FQHC Responsibilities

“Have systems in place to maximize collections and reimbursement for its cost...including written billing, credit, and collection policies and procedures.”—(Section 300(k)(3)(F) and(G) of the PHS Act)

Health Center must show “due diligence” in collecting fees for services
“Revenue maximization requires...prompt and accurate billing of third party payers..., and timely follow-up on all uncollected amounts”

“Participation in insurance programs used by the health center’s population is of critical importance...”
Your Responsibility

- Front Desk—is the first line of defense for getting correct patient demographic, insurance & Sliding Fee documentation
  - Collecting at the POS
  - Getting correct Insurance information
  - Verification of coverage and Eligibility*
  - Patient Education
Your Responsibility

- Billing – is the last opportunity to maximize revenue
  - Billing frequency
  - Provider Credentialing
  - Working denials, Aging Reports, and Self Pay
  - Patient Education
TEAM Work

Front Desk and Billing Staff
Working Together
TEAM Work

- A.I.D.E.T.
  - Acknowledgement
  - Introduce
  - Duration
  - Explanation
  - THANK YOU

- A.I.D.E.T.
  - Not just for Staff–Patient relationships
  - Also important for Staff–Staff relationships
TEAM Work

- **Acknowledge** the other person's position and realize that it is just as important as yours.
- **Introduce** educational material and knowledge across departments.
- Give the **Duration** of completing the process or correcting information.
- Provide **Explanation** for processes so that everyone understands you are not just making this stuff up.
- **Thank you** and thank each other for their contribution to the success of the Practice.
TEAM Work

- Staff must be able to communicate in order to correct processes that will decrease denials and maximize cash flow.

- We are all in this together. There is no “I” in team.

- Participate in ongoing training opportunities and stay abreast of industry changes.
Cause of Lost Revenue

- Failure to obtain current patient information
  - Check eligibility of Sliding Fee
  - Check eligibility of Insurance

- Failure to collect on previous patient account balances

- Failure to collect co-payments and minimum fees at POS
  - Not collecting co-payments is violating your contract with payer who require them
Cause of Lost Revenue

- Physicians not recording all services performed during the office visit
- Not filing claims timely
- Not working denials timely
Cause of Lost Revenue

- Failure to code correctly and not having codes updated in your PMS
- Failure to educate patients about the Health Center’s payment expectations
- Failure to redirect claims properly
- Not credentialing the Health Center and providers with Insurance Companies
Claim Processing Flow Chart
Denials vs. Return Claims

- Denials are claims returned by third party payers and patient accounts must be adjusted or charges redirected to the patient
  - Patient not eligible
  - Provider not enrolled
  - Time Expired

- Some denied claims can be appealed
Denials vs. Return Claims

Return Claims are claims returned by a third-party payer in which action can be taken to get current and future claims paid or claims in which the patient has not fulfilled their responsibility.

- Coding Errors
- Additional Information Required
- Patient has other Insurance
- Payment applied to deductible
Denials

- If not using a computer generated report, is there anyone in the office responsible for collecting this information?
- Does your vendor offer a reporting system?
- How often do you look at your denials?
- What does your Denial Report tell you?
- Who are you sharing your report with?
- What steps are you putting in place to correct them?
- How are you measuring your progress?
Denials

- Sort denials by type
  - Coding Errors
  - Insurance Eligibility
  - Credentialing
  - Capitation
  - Timely Filing
Denials

- Sort by Department
  - Front Desk
  - Clinical
  - Billing
  - Administration (if Credentialing is not handled in the Billing Department)
Denials

Sort Denials by Plan of Action

- Adjustment to patient’s account
- Update information and re-bill to Insurance Company
- Provide Additional Information and re-bill to Insurance Company
- Redirect charges to the patient
- Other-Company needs to take action
# Community Health Center USA

**Quarterly Billing Activity Summary Sheet**

**October–November 2010**

## Commonly Used Denials

(Currently being tracked by Finance)

<table>
<thead>
<tr>
<th>Adjustment to Pts. Acct</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Private</th>
<th>Select</th>
<th>Quarterly Total</th>
<th>Previous Quarter</th>
<th>Year To Date</th>
<th>Previous YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Expired</td>
<td>1</td>
<td>49</td>
<td>1</td>
<td>51</td>
<td>82</td>
<td>239</td>
<td>711</td>
<td></td>
</tr>
<tr>
<td>Duplicate</td>
<td>65</td>
<td>82</td>
<td>57</td>
<td>18</td>
<td>222</td>
<td>322</td>
<td>807</td>
<td>1,337</td>
</tr>
<tr>
<td>Suspended Claim</td>
<td>9</td>
<td></td>
<td>9</td>
<td>36</td>
<td>45</td>
<td>45</td>
<td>175</td>
<td></td>
</tr>
<tr>
<td>Capitation Payment</td>
<td>6</td>
<td></td>
<td>325</td>
<td>331</td>
<td>729</td>
<td>1,806</td>
<td>2,762</td>
<td></td>
</tr>
</tbody>
</table>

