scheduled patients vs. available visit /surgery / procedure appointment times.
- Percent of insurance eligibility verifications vs. total scheduled patients.
- Average number of missing charges vs. services rendered.
- Percent of denied/rejected claims vs. total claims filed.
- Percent of denied/rejected claims appealed successfully vs. total denial/rejections.
- Average days between receipt of payment and payment posted.
- Average number of unpaid claims resolved by day per collector.

TIP # 3

Don’t Buy Cheap Healthcare Management Systems. You get what you pay for.

Any system can bill but can your system “help” you collect?

The Key: Optimize Information Reporting

- Financial
- Managed Care
- Clinical

Invest in Technology like Remote Charge Capture, Auto Refill, and Cancelled Appointments Software.

Invest in New Hardware and System Upgrades.

Make a Significant Investment in:

- Practice Management Software
- Clearinghouse Provider
- Software Integration
- Internet Speed
- Phones
- Online reference and education
- Training

Optimize Clearinghouse

- The average error rate for paper claims is 28%. But using the right clearinghouse can reduce that to 2-3%.
- Using a clearinghouse to send medical claims electronically:
  - Allows you to catch and fix claim errors in minutes rather than days or weeks.
  - Rapid claims processing: Filing claims electronically can reduce reimbursement times to under ten days.
  - Reduces human error and the need to manually re-key transaction data over and over at each payer's website.
  - Avoid prolonged wait-times being on hold with Medicare and Blue Cross inquiring about claim errors.
  - If you subscribe to the best clearinghouses, you'll be speaking with a knowledgeable support person within just a few rings.
- Be careful not to blindly rely on the clearinghouse's messages. Don't assume that because it is billed and shows 'accepted' by the payor with your clearinghouse that this means it is processing.
- The relationship between your software, your clearinghouse, and the payors is a constant challenge. Your software vendor and clearinghouse should have a good working relationship.
- The billing software should have batch reports that easily match uploaded batches in the clearinghouse reporting system.
- There are numerous reasons given for claims going into the black hole and you have to stay on top of the process.
- Make sure that any change is communicated to the clearinghouse so they can properly set up and process the claims.

Optimize Clearinghouse

TIP Look for these highlights in a premium health care clearinghouse:

- Eligibility Verification
- Determine patient portion before appointment
- Electronic Remittance Advice (ERA)
- Automatically updates Payments & Adjustments
- Claim Status Reports
- Know the status of a claim at all times
- Rejection Analysis
- Have error codes explained in plain English
- Online Access
- Edit and correct claims day or night online
- Printed Claims
- Have claims automatically dropped to paper when necessary but still be able to track and manage them online.
- Patient Statement Services
- Have your patient statements put on ‘autopilot’ at a cost less than what you can mail them out yourself.
- Real-time Support
- The best clearing houses offer 1-on-1 personal support and training provided by experienced billers

TIP # 4
Hire the right people and put them in the right place

- Hire “Outside the Box”
- Compete for Talent
- Control Your Company Brand
- Do “Situational” Interviewing
- Check References
- Conduct Background Checks
- The #1 Question to Determine Before Hire, at 90 Days After Hire, 1 year after hire, and for the Lifecycle for the Employee after that!

5 interview questions you must ask to assess motivational fit

1. What was the best job you ever had? What were your responsibilities? Why do you consider it your best job? Is there anything you didn't like about it?

2. Tell me about the job that you enjoyed the least? What were your responsibilities? What did you not like about it? Was there anything that you enjoyed about this position?

3. What type of work environment to you work best in? Tell me about a time when you worked in this environment.

4. Describe your ideal supervisor? Tell me about a time when you worked for someone like this? What qualities do you not prefer in a supervisor?

5. Describe a job where you performed in a similar capacity to the job. What did you like about it? What did you dislike about this type of work?

THE COST OF A HIRE: Problem

Medical Practice Problem:

•Daily increase of AR over 120 days.

•Not being able to follow up on claims in a timely manner.

•It is harder today to get paid than it was even 6 months ago.

