

Missouri Department of Health and Senior Services

Billing for Public Health Services

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Assumptions

- Certain information in this presentation comes from a variety of sources such as:
 - CMS (their website cms.gov)
 - AHIMA, AAPC, Billing Companies, and STD-TAC
 - Various Public Health Agencies, Payers and Clearinghouses
 - Industry blogs, journals, etc.

Disclaimer: The materials for this course are for informational purposes only. Information on this topic does not constitute legal or business advice. Information in this course is provided without warranty of any kind, either expressed or implied, including but not limited to, the implied warranties of fitness for a particular purpose. Many policies, procedures, and codes will vary based on individual departments, services offered, and individual situations. Specific coding and payer guidelines should be reviewed prior to the submission of claims for reimbursement. Use of this material does not guarantee that claims have been formatted or submitted properly or that claims will be reimbursed as billing/coding requirements and insurance policies and coverage may change from time-to-time. It is the responsibility of every local health agency and agency to verify information as it pertains to their own individual agency or agency.

Objectives

- Understand why local public health agencies (LPHAs) should bill for public health services.
- Develop a general understanding of:
 - The billing process and guidelines for public health services.
 - How to bill Medicaid and Medicare for public health services provided through LPHAs.
 - How a clearinghouse fits in with billing and claims processing.
 - How to minimize denials through improved coding for services provided through LPHAs.
- Questions and Answers

Why bill for Public Health Services?

- Billing for public health services of insured individuals makes sense as a way to save money for federal, state, and local governments, assure proper stewardship of public funds and promote public and private payer participation in financing Missouri's public health programs.
- The 2010 Patient Protection and Affordable Care Act (PPACA) has increased the proportion of the population with insurance coverage for immunizations, strengthening the rationale for LPHA billing operations.

Why bill for Public Health Services?

- The costs of immunizing children and adults can place a burden on the scarce resources of LPHAs. State funding is provided in the form of Immunization Action Plan grants and State Aid for local public health activities.
- Ensure that compliance with state and federal programs such as the Vaccines for Children program and public third party payer requirements are maintained.

Delivery Models

- Local public health agency.
- Local public health agency partnering with community based organization(s) or individual physicians and other clinicians.
- Local public health agency partnering with laboratories.

Note: Some payers may categorize local public health agency clinics as “Rural health clinics”.

Services

- Screening/Evaluation
- Testing
- Diagnosis
- Monitoring
- Counseling
- Treatment

Providers

- Physician
- Nurse practitioner
- Physician assistant
- Peer counselors certified as Community Health Workers
- Community based organizations
- Laboratories

Foundations for Successful Billing- 3

Components

- Information System Capacity:
 - LPHAs need an information system or service that can provide:
 - Single-point patient data entry
 - Useful for multiple clinical service areas within an LPHA
 - Efficient data transmission
 - Electronic claim submission
 - Availability of service data for billing functions
 - Account reconciliation
 - Financial and statistical reporting capabilities
 - Data import and export capabilities

Foundations for Successful Billing- 3

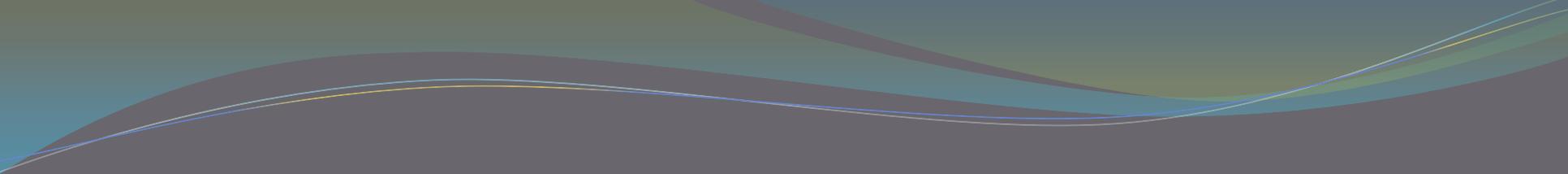
Components

- Third party relationships:
 - To obtain reimbursement for services provided to enrolled patients, LPHAs need to develop relationships with insurance plans, including:
 - Network agreements with insurance plans.
 - Credentialing of LPHA practitioners with insurance plans so that LPHAs can be reimbursed as network providers.
 - Clearinghouse agreements to enable streamlined LPHA communication with payers. These services may be free or require contract agreements.

Foundations for Successful Billing- 3

Components

- Workforce Capacity and Capability:
 - LPHAs need sufficient personnel resources to:
 - Handle scheduling and registration.
 - Submit claims, post payments and address outstanding accounts.
 - Handle electronic claims, enrollment process and submit paperwork for electronic funds transfer (EFT) deposits from payers.
 - Manage the health plan contracting and credentialing effort.
 - Handle IT support for software implementation, maintenance and troubleshooting.



Understand Billable and Non-billable Service Types

Identifiers Needed for Billing

- Taxonomy codes
- Tax Payer identification number
- Provider National Identifier number (NPI)

Taxonomy Codes

- In the medical billing and payment world, “provider taxonomy” refers to the national provider classification system defined by the Centers for Medicare and Medicaid Services (CMS).
- This national classification system was defined as part of the National Provider Identification (NPI) rule of the Health Insurance Portability and Accountability Act (HIPAA).
- The national provider taxonomy codes identify a provider’s type and area of specialization.
 - Taxonomy codes are 10 characters in length and include both letters and numerals. The first two digits are provider type, the next two digits are provider specialty, and the next five digits are provider subspecialty. The last character is reserved for future use so it will display as an “X.”

Tax Identification

- Tax ID = EIN (Employer Identification Number)
- Do you use the county's EIN or do you have your own?
- If you need a copy, request 147 C from IRS.
- If new Tax ID is required per your organization business structure, use IRS form SS-4 to apply.

National Provider Identifier (NPI)

- 10 digits
- <https://nppes.cms.hhs.gov>
- Individual = Type 1
- Organizational = Type 2
- If you wish to enroll as a group/org, you will need a type 2 NPI prior to applying (varying turnaround)
- Issued once; never expires or changes
- NPI registry (NPPES) accuracy is IMPORTANT-- SS#, DOB, Name spelling Systems talk to each other (SS PECOS MCS)
- Taxonomy chosen when you first get an NPI number, i.e.: specialty driven Mass Immunizer = 251K00000x (public health only)

National Provider Identifier (NPI)

- Every provider enrolling with an NPI number must have an NPI “base location” which is identified by three addresses the:
 - Physical location
 - Mailing address
 - Pay-to address
- The NPI base location is used to anchor all of the provider’s NPI-related specializations and related details.
- In situations where an LPHA utilizes multiple locations, each additional office or clinic is referred to as a NPI “servicing location” and referenced by two addresses: the location and mailing addresses.

Billable Service Types Could Be...

- Evaluation and Management Services
- Risk assessment counseling
- Information and pamphlets
- HIV/STD counseling and testing
- Linkage to Care & Patient Navigation/ Care Coordination/ Case Management
- Oral health
- Screening and treatment for:
 - HIV/AIDS/STDs

Non-billable Service Types

- Case management codes are not recognized by Medicare but other insurers may cover them, so it is important to check with the individual insurers.
 - Ryan White Funded Support Service

Understand Documentation Needed for Billing

Collect Billing Information

- Different sources
 - Providers
 - Clients
 - Insurers
 - Medicaid/Medicare
- From Clients/Insurers
 - Member number/Group number
 - Plan address
 - Beneficiary/Subscriber number
 - Client's social security number (may be optional)
- From Providers
 - Procedure and diagnosis information (CPT and ICD codes)

Understand Documentation Needed in Order to Bill

- Documentation within the health record must clearly support the procedures, services, and supplies coded.
- Accuracy, completeness, and timely documentation are essential, and LPHAs should have a policy that outlines these details.
- All services provided should be indicated on the Encounter Form/Superbill whether reportable or billable.
- Encounter forms should reflect the individual staff member's identification number assigned by the health agency's billing system.

Documentation Needed

- Documents might include:
 - The State Medicaid MCO model contract
 - The RFP summarizing the MCO's contractual obligations and the terms to be passed to providers
 - Draft contract between the MCO and your local public health agency/clinic and/or Community Based organization/provider
 - Exhibits
 - Referenced documents

Documentation Needed

- Documents might include:
 - Agency Certifications and Licensure – W-9, Liability Insurance, CLIA Certificate
 - Provider Numbers – LPHA NPI number, Medicaid or Medicare numbers
 - Documentation – charting of services
 - Coding – list of services and established fees you provide
 - Verification of Client Eligibility – knowing what the client is eligible for prior to providing service
 - Electronic Payment Management System – billing system able to receive electronic checks from providers

Policies

- LPHAs should have the following policies written and educate staff on:
 - List name of designated individual who will do the contracting, authorized signer, and that person's back up.
 - Confidentiality statement for person who is doing the contracting. (Have person sign it for compliance with HIPAA).
 - List of services provided by local health agency clinic.
 - List of contracted payers and provisions for services.
 - List of community based organizations and contact information.
- Key billing steps should be written and updated as changes are necessary or occur.

Review Contract Terms

- Review terms for:
 - Balance Billing - occurs when the LPHA bills the client for the difference between what they charge and the health insurance allowable amount.
 - Some contracts between insurers and LPHAs do not allow providers to balance bill. A provider who "Accepts Assignment" agrees not to balance bill patients.

Review Contract Terms (continued)

- Review terms for:
 - Fee-for-Service insurance - seldom pays 100% of what providers charge.
 - The "Allowable Amount" is the price that an insurance company will pay for a specific service.
 - This amount is based on a negotiated "Fee Schedule."
 - Sometimes it is based on the "Usual and Customary Charge" for providers in a given geographic area.

Fee Structures

- Fee schedules
- Fees and private insurance
- Standard fees for payers
 - Medicare
 - Medicaid
 - Private insurance
 - Self pay
- Payment policies
 - Sliding scale
 - Time of service/Cash discount

LPHA Service Charges

- The first “rule” to consider is that “your charge is your charge.”
 - For example, the LPHA may not vary their charge by payor source but may accept a variety of reimbursements as full payment for that service.
 - (e.g. The LPHA might have a charge of \$100 for a service, but accept as full payment: \$92 from Medicaid; \$85 from a particular industry in your community with whom you have negotiated a discounted rate; and \$0, \$20, \$40, \$60, \$80 or \$100 from self-pays, depending on where they fall on the sliding fee scale.)

