Evaluate and Assess Your Billing Process

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Richelle Marting is an attorney, registered health information administrator, and certified coder who focuses on healthcare coding, billing, and reimbursement issues. She has practical, in-the-trenches experience with coding and billing issues. She has served as an outpatient multi-specialty surgery coder, hospital-based outpatient coder and a compliance coordinator for a large multi-specialty medical group. As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare and OIG audits and investigations.

The information in this session is intended to be educational and is not legal advice. No attorney-client relationship is created by way of this informational session.
Overview

Assess Your Billing Process’s Health

HTRC Technical Assistance

KPIs to Consider
Technical Assistance

- Up to **10 hours of telehealth support** as part of our funding
- Evaluation of telehealth program
- Link to resources at the local, state, regional, and national levels
- Outreach and Education:
  - HTRC Education Series
  - Telemedicine ECHO program

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Assessment

- Organizational/internal readiness
- Current state, planning, evaluation
- Technology, data, & digital assessment
- Reimbursements, billing, & funding
- Specialty services
- Community needs assessment

Get started with eSTART ✓

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Assessment
Reimbursements, Billing, & Coding: Planning for Sustainability

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We’ll examine the steps of the billing cycle and identify common pain points.

Assess Your Billing Process’s Health

A full wellness checkup on your billing process is a head to toe (or start to finish) assessment.
Scheduling: Demographic Information Collection
Head to Toe
Start to Finish

**Scheduling:** Demographic Information Collection

**Check-In/Log In:** Verification
Scheduling: Demographic Information Collection
Check-In/Log In: Verification
Rendering the Service: Timely, complete documentation
Scheduling: Demographic Information Collection
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Charge Capture: Ensuring charges for all services are captured
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Rendering the Service: Timely, complete documentation
Charge Capture: Ensuring charges for all services are captured
Billing Entry: Applies units of service, modifiers, and other claim form rules and ensures timely filing
Head to Toe
Start to Finish

**Scheduling:** Demographic Information Collection

**Check-In/Log In:** Verification

**Rendering the Service:** Timely, complete documentation

**Charge Capture:** Ensuring charges for all services are captured

**Billing Entry:** Applies units of service, modifiers, and other claim form rules and ensures timely filing

**Rejections/Denials:** Corrects errors, refile or appeal
Head to Toe
Start to Finish

**Scheduling:** Demographic Information Collection

**Check-In/Log In:** Verification

**Rendering the Service:** Timely, complete documentation

**Charge Capture:** Ensuring charges for all services are captured

**Billing Entry:** Applies units of service, modifiers, and other claim form rules and ensures timely filing

**Rejections/Denials:** Corrects errors, refile or appeal

**Payment Posting:** Is amount paid the amount expected?
Head to Toe
Start to Finish

**Scheduling:** Demographic Information Collection

**Check-In/Log In:** Verification

**Rendering the Service:** Timely, complete documentation

**Charge Capture:** Ensuring charges for all services are captured

**Billing Entry:** Applies units of service, modifiers, and other claim form rules and ensures timely filing

**Rejections/Denials:** Corrects errors, refile or appeal

**Payment Posting:** Is amount paid the amount expected?

**Patient Responsibility:** Are you sending statements the way in which they’re most likely to be paid?
• Process to collect accurate demographic data
  – DOB helps drive authority to consent and bill
  – Contact information may help expedite pre-visit electronic registration
  – If communicating electronically, confirm consent to do so

• Health plan, member ID, group ID
  – May impact what services can be rendered, and by whom
  – Is plan in-network?

• For telehealth, consider confirming location and state where patient will be during the scheduled telehealth session
  – Impacts professional licensure and service coverage

• Chief complaint
  – Is the complaint one that is appropriate for telehealth?
  – Examples: frequency limits (e.g. wellness visits); in-person requirements; more complex care needs; potentially new patient visits or controlled substance script refills
Scheduling

- Have you reduced your scheduling process to writing?
- Do you have a checklist or script for schedulers to follow?
- Do you have a feedback loop if subsequent processes reveal an error at the point of scheduling?
- Do schedulers have a list of services that may qualify for a telehealth visit and/or a list of those providers consider mandatory in-person visits?
Check In/Log In

- Obtain copy of ID, insurance card
- Verify patient’s location
- Verify patient identification
- Confirm all pre-appointment registration has been completed
Render the Service

- If video isn’t an option, patient declines, document this fact
- Document patient’s location
- Record any applicable consent (e.g. care management)
- Consider documenting the duration of service
- Create note timely (e.g. with 48 hours)
- Authenticate the note following signature requirements
Render the Service

- Do you run missing ticket reports?
- Do you run unsigned note reports?
- Is there a coverage policy for any of the services? If so, are you obtaining ABN or comparable financial responsibility?
- Are any special forms required other than the progress note (e.g. Medicaid HCY forms)
Charge Capture

• Does your system ‘capture’ charges; do your providers capture charges; and/or do you have team members who code or otherwise capture charges?

• Commonly missed items:
  – Advance care planning
  – Preventive with problem-oriented
  – Alcohol, depression screening
  – Tobacco use cessation
  – AWV
  – Prolonged services
  – New versus established
  – Different specialties/subspecialties
Billing Entry

• Ensure captured charges get entered
• Common points of error
  – Wrong procedure codes (e.g. CPT v HCPCS)
  – Wrong diagnosis code (e.g., non-covered)
  – Verify units of service (time based codes – does the midpoint rule apply? Therapy 8-minute rule)
  – Wrong modifiers, omitted modifiers (-25, -24, -57, -59, -95, -FS, -CS, -93)
  – Supervising provider
  – PC/TC billing locality
Rejections/Denials

- Rejections should be worked promptly; they have not been ‘received’ by the payor
- Consider entering denials by reason code
- Run rejection/denial reports; look for trends
- Common rejections/denials: are they preventable?
- Do you agree with the denial? Evaluate appeal options
Payment Posting

• Did you receive what you expected?
• Did you receive payment timely?
• Allowable = insurance + patient
• Allowable = contracted rate
• Below allowable? Look for reason codes
• Below allowable? Payor policies and trends
• Below allowable? Potential source for contract negotiation point
• No contract? Have you authorized discounts?
Patient Responsibility

• Mechanism to timely send statements
• Policies for any adjustments (e.g. bad debt, charity care, financial hardship, small balance, prompt payment)
• Risks of non-collection
KPIs can be established to meet your needs. Professional associations often publish benchmarks as guides.

**Common KPIs to Consider**

Key performance indicators help you monitor your billing process and track progress, aberrancies.
Common KPIs to Consider

- Payor Mix
- Wrong Payer Rejections
- Initial Denial Rate
- Final Denial Rate
- Discharged Not Final Billed (DNFB)
- Days in A/R
Questions?

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Available Through Heartland Telehealth Resource Center for Technical Assistance

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