•It could take approximately 3-4 calls per claim and 1-2 faxes before we will receive payment.

Goal and Objective:

•To eliminate all AR over 120 days.

•To increase receipts.

•To decrease turnover ratio.

•Increase from 1-2 FTE's to 3-4 FTE's.

•Divide billing FTE's by financial classes.

THE COST OF A HIRE: Solution

Available Option 1 - Hire 2 more FTE's ASAP ($3,340- $4,400 per month)

- Follow up on all W/C claims within 2-3 weeks and all others after 30 days.
- Increase receipts after 6 weeks of hire date by at least $2000-$3000 per day, $8,000 to $12,000 per month, until over 120 AR is clean.
- Receive all W/C claim payments within 75 days or less.
- Decrease turnover ratio.

Available Option 2 - Continue with existing staff (no change)

- AR over 120 days continue to increase by approximately $2000 per week.
- Increase W/C turn over ratio to over 180 days.
- Increase in Denied claims due to timely submission.
- Increase turnover ratio.

TIP # 5

Train, Train, and Then Train Some More. When done with that, communicate, then TRAIN!

- Create Brand Ambassadors
- Document Internal Procedures and Policies
- Provide Up to Date Information (Price list, Contracts, Credentialing)
- Payer Billing Policies
- Work With and Ride-Along
- Provider Training
- Provider Scribing
- Desk Rotation
- Regular Staff Meetings
- Question: Do You Have a Knowledgeable Manager in Place!

6 Steps for Creating Sales Superstars

1. Make continuous learning a mission. To be a sales superstar, you need to learn every day. The future of “selling” belongs to those with an unquenchable thirst for learning, not just for those who work hard. Invest in professional training, books, seminars and audio talks related to sales, and watch your sales skyrocket.

2. Overcome your fear of rejection. Selling is basically a game of numbers. In other words, the more people you talk to, the more likely you make a sale. Speak to new prospects daily and when they are not interested, simply say, “Next!"

3. Keep your sales funnel full. To get better results in your sales, make sure you don’t lack prospects. Hire someone to help you generate leads full time. Always get referrals after closing each sale. Use Lead-generation tools to streamline sales and to save some time.

4. Make your enthusiasm Infectious. Imagine that a salesman comes to your office looking tired and worn out. Gazing at you, his eyes filled with disappointment, he pitches you in a whisper avoiding eye contact. “My organization can help you fulfill your nursing staffing needs," he says. "But then, you probably don’t really need that, do you? I mean, everybody has a preferred staffing agency they work with nowadays. You don’t happen to know any other home care agencies around here, do you?”

5. Present yourself as a problem solver, not a salesperson. What are you really selling? The value and benefits. How do you approach targets? Don’t just start selling products. Try to understand the needs of the client. Then recommended solutions to help them reduce the stress of the need. Don’t leave anything to chance. Prepare for every sales meeting or call. Dress the part too, look professional, and practice your pitch.

6. Close the sale. Many salespeople don’t *ask* for the sale. They assume that after their sales pitch, clients will take the initiative to pay. Ask for the sale today.

TIP # 6
Engage Patients in the Process

Challenge- Healthcare organizations are forced to rely more on revenue from patients due to the rise in popularity of high-deductible health plans. This means these organizations must focus more on how they collect dollars from patients to maximize reimbursement.

- Employ a Financial Coordinator onsite at each location to educate patients on insurance coverage.
- Back office Financial Coordinators provide phone and onsite support.
- Financial Coordinators Discuss Patient Obligations i.e. Out of Network, Co-Pay, and SOC.
- Financial Coordinators Discuss ABN and Financial Agreements
- Financial Coordinators Offer alternative options i.e. Cash discounts, medical credit cards, and payment program options, discount for early pay.

Provide Clear Financial Policy and Transparent Patient Financial Responsibility

- Financial policy can guide healthcare professionals in determining a patient's financial capacity, balance and status of claims. It also outlines ways on how to deal with denied claims. To ensure its efficiency, a financial policy should be reviewed and approved by legal experts and should be easily accessible to everyone involved in the billing process.