LPHA Service Charges

- Situations may exist where the LPHA must bill visits to Medicaid one way and private insurance (3rd party payors) a different way.
 - Examples include: STD & TB (LPHA bills a T1002 to Medicaid while billing a 99211 to private insurance since private insurers do not recognize the T codes).

Payment Terms

- Claims submission
- Clean claims
- Payment methods
- Payment amount
- Payment timing
- Under and over payments
- Recoupment
- Dispute resolution

Superbills, Charge Tickets, and Encounter Forms

- Communication tool between clinician and biller describing what occurred during the encounter
- Electronic or paper – includes Diagnosis, CPT, modifiers
- Be careful with EHR templates and pre-assigned codes
- Is it up-to-date and reflective of all services provided?
- Can clinicians sequence and note co-equal diagnosis codes?
- Can modifiers be noted?
- Reminder - Only the person providing the services should complete the superbill

Billing Codes

- CPT
 - E/M
 - Procedure
- Modifiers
- ICD-10 Diagnosis
- HCPCS

Nurse Visits

- 99211 may be billed for certain services provided by a Nurse.
- Not all payers recognize this service.
- Patient must be established.
- Provider-patient encounter must be face-to-face.
- An E/M service must be provided.
 - Generally, this means that the patient's history is reviewed, a limited physical assessment is performed or some degree of decision making occurs.

Nurse Visits

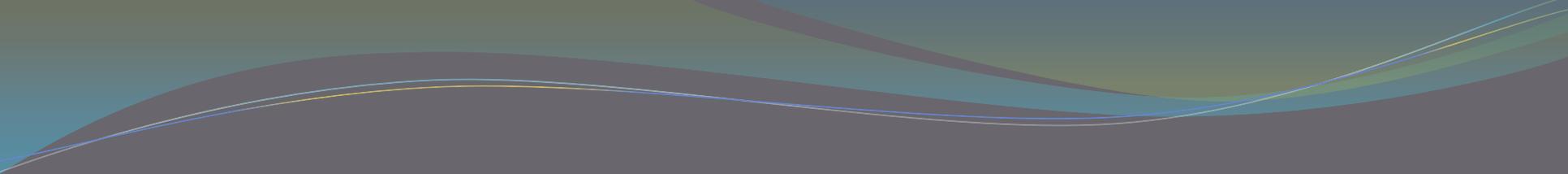
- Since 99211 is an E/M code, there are some minimal documentation requirements in order to meet medical necessity for use of the code
 - There must be a face to face encounter
 - Nature of the presenting problem with a diagnosis from prior visit with a clinician
 - Brief history of the problem
 - Documentation of vital signs (sole reason for visit should not be Blood Pressure check or Blood Draw)
 - Plan of care
 - Date/signature of the nurse or other provider

Services Not Billed Under 99211

- Administering routine medications by physician or staff whether or not an injection or infusion code is submitted separately on the claim
- Checking blood pressure when the information obtained does not lead to management of a condition or illness
- Drawing blood for laboratory analysis or for a complete blood count panel, or when performing other diagnostic tests whether or not a claim for the venipuncture or other diagnostic study test is submitted separately
- Faxing medical records

Services Not Billed Under 99211

- Making telephone calls to patients to report lab results and reschedule patient procedures
- Performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed, or payment is bundled with reimbursement for another service) whether or not the procedure code is submitted on the claim separately
- Recording lab results in medical records
- Reporting vaccines
- Writing prescriptions (new or refill) when no other evaluation and management is needed or performed



Understand Key Steps Needed for Billing

Billing Cycle

Work with Clearinghouse

Medical Coding

Client Data Entry

Claim Data Entry

Submit Claims

Claim Follow-up

Handle Insurance Denials and Re-submissions

Submits Claims to Secondary Payers

Process and Post Payments

Bill Clients

Work with Collection Agencies/Manage Clinic Write-Offs

Respond to Client Inquiries

Generate Reports

Collect payment at time of service

Billing Revenue Cycle

Elements of the Revenue Cycle	
Pre-Visit	<ul style="list-style-type: none">• Collect client information• Verify coverage• Determine client pay amounts• Communicate payment policies prior to service provision
Visit	<ul style="list-style-type: none">• For walk-ins collect client information and verify coverage• Collect client pay amounts (co-pay or co-insurance)• Document and code services provided
Post-Visit	<ul style="list-style-type: none">• Bill, collect and track payment for services

Billing Methods

- Billing Vendor
 - Outsourced billing services
- Billing Staff
 - Clinic staff bills to payer
 - Clearinghouse used by Clinic staff to bill

Bill Submission

Paper CMS
1500

- Mail
- Fax
- Email

Electronic File
Transfer (EFT)

- File saved to computer
- File is uploaded by other program(s)

Direct Data
Entry (DDE)

- Data entered on insurance website
- Logon to web based system

Remittance Methods

- Paper
 - Mail
 - Email (payment may come separately from remittance)
- Electronic
 - Sent directly to bank account through EFT
 - Clearinghouse
 - Payer makes on-line viewing and downloading of payment and/or remittance
- Auto-remit
 - Mail
 - EFT

Billing Requirements and Processes

- Distinguish between public health and private health policies and become familiar with minimum billing requirements.
- Assess your technical billing capabilities to identify the billing process that best fits your needs (i.e. use of paper claims versus electronic claims transactions; in house billing versus outsourcing to a clearinghouse or medical billing company).
- Learn what insurers want. There are a variety of ways to bill and products that span from large billing and provider-management systems to simple word processing and email.
- Ensure information is exchanged in a secure fashion.

Billing Requirements and Processes

- Identify the services you provide and the ones you want to bill for.
- Understand what processes are already in place.
 - You may already bill Medicaid, Medicare and your clients so you might not need to make that many changes.
- Identify processes, policies and resources needed to begin billing.
 - Once you know what your processes are, you can identify what changes are needed to begin billing.
 - Changes to processes are usually led or followed by changes to policies and resources.

Billing for Public Health Services

Note: Payer requirements may influence selection of diagnosis and procedure codes. Please refer to payer agreements for specifics.

Billing for Immunizations

- Based on services rendered, LPHA should select applicable diagnosis and/or procedure(s):

IMMUNIZATIONS	DX	CPT
DTAP	Z23	90700
Dtap /IPV	Z23	90696
Dtap /IPV/ Hep B	Z23	90723
Hep A Adult	Z23	90632
Hep A Child	Z23	90633
Hep B Adult	Z23	90746
Hep B Child	Z23	90744
Hep A / Hep B	Z23	90636
HIB	Z23	90648
HPV	Z23	90649
IPV	Z23	90713
MMR	Z23	90707
MMRV	Z23	90710
Meningococcal	Z23	90734
Pneumovax 23	Z23	90732
Prevnar 13	Z23	90670
Rotavirus	Z23	90681
Shingles	Z23	90736
TD	Z23	90714
Tdap	Z23	90715
Typhoid	Z23	90691
Varicella	Z23	90716
Vaccine Adm/1 Toxoid 0-18 yrs	Z23	90460
Add. Vaccine Adm./Toxoid 0-18	Z23	90461
Vaccine Administration 19+	Z23	90471
Additional Vaccine Adm. 19+	Z23	90472
Oral/intranasal Vaccine Adm.	Z23	90473

Billing for STDs/HIV

- Based on services rendered, LPHA should select applicable diagnoses and/or procedure(s):

STD	DX	CPT
Chlamydia Screen	Z11.8	87110
Gonorrhea Screen	Z11.3	87591
HIV Screen	Z11.59	86703
Syphilis Screen	Z11.3	86780
HIV Counseling-15 min	Z71.7	99211
STD Counseling-15 min	Z11.3	99211

Billing for Laboratory Services

- Based on services rendered, LPHA should select applicable diagnoses and/or procedure(s):

LAB SERVICES	DX	CPT
Blood Glucose Screening	Z13.1	82947
Hemoglobin (Finger stick)	Z00.129	85018
Lead Screening Child	Z00.129	83655
Pregnancy Testing-Negative	Z32.02	81025
Pregnancy Testing-Positive	Z32.01	81025
HIV Blood Draw	Z11.8	36415
Syphilis Blood Draw	Z11.3	36415
TB Skin Test-1 Step	Z11.1	86580
TB Skin Test-2 Step	Z11.1	86580
Urine Drug Screening (Collection Only)		
Capillary Blood Collection	Z00.129	36416

Billing for Nursing Services

- Based on services rendered, LPHA should select applicable diagnosis and/or procedure(s):

NURSING SERVICES	DX	CPT
Blood Pressure Screening		
Developmental Testing	Z00.129	96110
Head Lice Check/Recheck	Z11.8	99211
Health Risk Pre Natal	Z34.00	H1000
Health Risk Post Natal	Z13.89	99420
Hearing Screening	Z01.10	92551
Injections (serum provided by client, i.e. B12)		
Insulin Syringe Pre-fill (Max 2 weeks)		
Oral Medication Set Up (Max 2 Weeks)		
Routine Infant 0-12 Mo. NEW	Z00.129	99381
Routine Child 1-4 Yrs. NEW	Z00.129	99382
Routine Infant 0-12 Mo. EST.	Z00.129	99391
Routine Child 1-4 Yrs EST.	Z00.129	99392
Topical Fluoride Varnish	Z41.8	D1206
Vision Screening Child	Z01.00	99173

Billing for Flu Shots

- Based on services rendered, LPHA should select applicable diagnosis and/or procedure(s):

Flu Shots	DX	CPT
Pediatric 6-35 months	Z23	90685
Adult >3yrs	Z23	90686
High Dose 65+	Z23	90662
Flu Mist 2-49 Years	Z23	90672

Does the Biller Know...

Payment Rates:

- Can I get a list of the FFS payments by Evaluation and Management (E&M) code for office visits?
- Are enhanced payments available for care coordination? How do we apply for those enhanced payments?
- What is the plan's policy for timely payment?
- What is your plan's rate of denied claims for primary care visits? For infectious disease visits?