## Update Information and Re–bill to Insurance

| Additional Information Needed | 9 | 1 | 54 | 79 | 255 | 715 |
| Incorrect ID Number           | 3 | 29 | 33 | 92 | 308 |
| Other Insurance               | 13 | 16 | 46 | 3 | 78 | 78 |
| Incorrect Insurance Address   | 3 |          | 13 | 29 | 22 |

## Coding Error–Re bill to Insurance

| Code Not Covered | 25 | 35 | 21 | 81 | 124 | 226 | 521 |
| Missing 4th or 5th Digit     | 1 | 2 |          | 5 | 11 | 42 |
| Incorrect Code               | 11 |          | 35 | 88 | 169 |

## Pt.. with Ins – Redirect to Pt.

| Applied Deductible | 47 | 69 | 171 | 391 |
| Family Planning    | 15 | 6 | 17 | 46 | 250 |
| HMO                | 26 | 64 | 112 |
| No Prior Authorization | 56 |
| Not Primary Care Provider | 73 | 3 | 126 | 211 | 874 |
| Out of Network     | 9 | 12 | 20 | 42 |
| > Allowed Amount    | 1 | 35 | 62 | 487 |
| Service Not Covered | 3 | 100 | 423 | 714 |
| Visits Exceeded    |          | 0 | 0 | 2 |

## Patient w/o Ins– Redirect to Pt.

| Not Eligible | 6 | 15 | 81 | 239 | 354 |
| Service After Cancellation Date | 13 | 13 | 52 | 139 |
| Service Prior To Coverage       | 1 |          | 4 | 6 | 38 |

## Other

| Refund Request | 21 | 21 | 6 | 29 | 7 |
| Part of Primary Procedure | 3 | 11 | 13 | 96 |
| Provider Not Eligible         | 3 | 2 | 5 | 24 |
| Amount Withheld               | 1 | 0 | 1 | 2 | 101 |
| Other                         | 6 | 16 | 11 | 33 | 17 |

## Total Claims Denied

| Total Claims Denied | 117 | 268 | 495 | 505 | 1,385 | 1,742 | 5,295 | 11,741 |
Rejected Claims Comparison
Apr 2009-Mar 2010 vs. Apr 2010- Nov 2011

- 1 Time Expired
- 3 Suspended Claim
- 5 Additional Information Needed
- 7 Other Insurance
- 9 Code Not Covered
- 11 Incorrect Code
- 13 Family Planning
- 2 Duplicate
- 4 Capitation Payment
- 6 Incorrect ID Number
- 8 Incorrect Insurance Address
- 10 Missing 4th or 5th Digit
- 12 Applied Deductible
- 14 HMO
Denials

What Next?

- Established a Plan of Action
- Make sure staff is properly trained
- Measure your progress
Not all denied claims should be considered lost revenue. There are times when claims can be redirected to the patient.

- Patient has not met their deductible
- Patient does not have coverage or coverage ended
- Services not covered
- Patient has exceeded number of visits
Redirecting Claims to S/P

Redirecting claims to patients

- When redirecting charges to a patient it is good to call the patient before they get the statement in the mail.

- Let the patient know the reason why the charges are being redirected and ask for additional insurance information (they may have other coverage you are not aware of).
Redirecting Claims to S/P

- Educate them about the Sliding Fee Program and inform the patient of any payment plan your Center may have
Appealing Claims

- Insurance Companies are not perfect, they make mistakes too.
- Know when to Appeal a claim
- Make sure the claim is valid
- Make sure that the initial claim was filed timely
Be sure that services provided was covered on DOS

Be able to prove the patient had coverage on that DOS
  ◦ Verify correct ID number was entered
  ◦ Show printout from verification system

In some cases you will need to make sure the Insurance Company is aware that your Center is a FQHC
Some claims can be corrected and resubmitted to the third-party payer for payment
- Incorrect ID number
- Diagnosis Code invalid or missing 4th or 5th digit
- Additional information is needed
Some Insurance Company may require you to notated on the claim that it is a “Corrected Claim” – this helps to avoid the claim being returned again for untimely filing.
Secondary Claims

- Always bill secondary Insurance Company

- If a patient has Medicare and Medicaid
  - Medicaid is always secondary
  - If payment received from Medicare is less than your Medicaid encounter make sure to bill the difference to Medicaid. Do not consider the claim ‘Paid–in–Full’
Aging Reports

- Medicare and Medicaid
  - Easiest source of revenue
- Private Insurance Claims
  - Insurance Claims >120 days
  - Insurance Claims >90 days
- Always check with your Insurance Company to determine filing period for timely filing
- Aging Reports can be used during the same time you are addressing return claims.
  - Can allow you to clear a patient’s account balance
Aging Reports should be reviewed and updated when posting payments.