- Health systems should pay attention to automation and specifically use analytics that provide meaningful information to improve issues.

- Employee engagement with respect to financial challenges. If health systems can provide strong financial policy, regular employee training, and analytics around cost and quality outcomes, employees can be more informed and provide better patient financial counseling that can ultimately lead to an improved financial picture for the organization.

TIP # 7
Set YOUR Benchmarks

1. **Days in A/R —** Fewer than 45 days for a combination of paper and electronic billing; 20 to 35 days for mostly electronic billing.
2. **Insurance verification —** Within three to five days before date of service.
3. **Transcription —** Within 24 hours or less after the date of service.
4. **Coding —** Completed within 48 hours or less. The claim should also go out the door the same day it is coded and charged.
5. **Claims billed out —** Within 24 to 72 hours from date of service.
6. **Claims follow-up —** Within 28 days for those that remain unpaid. All claims need to be touched, again, at least every 28 days until the claim is resolved.
7. **Denial rate —** 1 to 2 percent.
8. **Accounts per collector —** One collector per 350 to 400 procedures per month. One collector assigned per every 800 accounts. Accounts are worked a minimum of every 15 to 30 days.
9. **Cash collections as a percent of net revenue —** At a minimum, the collection goal should be 100 percent of your monthly average net revenue for the preceding three months. "Are we collecting as much cash as we possibly can?" If the answer is no, your first question should be, "What should I expect our net revenue to be?"
10. **Aged A/R greater than 60 days and aged A/R greater than 120 days —** Less than 25 percent of your A/R in the 60-day bucket and less than 10 percent in the 120-day bucket.

TIP # 8
Optimize Patient Collection Practices

- Full time experienced A/R staff.
- Full Cycle Billing by Account.
- Increased Statement Activity.
- Outsourced old A/R.
- Scrubbing and Validation of Claims before Submission with two Sources.
- Working Denial Reasons.
- Documenting a Denial Resolution Process.
- Make Sure Claims Get Out The Door Quickly
  - Benchmark for Submitting Office Charges: 1 Day
  - Benchmark for Submitting All Other Services: 5 Days
- Start Follow Up Efforts Early For Unpaid Insurance Claims.
- For Patient A/R – Use 10 Day Letter.
- For Patient A/R – Use 10 Day Letter.
- No Such Thing as “Lazy” Follow Up- If the A/R is 60-120 days, manager review.
- Benchmark Average Collection Cycle- For Payers: 30 – 45 Days.

Improve Front of House Collection Efforts

- Staff Sales Minded People.
- Financial Coordinators should be collecting at least 90% of daily, allowable visits.
- Authorizations in file before time of service 100%. You don't always get an authorization at the moment when you make that call. As soon as insurance verification is completed, you need to turn around and call patients to notify them of their responsibilities, prior to their date of service.
- Train All Staff on New Rules and Regulations. i.e. CMS has selected 31 items of durable medical equipment to be subject to required prior authorization beginning nationwide on September 1, 2018. 2018.
- All employees on site are trained and actively involved in collection efforts.
- Offer additional payment options.
- If Benchmarks Not Met, Ask Staff Where are Bottlenecks

TIP: Question: Have you staffed enough people appropriately?

Continually Review and Monitor The EOBs

- Shows if practice's fee schedule is adequate.
- Shows if the receivables management process is working or not.
- Shows how quickly the practice is getting paid by insurers.
- Shows if the practice getting paid according to contracted rates.
- Shows if practice is coding properly.
- Shows if practice is filing its charges correctly.
- Shows if practice is having problems in the billing process.
- Shows if practice's personnel are competent.

REMEMBER: IN TODAY'S ENVIRONMENT, "CODING" IS EVERYTHING!