Does the Biller Know...

Access to Providers/Specialty Care:

- As an infectious diseases provider [or HIV primary care provider] – are referrals required for patients with HIV to see me?
- Can specialists serve as primary care providers for their patients?
- Does the insurer recognize HIV as a specialty or subspecialty?
- What is the plan's credentialing requirements for primary care providers, infectious disease specialists, nurse practitioners, physician assistants [or other clinicians in your practice]?

Does the Biller Know...

Access to Providers/Specialty Care:

- What access standards must the provider address?
 - For example, does the insurer have requirements regarding hours and days of operation, coverage during evening and weekend business hours, after-hour and on-call coverage when a designated provider is unavailable, maximum waiting time for an appointment, required intervals for providing specific services, and maximum waiting-room times?
- For private plans in the Marketplace: I receive Ryan White funding and am considered an Essential Community Provider (ECP). What is the process for contracting as an ECP?

Does the Biller Know...

Coverage and Benefits:

- Who determines medical necessity? Where are the criteria posted?
- What is the process for reconsideration of a determination that a service is not a medical necessity?
- Is an infectious diseases physician on the committee that makes formulary decisions?
- Is prior authorization required?

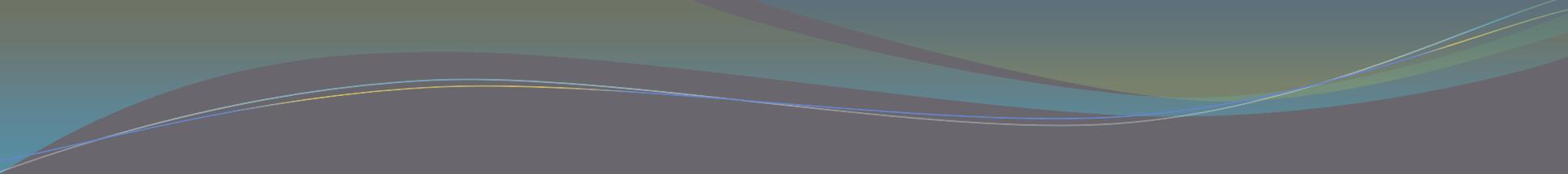
Does the Biller Know...

Coverage and Benefits:

- What is the plan's policy for covering CD4 count tests, viral load tests and genotype and phenotype resistance tests?
- Does your plan cover testing? If so, is there a restriction on the number of tests that may be covered per year?
- Are disease managers or case managers routinely assigned by your plan to patients with HIV? What is their role in coordinating care? What are their clinical training requirements and expertise?
- What utilization management and review procedures does the insurer employ?

Other Considerations...

- Is payment based on discount of full charges or fee-for-service?
- How much revenue will this insurance company create for the LPHA?
- What is the claim submission and reimbursement schedule?
- Are billing requirements and covered services clearly defined? (Balance Billing)
- Is client insurance coverage eligibility and verification easy to acquire?
- What is your staff capacity to manage the billing process?



Medicare and Medicaid Billing Guidelines and Process for Public Health Services

Medicaid/Medicare Billing Terminology

- Crossover: A claim billed to Medicaid for the Medicare deductible and/or coinsurance is called a crossover claim.
 - This type of claim has been approved or paid by Medicare.
- Deductible: The dollar amount Medicare recipients must pay for Part A or Part B services prior to receiving Medicare benefits.

Medicaid/Medicare Billing Terminology

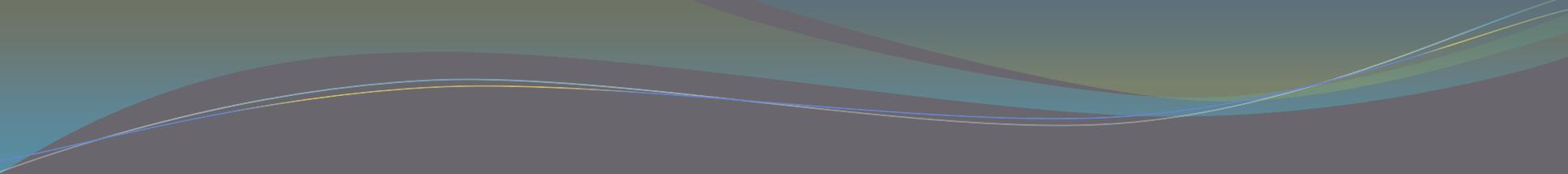
- **Coinsurance:** The remaining balance of the Medicare Allowed Amount after a Medicare payment.
- **Co-payments:** The amount required by Medicare Part C or D when services are rendered or drugs are purchased. (LPHAs may choose to waive these co-payments or may deny service if a recipient cannot pay this amount. Medicaid does not generally pay for co-payments.)
- **Health Insurance Claim (HIC) number:** The Medicare recipient's identification number.

Medicaid/Medicare Billing

- LPHAs now bill for services using the NPI of the provider who sees the client or for the provider/medical director who signs the standing orders for the nurse to provide the service.
- This means that services provided by nurses (including Enhanced Role Nurses) should be billed using the NPI of the physician who wrote the standing order to provide the examination.

Medicaid/Medicare Billing

- Further, nurses providing services for which they would bill a 99211 should bill that visit under the Medical Director's NPI unless there is a specific order from another physician for that particular client to support the visit.
- Physician Assistants (PAs) may now directly enroll with Medicaid so should bill under their own NPI.
- All services on the Encounter Form should continue to use the individual staff member's identification number assigned by the LPHA's billing system, whether reported or billed.
- LPHAs should verify each client's Medicaid eligibility prior to providing services.



Medicaid Billing Guidelines and Process

What is Medicaid?

- Medicaid is the nation's single largest source of health insurance for children and adults.
- Unlike the Medicare entitlement program, Medicaid is a means-tested, needs-based social welfare or social protection program rather than a social insurance program.
- Some people are eligible for both Medicare and Medicaid.

What is Medicaid?

- Medicaid is available only to certain low-income individuals and families who qualify for an eligibility group as determined by each state.
- Benefit packages for particular groups range from complete major medical to family planning or other specific services only.
- Usually, Medicaid reimbursement is considered payment in full.

Types of Medicaid Coverage

- Benefit Services Packages are different types of coverage offered through the Medicaid program.
 - Examples of packages include:
 - QMB (Qualifying Medicare Benefits Only)
 - Family Planning Only
 - Primary Insurance and Medicaid
 - CNP (Categorically Needy Program)
 - GAU (General Assistance—Unemployable)
 - LCP—MNP (Limited Casualty Program— Medically Needy Program)

Medicaid Member Eligible for Medicare

WHAT IF...the Medicaid Member is also eligible for Medicare?

SERVICE BY MEDICAID PROGRAM	MEDICARE	MEDICAID
Health Check/Immunization	Does not Cover	Primary Payer
Family Planning	Does not Cover	Primary Payer
Perinatal Case Management/Pregnancy Related Services	Does not Cover	Primary Payer
Dental Services (Health Check, Adult)	Does not Cover	Primary Payer
Adult Services/Immunizations	Primary Payer-Flu, Pneumonia, Hep B; MNT; Preventive Services	Secondary Payer
Nurse Practitioner/Physician Services	Primary Payer	Secondary Payer

Medicaid Member Eligible for Other Coverage

WHAT IF...the Medicaid Member is also eligible for other private insurance coverage?

SERVICE BY MEDICAID PROGRAM	PRIVATE INSURANCE	MEDICAID
Health Check/Immunizations	N/A	Primary Payer
Perinatal Case Management/Pregnancy Related Services	N/A	Primary Payer
Family Planning	COB REQUIRED	
Adult Services/Immunizations	COB REQUIRED	
Nurse Practitioner/Physician Services	COB REQUIRED	
Dental Services (Health Check, Adult)	COB REQUIRED	

Medicaid Claims Filing

- LPHAs must take all reasonable measures to determine a 3rd Party Payer's liability for covered services prior to filing a Medicaid claim.
- If a 3rd party insurance plan denies or pays insufficiently the applicable reimbursement rate, a LPHA may submit a claim to be paid the applicable reimbursement rate minus any reimbursement received from other resources.
- These claims must be billed to Medicaid within 3 months of the date of the denial/payment but not more than 12 months from the date of service.
- Claims that do not generate a response from the carrier may be filed with Medicaid using the COB Notification Form.

Medicaid Claims Filing

- Medicaid is always the last payer so be sure to determine if another payer exists.
- The LPHA will be required in most instances to submit an Explanation of Medicare Benefits (EOMB) from Medicare or an Explanation of Benefits (EOB) from another primary insurer as backup to Medicaid claims.
- If Medicare NEVER covers a procedure code, the LPHA can bill it directly to Medicaid.
- If Medicare sometimes covers the service, Medicare must be billed first.

Medicaid Claims Filing

- If the LPHA intends to bill Medicaid on paper, paper billing requires the use of CMS-1500 claim forms.
- Medicare crossover claims are also submitted on the CMS-1500 form.
- The only acceptable claim forms are printed in Flint J-6983 Red OCR Ink (or exact match).
- A remittance and status report (RA) is a report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.
- Clearinghouses refer to RAs as “835s.”

Medicaid Billing - Immunizations

- Medicaid has a variety of programs under which immunizations are covered.
 - *Vaccine for Children (VFC) Program Eligibility*
Any child 18 years of age or younger who meets at least one of the following criteria is eligible for the VFC Program:
 - Eligible for Medicaid Title XIX (19).
 - American Indian or Alaska Native, as defined by the Indian Health Services Act.
 - Uninsured.
 - Underinsured.

Medicaid Billing - Immunizations

- Underinsured –includes those who are insured, but plan doesn't cover vaccines or doesn't cover all ACIP recommended vaccines. The person would be VFC eligible only for the vaccines not covered by the private insurance. Person's policies that have a high or unmet deductible, copay or coinsurance are not considered to be “underinsured”.
 - LPHAs that have a signed deputization agreement with a federally qualified health center (FQHC) or rural health clinic (RHC) can administer VFC vaccine and collect the administration fee, or waive based on family's ability to pay.
 - Note: Private VFC providers must refer underinsured patient to a deputized LPHA, FQHC, or RHC; underinsured children cannot receive immunizations from a private health care provider using VFC vaccine.