If you are manually posting also look at the past DOS to make sure that there are no outstanding items or missing payments.
Statements

- Statements need to be mailed the same time every month
- Bad addresses should be flag in the PMS and patient should be required to update their information before being checked in during the next visit.
- If staffing permits patients should be contacted in an effort to obtain the correct information
- Offer payment plans and payment–by–phone
A Medicaid Manage Care plan did not pay for DOS because the diagnosis code did not match the procedure code.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>Office Visit</td>
</tr>
<tr>
<td>87880</td>
<td>Rapid Strep</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>079.99</td>
<td>(unspecified viral infection)</td>
</tr>
</tbody>
</table>
Denial Sample #1

- Research the diagnosis code (encounter, patient notes)
- Communicate with the Provider why the claim was returned and indicate that a different code will be needed
- Resubmit the claim to the Insurance Company
Private Insurance Company returned claims because the CPT code is considered to be part of the VFAC program.

- Verify CPT Code and program association
- Correct claim to reflect CPT Code with appropriate immunization/administration code
- Resubmit claim to payer for reimbursement
- Note: Payer will adjust charges for CPT Code associated with VFAC but will pay for administration
Denial Sample #3

Patient DOB Does NOT Match Diagnosis

Missing Patient Info. & Insurance Info.

Diagnosis Code Does Not Match Age

Missing NPI Number
Claim was returned by payer because the primary diagnosis is not covered

- If there are multiple diagnosis you may try billing the secondary diagnosis as primary
- If there is only one diagnosis you may have to adjust charges according to the EOB
Denial Sample #5

- The Private Insurance Company denied a claim because the patient was not covered at the time of service
  - Check for insurance on file
  - Check charts or notes to see if Insurance Verification was completed on the DOS
  - Verify ID number is correct and check eligibility
  - If patient was not covered, charges should be redirected to the patient
Denial Sample #6

**Health Insurance Claim Form**

<table>
<thead>
<tr>
<th><strong>1500</strong></th>
<th><strong>BLUICH CROSSL BLUE SHIELD, 36</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH INSURANCE CLAIM FORM</strong></td>
<td><strong>P.O. BOX 166300</strong></td>
</tr>
<tr>
<td><strong>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE</strong></td>
<td><strong>COLUMBIA, SC 292002</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>1.</strong></th>
<th><strong>INSURER NAME</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICARE</strong></td>
<td><strong>MEDICAID</strong></td>
</tr>
<tr>
<td><strong>INSURANCE</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3.</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP PLAN IDENTIFICATION NUMBER</strong></td>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>4.</strong></th>
<th><strong>INSURER NAME</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LAST NAME</strong></td>
<td><strong>FIRST NAME</strong></td>
</tr>
<tr>
<td><strong>MIDDLE INITIAL</strong></td>
<td><strong>DATE OF BIRTH</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5.</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP PLAN IDENTIFICATION NUMBER</strong></td>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>6.</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP PLAN IDENTIFICATION NUMBER</strong></td>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>7.</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP PLAN IDENTIFICATION NUMBER</strong></td>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>8.</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP PLAN IDENTIFICATION NUMBER</strong></td>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>9.</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP PLAN IDENTIFICATION NUMBER</strong></td>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>10.</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP PLAN IDENTIFICATION NUMBER</strong></td>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>11.</strong></th>
<th><strong>PATIENT IDENTIFICATION NUMBER</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP PLAN IDENTIFICATION NUMBER</strong></td>
<td><strong>MEDICARE</strong></td>
</tr>
<tr>
<td><strong>MEDICAID</strong></td>
<td><strong>INSURANCE</strong></td>
</tr>
<tr>
<td><strong>CHAMPVA</strong></td>
<td><strong>CHAMPVA</strong></td>
</tr>
</tbody>
</table>

**Missing Diagnosis for Sick Visit**

**Missing NPI Number**

**Missing Modifier**
Denial Sample #7

- Contracted Center’s claim was returned by Insurance Company and the allowed amount was applied to the patient’s deductible
  - Redirect the allowed amount that was applied to the deductible to the patient
  - Call the patient and inform them and reeducate them about the Sliding Fee Program and payment options.
Denial Exercise

- List your top 4 denials
- Determine cause of denials (by Department, Personnel, MIS)
- Develop plan of action to address denial type and resolution
- Determine if denial can be rebilled or should the patient account be adjusted
Get Paid

- SMILE AND ASK
  - Fees and Co-payments

- MUST Verify Patient Demographic
  - Name Spelled Incorrectly
  - Date of birth doesn’t match
  - Subscriber number missing, invalid, or missing digits
  - Zip Code (Medicare)
Get Paid