TIP # 9

(this is really Tip #1 but I wanted to end with important stuff)

Optimize The Provider Experience

- Increase Volume and Revenue.
  - Increase Provider Schedule Availability.
  - Increase outpatient clinic hours.
  - Provide training to Providers to perform procedures that build revenue.
  - Educate providers to capture all charges available.
  - Add additional billable services i.e. Diagnostics, Telehealth, DME, Medication, and Specialty Encounters.
  - Market Providers.
- Monthly peer chart review.
- Regular Provider Updates and Feedback.

When was last time you renegotiated a contract?

- Evaluation of Existing Payor Contracts.
- Sourcing New Payor Contracts.
- Evaluation of Payor Guidelines and Rules.
- Networking and Creating Payor Relationships.
- Standardize Credentialing Process.

TIP: Try Cloud Based Credentialing like Silversheet

Invest In Regular Provider Coding and Documentation Training to Support Treatment

Example: 6 STEPS TO IMPROVED E&M CODING

1. Identify the Category and Subcategory of Service
2. Review Reporting Instructions
3. Review Descriptors and Examples in Category
4. Determine the Extent of History Obtained
5. Determine the Extent of Examination
6. Determine Complexity of Medical Decisions

Documenting: Who? Where? What?

Who?

Who is the Referring Doctor?

Who is the Patient?
- Name
- DOB
- Medical Record Number

Who is the Service Provider?

Who is the Billing Provider?

Where?

Why Are Places of Service So Important?

- Determines Appropriate CPT Codes
- Information is Required on Claim
- It can negatively affect how you bill
- It can negatively affect how other providers bill
- Can Result in Billing Fraud. The correct place-of-service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the service when the service is performed in a facility setting

Separate code families exist for all places of service:

- inpatient
- outpatient
- inpatient observation
- emergency department
- nursing home
- rehabilitation

What?

Capture All Charges.
- All Performed Services Billable or Not.
- Record Everything!

Provider CPT Code Research and Education allows you to:
- Add New Services
- Associated Services

Keep Current Price List

Check Pre Authorizations

Use a Superbill

Timely Billing Submission

Set Up Healthcare Management System

Encounter Notes and Short Lists to Maximize Revenue

Missed Charge Capture Opportunities

CPT CODE 99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Typically, 5 minutes are spent performing or supervising these services.

Examples - Patient finishes a consult or procedure with provider. Complains of elevated blood pressure at check out. MA reports and provider requests blood pressure monitoring by MA.

CPT CODE 99080 Special reports such as insurance forms, medical data review more than the information conveyed in the usual medical communications or standard reporting form. $69.97

CPT CODE 99456 Work related or medical disability examination by other than the treating physician that includes: Completion of a medical history commensurate with the patient's condition; Performance of an examination commensurate with the patient's condition; Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; Development of future medical treatment plan; and Completion of necessary documentation/ certificates and report. $350

CMS Fall Assessment and Prevention PQRS plus $100-$300 G0402 $183.26

TIP # 10
Hold Everyone Accountable

Avoiding claims denials should be the responsibility of everyone:

•The scheduler must collect accurate demographic and insurance information;

•Registration must verify the patient's information;

•Nurses must accurately enter the patient's medical data in the electronic health record; Clinical or support staff must note potentially non-covered services and obtain advance beneficiary notices from Medicare patients and non-covered services notices from commercial health plan

•Physicians must ensure their documentation reflects services performed;

•Coding and billing staff must translate documentation into diagnosis codes, procedure codes, modifiers and other claims data;

•The billing office must submit claims in a timely manner and interpret remittance advices for appropriate and efficient correction of any issues.

- When people say they are doing something, go behind them and see for yourself are policies and procedures being followed?
- Make people take vacations.
- Rotate job duties for a period of time.
- Provide Progressive Discipline for Poor Performers
- Hold Yourself Accountable to TRACK EOBS AND ANALYTICS DAILY!

Q&A

Let’s solve real-world examples of issues you face today

As a medical executive, management consultant, and small business owner, Shaunna has advised businesses across the U.S. in revenue cycle, sales, marketing, operations, financial, and labor management. Through her relationship with the Score mentoring program, a resource partner of the U.S. Small Business Administration (SBA). She provides business coaching and leadership training, investment and financial services advice.

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