Medicaid Billing - Immunizations

- *Vaccines for Children 18 Years of Age or Younger*

Vaccines provided to members 18 years of age or younger who are Medicaid Title XIX (19) eligible are available through the federal VFC Program at no cost to the provider.

- Vaccines that are commonly combined are not separately reimbursable unless the medical necessity for separate administration of the vaccine is documented in the member's medical record.

Medicaid Billing - Immunizations

- If a patient encounter occurs in addition to the administration of the injection, LPHAs may receive reimbursement for the appropriate evaluation and management (E&M) procedure code that reflects the level of service provided at the time of the vaccination.
- If an immunization is the only service provided, the lowest level E&M office or other outpatient service procedure code may be reimbursed, in addition to the appropriate vaccine procedure code(s).

Medicaid Billable Service Type

- Medicaid eligible individuals enrolled through one of the Medicaid Health Plans may receive treatment services for STD/HIV and other communicable diseases from local public health agencies without prior authorization.
- Medicaid Health Plans are required to cover all services on the Medicaid fee schedule as defined in the Medicaid State Plan.

Medicaid Billing - STDs

- Traditional Medicaid, or fee-for-service Medicaid, allows for the coverage of diagnosis and treatment of HIV/AIDS and STDs with the same level of benefits as Medicaid Health Plans.
- Traditional Medicaid would be required to cover family planning services with no out-of-pocket cost and services for STDs and HIV/AIDS testing.
- It is important to check eligibility for all previously uninsured members so that payment can be received from traditional Medicaid.
- This is preferable to covering services through Ryan White or not receiving payment for services rendered.

Medicaid Billing - Labs

- Bill laboratory codes for laboratory tests done on site.
 - CPT Code 36415 = one venipuncture collection fee when the lab work is sent out to an outside lab regardless of the number of specimens drawn.
 - CPT Code 99000 = handling, transfer and/or conveyance of specimen from LPHA to another laboratory.
- Medicaid does not reimburse for a 99000 but 3rd party payers do.
 - Remember: if you bill this code you have to bill it to everyone including self-pay patients.
 - Once you get a denial from Medicaid on the 99000, you do not have to keep billing the code to Medicaid.
 - Put this process in your billing policies.

Medicaid Billing – Child Health Services

- Child Health Periodic and Interperiodic visits are all coded to Health Check (HC) program type in HIS regardless of payor source, but be sure to use the EP modifier when the payor source is Medicaid.
- This includes all components for the periodic and interperiodic visit types using the EP modifier including:
 - Immunization administration
 - Vision
 - Hearing
 - Developmental and health risk assessments
 - Behavioral risk assessment codes

Medicaid Billing – Child Health Services

- Developmental Screening (ASQ or PEDS) 96110 is required for ages 6, 12, 18 or 24 months and 3, 4 and 5 years.
- It is part of the required service for these Health Check visits and must be reported with visit.

Medicaid EOB Privacy

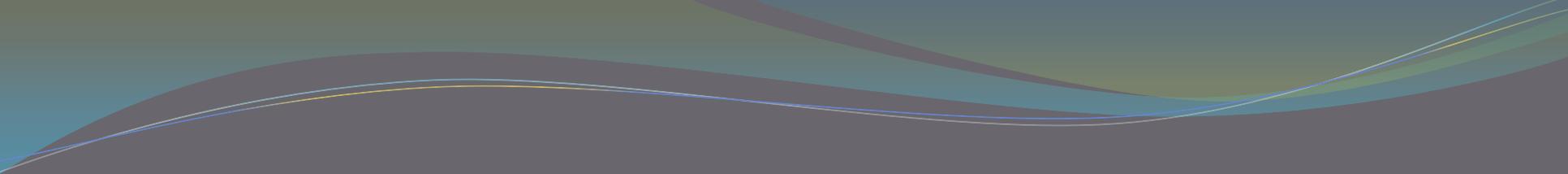
- Medicaid/Medicaid Health Plans are precluded from printing any EOBs with sensitive information.
- Patients who seek services at the LPHA or STD/HIV resource centers should be made aware that billing Medicaid fee for service or Medicaid Health Plans will not result in an EOB sent to the member's address.
- Medicaid Health plans must prove to the State through annual audits that the privacy and security of this information is protected at all times.

Key Steps to Billing Medicaid

- Determine providers and services that are reimbursable.
- Determine codes and establish system to track services provided.
- Pay particular attention to Medicaid Specific Modifiers:
 - EP modifiers are used for immunizations, preventive visits and other services under Health Check.
 - FP modifiers are used in Family Planning program type with Family Planning related services.
 - TJ modifiers are used for immunizations, preventive visits and other services under Health Choice.
 - UD modifiers are used to identify contraceptives purchased with 340b pricing.

Key Steps to Billing Medicaid

- Establish system to determine Medicaid eligibility for clients and patients.
- Bill State directly for services provided.



Medicare Billing Guidelines and Process

What is Medicare?

- Medicare is the nation's largest health insurance program.
- It was established by the U.S. Congress in 1965.
- Medicare provides care for people over 65 and people of all ages with certain disabilities.
- Doctor's services, outpatient care, and other medical services, such as immunization, are covered under Part B of the program.

What is Medicare?

- LPHAs must enroll in the Medicare program to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries.
- LPHAs must enroll even if immunizations are the only service they will provide to beneficiaries.
- The Medicare enrollment application for LPHAs is Form CMS 855B (Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers).
- LPHAs should complete the online application through the CMS Provider Enrollment, Chain and Ownership System (PECOS) or download and print a paper copy of Form CMS 855B at the Medicare Provider Supplier Enrollment website.

What is Medicare?

- PECOS and Form CMS-855B will ask the LPHA to properly identify its supplier type. Most LPHAs fall into the category of “Mass Immunizer” or “Other.”
- If your LPHA provides Part B services in addition to the influenza virus and/or pneumococcal vaccinations and wishes to bill for these other services, identify your clinic or organization as “Other”.
- If the LPHA will bill Medicare only for mass immunization programs, enroll as a Mass Immunizer.

Medicare Health Care Coverage

- **Scope of Coverage:** Medicare divides its services into specific classifications: Part A, Part B, Part C and Part D. Recipients may be covered for Part A only, Part B only, Part D only or a combination of services.

Service Type	Description
Part A	Inpatient Hospital Services, Skilled Nursing Facility Services, Hospice, and Home Health Care
Part B	Outpatient Hospital Services, Physician Services, and Home Health (if recipient is Part B eligible only)
Part C	Medicare Advantage Plans (MSA/PFFS/SNP/HMO/PPO – not crossover claims)
Part D	Prescription drugs not covered by Parts A, B or C (not crossover claims)

Medicaid/Medicare Claims Filing Time Limits

<u>Medicaid</u>	Submission: 6 months after the date of service. Appeals/Payment Disputes: Within 3 months of the month in which the denial occurred.
<u>Medicare</u>	Submission: Claims must be received within 1 calendar year from the date of service. Appeals/Reconsiderations: Must be submitted within 6 months of the date on the notice of redetermination letter.

Medicare Crossover Claims

- **Crossover Claims:** A Medicare crossover claim is any claim that is approved by Medicare and then sent to Medicaid for consideration of payment not to exceed the sum of the Medicare
- The claim must be approved by Medicare in order to be considered a crossover claim. “Approved” does not mean paid; sometimes the charges approved by Medicare are applied to the deductible. In these situations, the claim is approved, but no payment is made by Medicare.
- It is important to remember that claims that are denied by Medicare are not crossover claims. If a member is a Qualified Medicare Beneficiary (QMB) and Medicare denies the claim, do not bill Medicaid.

Medicare Crossover Claims

- The receipt of a crossover claim by Medicaid does not mean that Medicaid will make a payment on the claim.
- If Medicaid approves the claim, a payment of the sum of the coinsurance and deductible may be made.

Medicare Billing Immunizations

- For the most part, covered under Medicare Parts B and D.
- Any individual or entity meeting State licensure requirements may qualify to bill Medicare for furnishing and administering the influenza and/or pneumococcal vaccines to Medicare beneficiaries enrolled under Part B.
- Medicare Part B pays for pneumococcal vaccines, influenza virus vaccines, and their administration without coinsurance or deductibles.
- It is inappropriate to require a client to pay for the vaccination up front and to file their own claim for reimbursement.
- All Medicare providers are required to file claims on behalf of the client per §1848(g)(4)(A) of the Social Security Act.

Medicare Billing Immunizations

- A mass immunizer offers seasonal influenza virus and/or pneumococcal vaccinations to a large number of individuals.
- A mass immunizer may be a traditional Medicare provider or supplier or a non-traditional provider or supplier (such as a senior citizens' center, a public health clinic, or a community pharmacy).
- Mass immunizers must submit claims for immunizations on roster bills and must accept assignment on both the vaccine and its administration.
- A mass immunizer should enroll with the Medicare Administrative Contractor (MAC) prior to each influenza season.

Medicare Roster Billing

- Roster billers must use CMS-1500 claim forms that are preprinted to include standardized information particular to the LPHA.
- A single copy of the completed CMS-1500 form is then attached to each completed roster form.
- LPHAs submitting Part B claims are not required to immunize at least five beneficiaries on the same date in order to qualify for roster billing.
- However, the rosters should not be used for single patient bills, and the date of service for each vaccination administered must be entered.

Medicare Roster Billing

- LPHAs that do not mass immunize should continue to bill for the influenza and pneumococcal vaccine using the normal billing method, i.e., submission of a CMS-1500 form or electronic billing for each client.
- The LPHA will still be required to accept assignment on vaccine.

Medicare Electronic Billing

- CMS generally requires electronic submission of billing claims through the Medicare Electronic Data Interchange (EDI) and submission of electronic media claims (EMC).
- EDI allows for electronic transmission of roster claims as well.

Medicare Electronic Billing

- The claim is electronically transmitted in data “packets” from the provider’s computer system to the Medicare contractor’s.
- The Medicare contractor then performs a series of edits.
- The initial edits are to determine if the claims in a batch meet the basic requirements of the HIPAA standard.
- If errors are detected at this level, the entire batch of claims would be rejected for correction and resubmission.

Medicare Electronic Billing

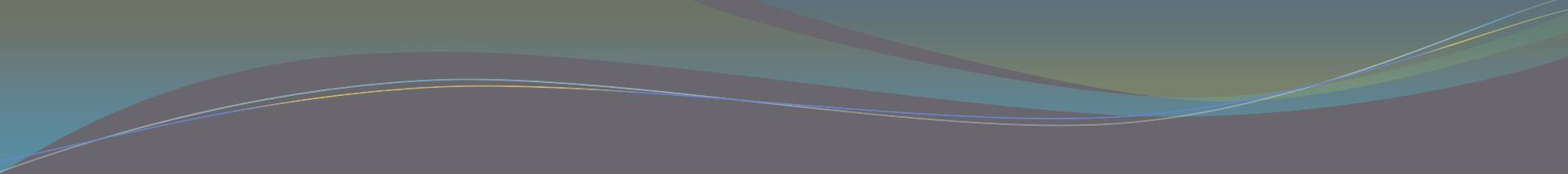
- Claims that pass these initial edits, commonly known as front-end edits or pre-edits, are then edited against implementation guide requirements in those HIPAA claim standards.
- If errors are detected at this level, only the individual claims that included those errors would be rejected for correction and resubmission.
- Once the first two levels of edits are passed, each claim is edited for compliance with Medicare coverage and payment policy requirements.
- Edits at this level could result in rejection of individual claims for correction, or denial of individual claims.

Medicare Electronic Billing

- In each case, the submitter of the batch or of the individual claims is sent a response that indicates the error to be corrected or the reason for the denial.
- After successful transmission, an acknowledgement report is generated and is either transmitted back to the submitter of each claim, or placed in an electronic mailbox for downloading by that submitter.
- Additionally, if your LPHA will need to submit claims to multiple payers, it will require billing staff to understand multiple transmission methods, error codes, claim status reports, file names and file types.

Medicare Billing STD

- Medicare Part B covers HIV screenings and sexually transmitted disease (STD) screenings for chlamydia, gonorrhea, syphilis and/or Hepatitis B once every 12 months or at certain times during pregnancy.
- Those with Medicare Part B who are at increased risk for STDs can also receive up to 2 individual 20 to 30 minute, face-to-face, high-intensity behavioral counseling sessions each year.



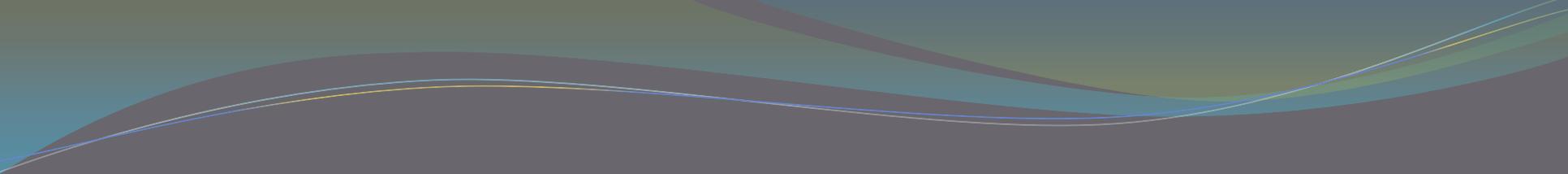
How a Clearinghouse Fits in with Billing and Claims Processing

What is a Clearinghouse?

- It is an entity that receives the electronic transmission of claims from the local health agency (LPHA) and translates it into a standard format prescribed in HIPAA regulations.
- Clearinghouses are considered “covered entities” therefore need to be HIPAA compliant.

What is a Clearinghouse?

- According to HIPAA:
 - “Health Care Clearinghouse: Under HIPAA, this is an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.”



How to Tell if You Need One

How to Tell if You Need One

Answer these questions:

- Does the LPHA bill (or plan to soon bill) electronically?
- Does the LPHA bill a number of insurances; ..or just one?
- Is the LPHA staff experienced at billing electronically? (The less experience, the greater the need, and greater the benefit).
- What is the LPHA claim volume? The cost of a clearinghouse is often offset by no longer having to send in paper claims.

How to Tell if You Need One

- Would it help to quickly and greatly reduce medical claim errors?
- Would it help to drastically shorten reimbursement times?
- Do you have better things to do than be on hold with Medicare, Blue Cross and other payers trying to figure out claim errors?

Electronic Data Interchange (EDI)

Electronic Data Interchange (EDI)

- Used for transmission of health insurance claims
- Transmitted data is encrypted
- Improves efficiency of claims submissions

Benefits of Electronic Claim Submission

- No searching for an insurance carrier's address
- No signatures or stamps
- No postage costs or trips to post office
- No need to store or file claim forms
- Electronic claims leave an audit trail
- Improved cash flow
- Quicker processing time and payment
- Reduced overhead and labor costs

Methods for Sending Claims

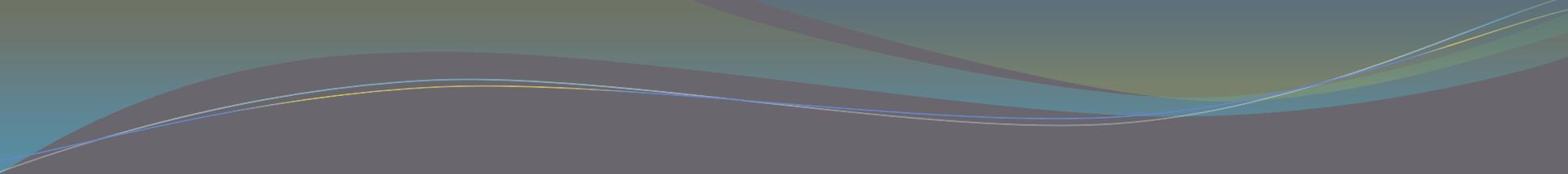
- Cable modem
- Digital subscriber line (DSL)
- T-1
- Direct data entry (DDE)
- Application service provider (ASP)

Computer Claims Systems

- Insurance Carrier-direct
 - The LPHA has its own computer and software to process claims.
 - The insurer sometimes leases a dedicated terminal to the LPHA.
- Clearinghouse
 - The LPHA sends paper claims or a disk or tape to the clearinghouse, which forwards a batch of claims to the insurer.

Transmission Reports

- Send and receive files and reports
- Scrubber report
- Transaction transmission summary
- Rejection analysis report
- Electronic inquiry or claims status review



Potential Clearinghouse Services

Clearinghouse Services

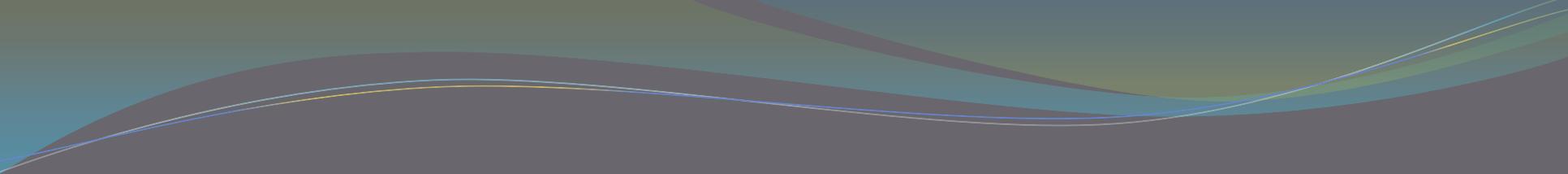
- **Eligibility Verification** – Determine patient portion before appointment
- **Electronic Remittance Advice (ERA)** – Automatically updates Payments & Adjustments
- **Claim Status Reports** – Know the status of a claim at all times
- **Rejection Analysis** – Have error codes explained in plain English
- **Online Access** – Edit and correct claims day or night online

Clearinghouse Services

- **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.

Clearinghouse Services

- **Real-time Support** – The best clearing houses offer 1-on-1 personal support and training provided by experienced billers.
- **Affordability** – When you take into consideration the cost of purchasing forms, the cost of printing, envelopes, postage, and time spent; a clearinghouse ends up costing far less than processing paper claims, plus electronically you have the many added benefits.



Benefits of a Clearinghouse

Benefits of a Clearinghouse

- Translation of various formats to the HIPAA-compliant standard format
- Reduction in time of claims preparation
 - Reduces or eliminates need for paper forms, envelopes and stamps.
 - Eliminates the need to prepare claims and manually re-key transaction data over and over for each payer.
- Cost-effective method through loss prevention

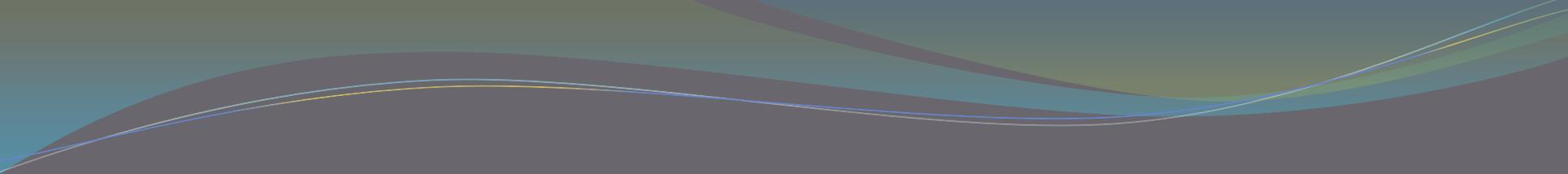
Benefits of a Clearinghouse

- Fewer claims rejections
 - Allows biller to catch error and correct prior to sending.
- Fewer delays in processing and quicker response time
 - Submit electronic claims in a batch at once, rather than submitting separately to each individual payer.
- More accurate coding with claims edits
- Consistent reimbursement
- Proof of timely filing

Reasons for Not Choosing a Clearinghouse

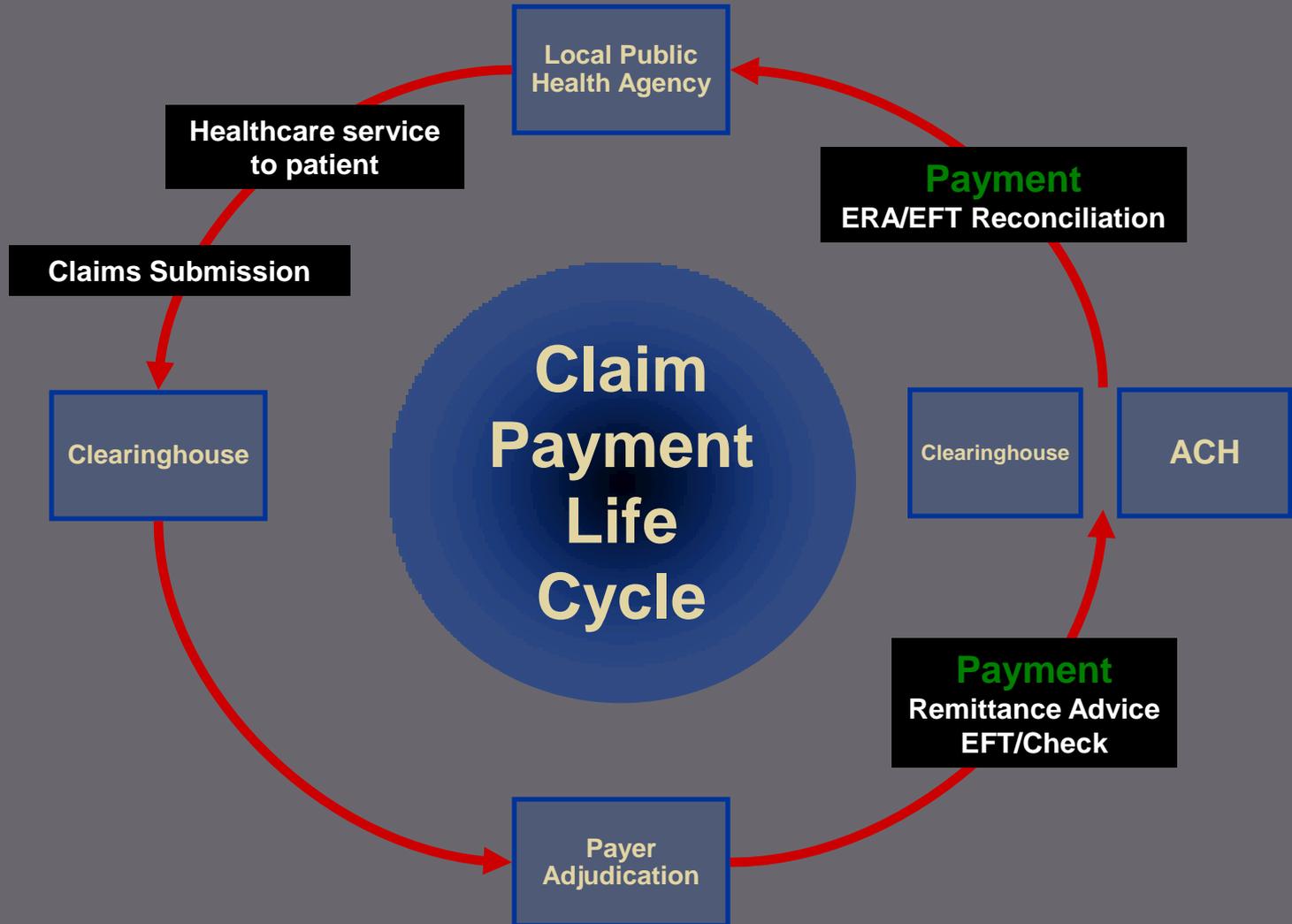
Reasons for Not Choosing a Clearinghouse

- Many large payers such as Medicaid, Medicare or BlueCross do their own claim processing and allow you to submit claim information directly to them. Here are the advantages:
 - Ability to submit claims directly to the payer without a middleman
 - Free claims. No recurring fees.



How a Clearinghouse Fits in With Claims Payment Cycle

Standard Electronic Claim Payment Cycle



How a Clearinghouse works...

- Medical billing software on LPHA's desktop would create an electronic file (the claim) known as the ANSI-X12 837 file.
- The electronic file is then uploaded (sent) to the medical billing clearinghouse account.
- The clearinghouse then scrubs the claim checking it for errors (arguably the most important thing a clearinghouse does).
 - For example, if the date of birth is missing on the claim, the clearinghouse will flag the claim as incomplete and sends it back to the LPHA.

How a Clearinghouse works...

- Once the claim passes inspection, the clearinghouse securely transmits the electronic claim to the specified payer with which it has already established a secure connection that meets the strict standards laid down by a HIPAA.
 - (Medical claims are also known technically as ‘HIPAA Transactions’, and it is because of HIPAA that we cannot send claims for patient billing to insurance payers simply by email.)

How a Clearinghouse works...

- Claim is either accepted or rejected by the payer.
- A status message is usually sent back to the clearinghouse.
- Clearinghouse updates that particular claim's status in your control panel.
- If claim is rejected, you have a chance to make any needed corrections and then re-submit the claim.
- Assuming there are no other corrections required, and the patient's insurance was verified before hand, you'll receive a reimbursement check along with an explanation of benefits (EOB).

How a Clearinghouse works...

Common reasons for rejected claims:

- Member not found.
- Member Identification Number
 - Submit the ID number as displayed on the patient's ID card.

How a Clearinghouse works...

Common reasons for rejected claims:

- Patient Date of Birth (in the subscriber or patient loop as applicable)
 - Submit a valid, correct date of birth for the patient.
 - Do not send "00" for the month or date.
 - Do not send dummy dates such as "17760704".
 - Do not send a date of birth greater than the date of service.

How a Clearinghouse works...

Common reasons for rejected claims (continued):

- A claim will be rejected if the date of birth does not match the date of birth on file in the Clearinghouse system.
 - If this is the case, please verify the patient date of birth with the patient or policyholder.
- Date Format Submit all dates in the following format CCYYMMDD unless otherwise specified.
 - Submit valid dates of service.
 - Do not submit future dates of service.

How a Clearinghouse works...

Common reasons for rejected claims (continued):

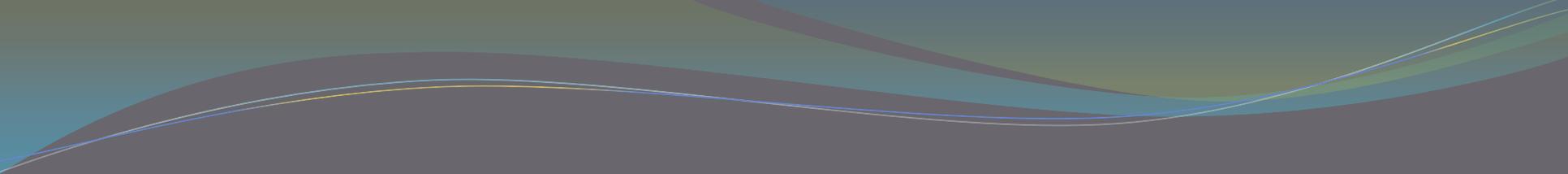
- **Monetary Amount Format:** Include the decimal point in all monetary amounts unless otherwise specified.
 - Do not submit negative dollar amounts.
- **Coding Detail:** Consider the following when verifying service codes and/or modifiers that have been rejected.
 - Submit service codes and modifiers appropriate to the age and gender of the patient.
 - Submit service codes and modifiers appropriate to the date of service.
 - Submit service codes to their greatest level of specificity.

How a Clearinghouse works...

- Claim volume is a significant factor in working with a clearinghouse.
 - May charge:
 - A monthly flat fee
 - Claim transaction fee based on volume
- If there is a fairly low volume of claims (less than 500 per month), a monthly flat fee may be more cost effective.

LPHAs Procedure for Claim Transmission

1. Set up the database.
2. Enter data.
3. Batch or compile a group of claims.
4. Connect the computerized database with the clearinghouse or direct to the payer.
5. Transmit the claims.
6. Review the clearinghouse reports.



Questions to Ask a Clearinghouse

Questions to ask...

- What is the enrollment and set up process going to require?
- Do they offer training for LPHA staff?
- What type of commitment is required? Can you do month-to-month service?
- Is their support team knowledgeable about the services the LPHA provides?
- What do the existing customers using clearinghouse say about them? (testimonials)

Questions to ask...

- Does the clearinghouse support HIPAA? If so, which transactions and version?
- What is your current status for format compliance with HIPAA?
- Has your software been certified by a third party certification vendor and by the payers?
- When will my software be available to use?
- How will I receive my HIPAA compliant software?
- Will my system require hardware as well as software upgrades?

Questions to ask...

- Cost and support? What is included, what is not?
- Will I need to establish relationship with new vendors/clearinghouses to support this transaction?
- Will my software allow me to submit void and replace transactions?
- Will my software allow me to receive and integrate an 835 transaction?
- When can I test with payers?

Questions to ask...

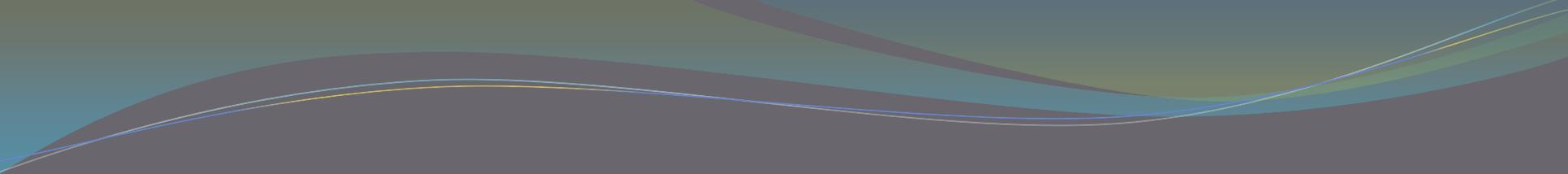
- How will the clearinghouse affect the current LPHA system and workflow?
- Does the clearinghouse offer access to payers that represent a significant portion of who LPHA bills?
- What is the relationship between the payer and clearinghouse?
- How are the charges to the LPHA assessed (e.g.: Monthly, per user, per transaction)?
- What is the typical term for payment (e.g.: net 10, 15, 30 days)?
- What method of payment is acceptable?

Questions to ask...

- What are the system requirements for the LPHA?
- What is the clearinghouse claims transaction process for gathering data from the LPHA and submitting the claim to the payer?
- Does the clearinghouse allow for real-time connection and resubmission of claims to all payers accessed through the clearinghouse?

Questions to ask...

- What additional services does the clearinghouse offer and, if applicable, what are the charges?
- What types of reports does the clearinghouse provide to the LPHA regarding claims submission and payment?



Steps to Selecting a Clearinghouse

Steps to Selecting a Clearinghouse

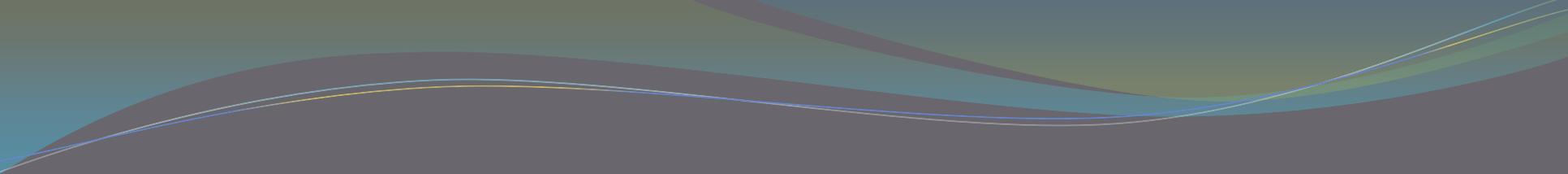
- Review the payer lists from the clearinghouse website and make sure the insurance carriers the LPHA bills are on the list and that they have a large number of payers.
- If you are planning to use a clearinghouse for Medicaid, confirm that they are familiar with submission regulations for Medicaid, as they vary widely from state to state.
- Try contacting the clearinghouse support line to ensure there is timely service and response.
- Confirm and demo the claims acknowledgement reports.

Steps to Selecting a Clearinghouse

- Review the terms of contract and steps for terminating contract if needed.
- Confirm there is online access to update, track, and manage the claims that were submitted and electronic remittance advice downloads.
- Understand enrollment process and documentation needed to set up account(s) with clearinghouse.

Steps to Acquiring a Clearinghouse

- Contact the customer service line of the selected clearinghouse and request the documents that are needed to be filled out in order to enroll for their services.
- Once there is approval, then have the designated LPHA staff person complete the documents and submit to the clearinghouse contact person.
- Review the payer lists in the LPHA's system and update the list to include the payer number assigned by the clearinghouse.
- Contact the clearinghouse technical support to schedule the training and testing.



Documentation and information needed by a clearinghouse

LPHA Information

- LPHA Name
- LPHA Federal Tax ID
- NPI (Billing) – only pay-to NPIs are required. For multiple NPIs attach a list to the enrollment form.
- Medicare PTAN is required if Medicare 837 is marked. If PTAN is not provided Medicare setup will not be completed. For Multiple PTANs attach a list to the enrollment form.
- Submitter Number - write NEW if applying for a submitter number .
- Complete address, phone number and e-mail address is required.

Examples of Clearinghouses

- Navicure
- Apex EDI
- CompuClaim
- ZirMed
- Gateway EDI
- ENS Health
- RealMed
- HeW
- TransactRx

- Emdeon
- MD-Online/MCC
- RelayHealth
- Ingenix
- HealthSmart
- NHS Net Healthclaims
- Datatrans Solutions
- Upp Technology/Harris
Public Health Solutions

How Payment Denial is Defined

Clean Claims

- “A claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that otherwise prevents timely payment being made on the claim...”
- What is the LPHAs’ ‘clean claim rate’?
 - Percent of money paid the first time without re-submitting?
 - When claims get denied, what happens?
 - Charts go back to staff for review?
 - Internal Audits completed?

Denials as Payment Discrepancies

Denial

- A refusal to pay as a result of the provider not adhering to insurance company policies/procedures, or pending receipt of additional information

Underpayment

- Incorrect payment resulting from pricing inaccuracies or differences in contract interpretation

“Lost” Revenue

- Undetected Underpayments
- Incorrect payment due to incomplete or inaccurate billing.
- Charges or codes are missing from the bill and are thus never considered for payment

Types of Denials

Hard Denials

(Appeal Required)

- Denied days, service, or level of care for no concurrent authorization
- Denied as not financially responsible
- Denied as not a covered service
- Denied charge/procedure as bundled
- Denied for untimely submission

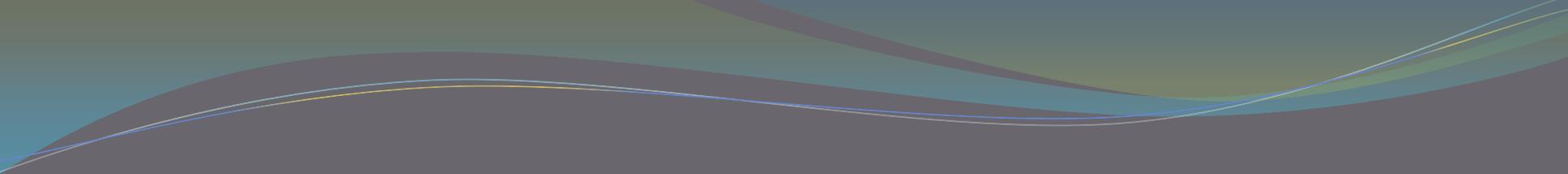
Soft Denials

(Additional Information Required)

- Denied claim due to missing/inaccurate information
- Denied claim due to charge/coding issues
- Denied charges pending receipt of itemized bill
- Denied drug/implant reimbursement pending receipt of invoice
- Denied secondary payment pending receipt of primary EOB

Common Denials

- Patient not eligible
- No authorization
- Not medically necessary
- Incorrect codes
- Duplicate claim
- Non-covered
- General technical billing errors i.e. Incorrect subscriber ID, missing info on UB format, etc...
- Timely filing
- Additional data is required



Understand Documentation Needed

In Order to Bill Services...

LPHAs should:

- Document services in the Medical Record
- Capture WHAT services LPHA provides – CPT / HCPCS
- Capture WHY LPHA did the services – ICD
- Document any special circumstances – Modifiers

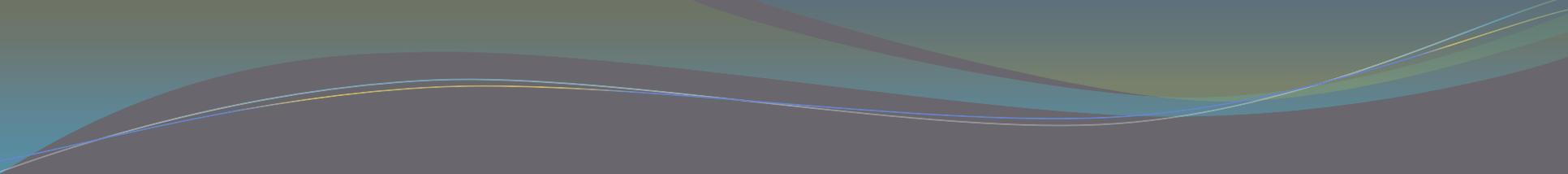
Why document?

- Improves compliance
- Improves patient care
- Improves clinical data for research and education
- Protects the legal interest of the patient, facility and clinician
- Enables proper reimbursement for services performed

If it isn't documented – it can't be coded and ultimately billed! It didn't happen.

Billing Documents- Superbill/Encounter Form

- Communication tool between clinician and biller describing what occurred during the encounter
 - Electronic or paper – includes Diagnosis, CPT, modifiers
 - Be careful with EHR templates and pre-assigned codes
- Is it up-to-date and reflective of all services provided?
- Can clinicians sequence and note co-equal diagnosis codes?
- Can modifiers be noted?



Key Steps to Minimizing Denials

Key Steps to Minimizing Denials

- Don't rely entirely on the claim scrubber. Claim scrubber software analyzes data on a claim to ensure accuracy before the claim is submitted. Although scrubbers catch many errors before claims are sent, they don't catch 100% of them.
 - For example, the software can't scan documentation to ensure that a particular ICD-10 code is justified. Thus, LPHAs may be surprised when certain codes pass through the scrubber because they meet medical necessity only to be subsequently denied by insurers because documentation may not justify their assignment.
- Claim scrubbers also don't catch every modifier-related error. Although some software flags claims for which modifiers might be missing, it won't catch errors on claims for which modifiers are already appended incorrectly.

Key Steps to Minimizing Denials

- Some LPHAs may incorrectly append modifier -59 (distinct procedural service) as a general rule of thumb when more than one service is performed.
 - By doing so, the LPHA is paid 100% for each service rather than 100% for the first service and 50% for any additional services.
 - However, automatically appending modifier -59—as well as appending it when a physician only performs one service—will most likely send up a red flag for auditors.
- Coders and those charged with coding and billing functions within the LPHA should take the time to review proper modifier usage.
 - In particular, LPHAs should learn more about modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) and modifier -59.

Key Steps to Minimizing Denials

- Designate the principal diagnosis.
 - The principal diagnosis must indicate the reason the patient presents for the visit on that particular day.
 - Although physicians may document or check off a list of multiple diagnoses on a superbill, what they *don't* do is indicate which diagnosis is principal.
 - Physicians must number the diagnoses, and those numbers must indicate the order of importance. This will help avoid medical necessity denials.

Key Steps to Minimizing Denials

- Establish a procedure to identify non-covered codes.
 - Non-covered codes refer to codes that payers simply won't cover.
 - Patients presenting for non-covered services should receive an Advanced Beneficiary Notice (ABN) indicating that they are responsible for payment.
 - For example, if the LPHA anticipates a denial due to lack of medical necessity, the patient should receive an ABN so the LPHA can report the service with modifier -GA.
 - By appending this modifier, the LPHA indicates that the patient received and signed an ABN.
 - LPHAs should also report it when a patient receives an ABN but refuses to sign it.
 - Reporting this modifier ensures that upon denial, Medicare will automatically assign liability to the beneficiary.

Key Steps to Minimizing Denials

- LPHAs that don't obtain a signed ABN in anticipation of non-covered services will receive a denial and may bill the patient.
- Watch for coding requirements, updates, and process changes.
 - Invalid codes refer to codes that have been deleted, and in most cases, replaced by new codes. Outdated superbills often perpetuate errors due to invalid codes.
 - At a minimum, superbills should be updated in October when new ICD codes become effective and in January when new CPT codes become effective.

Key Steps to Minimizing Denials

- When the code changes are released, the LPHA should update their encounter forms/super bills and systems where codes are stored and used for claim submission.
- Educate providers and coders on the new and revised codes and the documentation needed to support the codes.
- Review the revised CPT[®] coding guidelines.
 - These can be quickly identified because the changes are in green text in the CPT[®] code book.
 - Sometimes the guidelines will change or clarify proper code selection even though the codes are not changed.
- Review the National Correct Coding Initiative (NCCI) edits to determine the bundling of codes.

Key Steps to Minimizing Denials

- Establish a quality assurance (QA) process with standardized measures of coding quality performance.
- The LPHA internal coding audit acts like a baseline indicator of coding accuracy.
 - It helps the LPHA identify root causes for coding errors.
 - It will also point to strengths and weaknesses in LPHA coders.
 - It will help the LPHA set coder education goals.

Key Steps to Minimizing Denials

- Determine the frequency and style of QA
 - If you're not doing internal coding audits at all, you know you just need to start.
 - But “how often” is a valid question. Once a month? Quarter? Year? There is actually no right or wrong answer, but there are parameters that will help you determine what's right for your operation.
 - Specialties that are deemed complex may require a more frequent auditing schedule.
 - New hires or coding a new specialty may also require a more frequent audit schedule.
 - The important part is determining a consistent schedule.

Key Steps to Minimizing Denials

- Your coders should *want* to be audited. Seriously. It should be presented to them as a learning opportunity.
 - Coders who are empowered — who believe that the work they do impacts the entire revenue cycle — will appreciate and even look forward to audits, because they understand they are part of something much bigger than a pile of charts or total charges at the end of each day.
- Empowering your coders to do their best will contribute to organizational success.

Key Steps to Minimizing Denials

- Use your QA process to onboard new coders.
 - No, not as a scare tactic, but as a reassurance method. Even experienced coders need training and a ramp up period to learn a new specialty, work in a different system or with previously unfamiliar payers.
- When a coder is hired at the LPHA, his or her work should be audited to identify and address any issues that may arise as they settle into their position.
- Monthly audits should be performed to keep an eye on their progress.

Key Steps to Minimizing Denials

- Once a coder completes three consecutive months with 95% or greater coding accuracy, the coder is promoted to “verified” coder status.
- From that point, quarterly quality audits should continue to ensure that high standards are maintained and to provide crucial and consistent feedback to the coder.

Key Steps to Minimizing Denials

- Update fee schedules to include the payment rates for the new and revised codes.
- Review provider contracts
 - Many claims are denied on the basis of incomplete data, incorrect data, or insufficient supporting documentation.
 - Each provider has their own set of rules and requirements for claim submission.

Key Steps to Minimizing Denials

- Create summary documents for each provider or an overall summary that identifies each provider's individual requirements. Include information such as:
 - What format you need to use (i.e. spelling out the name of a state versus using the abbreviation).
 - The timeframe for submission.
 - The timeframe within which the LPHA can reasonably expect payment.
 - How claims are submitted (electronically, by mail, or other).
 - What supporting documentation is required.
 - Who to contact should any questions arise.

Key Steps to Minimizing Denials

- Measure the number of claims that are denied:
 - Tracking and reporting your claim denials will require knowledge of your billing management system.
 - It will also require entering your denials so that you can then report on them. If the LPHA posts payments electronically, then this data will already be available to you.
 - If you are not taking advantage of electronic payments or not all of your payers offer this to you, then you'll need to manually enter your denied claims (zero payment remittances) into your billing management system.

Key Steps to Minimizing Denials

- With that data entered, you'll want to measure the following:
 - A. Total claims filed to a payer (number and total charge amount)
 - B. Number and dollar value (charge) of denied line items
 - C. Calculate percentage denied (B divided by A)
 - D. And calculate these percentages for the LPHA by payer, reason, provider, specialty, and location (if you have more than one office)

Key Steps to Minimizing Denials

- Review all denials. Most billing management systems allow you to run reports by payer and denial reason code.
 - It is helpful to categorize the report to work the biggest problem first.
- Research the denial to determine the cause.
 - Make sure the information was submitted accurately on the claim.
 - If the wrong codes were submitted originally, make the necessary corrections and resubmit the claim.
 - If the claim was submitted correctly and the denial is due to medical necessity, check the payment policy for the payer to determine if the patient's diagnosis supports the policy.

Key Steps to Minimizing Denials

- Review the documentation required to support the service.
 - If you need to file an appeal to resolve the denial, most payers require the medical record for the date of service to make the appeal determination.
- Categorize Denials By Cause
 - Create categories according to cause of denial, then sort claims within each category from high to low based upon monetary value.
 - This will identify which categories will provide the greatest financial benefit to your organization and should thus be your first priority.

Key Steps to Minimizing Denials

- Some of these categories may include (but are not limited to):
 - Incorrect claim data
 - Incomplete claim data
 - Insufficient supporting documentation
 - Incorrect coding
 - Terminated coverage
 - Timeliness of submission
 - Provider error
 - Failure to obtain prior authorization
 - Improper benefit coordination

Key Steps to Minimizing Denials

- Create Subcategories Within Each Denial Category.
 - Look for ways to quantify, target and address each of the major denial categories.
 - The goal is to identify commonalities and specific areas to focus on in order to resolve the issues.
 - Here are several areas to consider when creating subcategories:
 - Incomplete information: Determine if the same information is missing from each claim, or if multiple types of information are missing.
 - Incorrect information: Identify if claims were submitted to the same provider, or multiple ones, then check if any of these providers recently made changes to processes/codes or if they are new providers.

Key Steps to Minimizing Denials

- Coding issues: Establish if particular codes are denied more than others.
- Missing supporting documentation: Determine if it is always the same documentation or always the same provider.
- Develop a tracking/reporting system that will allow your LPHA to track your performance over time.
- Set up process for communication for “Claims with Coding Issues”

Key Steps to Minimizing Denials

- Create a Plan of Action.
 - Identify the top three broad categories in terms of the amount of revenue lost and drill down to the subcategories for each.
 - List proposed methods for correcting each subcategory and identify how these corrections will be implemented.
 - This might include:
 - Training (or retraining) staff on correct claim submission
 - Implementing a checks and balances system
 - Setting up conference calls with payers to clarify certain issues
 - Improving documentation (i.e. policies and procedures, provider requirement summaries, training manuals)
 - Establishing better methods for gathering and tracking data

Key Steps to Minimizing Denials

- Implement the Plan.
 - Share your plan with your staff and explain the issues, their causes and the proposed course(s) of action.
 - Identify the end goals and what achieving these goals will mean for both staff and the organization as a whole, stressing the importance of collaboration.
- Provide continuous feedback throughout the process, and continuously review and tweak the process as you go along in order to ensure everything is going according to plan.
- Set up meetings with providers to discuss your goals and how you intend to accomplish them.
 - Collaboration with providers is key and will help the entire process run much more smoothly.

Summary

- Understanding the business processes for the services the local public health agency provides is the beginning step.
- Each local public health agency must thoroughly understand the steps involved in providing a service— from checking a client into the clinic, to delivering the service, to billing claims, and paying staff.
- Accuracy, completeness, and timely documentation are essential, and LPHAs should have a policy that outlines these details.
- All services provided should be indicated on the Encounter Form/Superbill whether reportable or billable.



Summary

- Medicaid is the nation's single largest source of health insurance for children and adults.
- Medicare is the nation's largest insurance source for people over 65 and people of all ages with certain disabilities.
- LPHAs must take all reasonable measures to determine a 3rd Party Payer's liability for covered services prior to filing a Medicaid claim.



Summary

- In order to bill and expect reimbursement for services, need to:
 - Understand and follow the requirements and rules of Medicaid, Medicare and other commercial insurances.
 - Understand the diagnosis & procedure codes that best represent services/care.
 - Have checks and balances in place to avoid unintended problems.
 - Understand how each of the billing roles impact the LPHA's revenue cycle and success.



Summary

- A claims clearinghouse is a company that receives multiple claims from healthcare providers, edits each for validity and accuracy, and routes the edited claims on to the proper carrier for payment.
- Studies have shown that a clearinghouse is the best method of submitting electronic claims if the provider submits claims to multiple carriers. Direct claim submission is the method of choice if most claims are being sent to a single carrier.
- It is very important that you choose a medical billing clearinghouse that is contracted with the majority of the insurance carriers that LPHAs use most often.



Summary

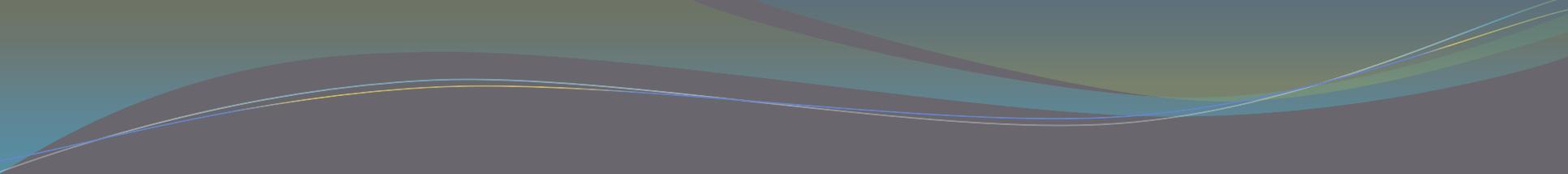
- If you're considering a "free" clearinghouse, make sure you understand how they make their profit. Is it by offering "other" services for a higher fee or are they offering less customer service/support than their "paid" competitors.
- Take the time to do the research to see if a clearinghouse will be beneficial for the LPHA.



Summary

- Develop policies and procedures for processing denials and rejections that are based on coding.
- Develop policies and procedures for requests made to change codes that may originate from the physician or patient.
- Always keep an audit trail as to why the codes were changed.
- Understand the differences with “Correct Coding” and “Administrative Policy” for a payer.
- Identify types of cases where the coding requirements conflict with standard coding methodology for a particular payer due to their administrative processing .
- See if the requirement can be incorporated into your coding policies.





Questions?