- MUST Verify Insurance Coverage at every visit
  - Coverage Terminated
  - Coordination of Benefits (Patient has other insurance)

- MUST Verify Service Covered by Insurance Company

- MUST Verify ICD–9, CPT or HCPCS Codes
  - Usage of 4th or 5th digit ICD–9 codes
  - Proper use of modifiers
Get Paid

- MUST Bill Frequently
  - Claims not billed timely
    - Be aware that some payers are requesting that claims be submitted within 90 days from the DOS

- Make sure your Practice and Providers are properly credentialed

- Know your Insurance Company and understand how services affect your facility
Get Paid

- Know billing regulations by payer

- Make sure that your facility has policies and procedures in place for billing and collections

- Remember: Revenue DOES NOT start in the Billing Department
Verify Insurance Eligibility for Every Patient at Every Visit

Eligibility of Medicare should be verified for patients <65 years old

Eligibility of Medicaid should be verified for children age 0–18 years old
  ◦ Establish a relationship with the Medicaid Eligibility Worker in your area to assist with this process

Verify Primary and Secondary Insurance
Check Eligibility

- Medicaid Manage Care Plans
  - When verifying Medicaid ALWAYS verify if the patient is in a Medical Homes Network or Manage Care Plan
  - If the patient is not assigned to your facility or physician make sure to obtain prior authorization for the PCP
  - Educate the patient about changing their PCP with the Insurance Company if they plan on continuing to use your services
  - Authorization and Referral numbers are reported in field 17A of the HFCA 1500. Not reporting this number may cause denials
Check Eligibility

- NaviNet.com (Aetna, Cigna, Select Health)
- Webclaims.scmedicaid.com/SCWST/welcome/info.aspx
- SouthCarolinaBlues.com
- Clearinghouse (i.e. ZirMed, Payer Path)
- Telephone
- Company Direct Website
Check Eligibility

- Medicare is primary to Medicaid
- Medicare is primary to Private Insurance
  - Retired—Medicare is still primary
  - Actively Employed—Private Ins is primary
- Private Insurance is Primary to Medicaid
- Multi—Private Insurance
Why Get This Information?

- Improves proper classification of patients
- Improves workflow
- Improves proper billing
- Reduce denials
- INCREASE REVENUE
Insurance Tips

- Always check eligibility
- Enter the name as it appears on the card
- Enter the policy number as it appears on the card

Relationship Fields
- Always chose ‘Self’ for Medicare (Advantage) and Medicaid (Manage Care)
- Relationships should be properly identified for other Private Insurance companies (Self, Child, Spouse)
- Patients with their own ID number classify as ‘Self’

- Verify the patient’s date of birth and zip code
Insurance Tips

- Medicaid Patients
  - Family Planning
    - Family planning only covers contraceptives, V25.__
    - Other medical services may be charged directly to the patient
  - Medicaid does not allow a Well Child Care Visit (EPSDT) and Sick visit to be reported separately on the same date of service even if using a modifier
  - To maximize reimbursement charges, they should always be more than the allowable amount
Injections vs. Immunizations

- **Injections** – the forcing of a liquid into a part, as into the subcutaneous tissue, the vascular tree, or an organ
  - Bill E&M code with a ‘25’ modifier
  - Include the NDC# for the injections on the claim
  - **Administration Code** –
    - CPT 96372 for J Codes (use 20610 for Major Joint)
    - Use your CPT code book to verify administration code based on ‘point’ of injections
Immunizations – a process or procedure that protects the body against an infectious disease. (vaccination)

- Include the NDC# for each immunization on the claim
- Administration Codes
  - CPT 90471–90474 for Adults (age 19 and over)
    - 90471 ➔ Single or combination vaccine (intramuscular)
    - 90472 ➔ Each additional vaccine
    - 90473 ➔ Administered by intranasal or oral route
    - 90474 ➔ Each additional vaccine
  - Used when there is no face-to-face counseling
Injections vs. Immunizations

• CPT 90460 & 90461 for Children
  • 90460  ➞  Single or combination vaccine
  • 90461  ➞  Each additional component

• HCPCS G codes are still reported to Medicare w/ with a limited number of vaccines
  • G0008 – Influenza (90658)
  • G0009 – Pneumonia (90732)
  • G0010 – Hepatitis B (90746)
  • G9141 – Flu H1N1 (G9142)
Effective January 1, 2012

Changes with format in collecting and reporting data

You are responsible for making sure your practice, billing service, or clearinghouse are in compliance
HIPPA 5010

- Paper Claim Box 24/ EDI Loop 2310B
  - Rendering and Attending Provider Number
    - NPI is the primary identification allowed

- Paper Claim Box 33/ EDI Loop 2010AA
  - Billing Provider primary service address
    - NO PO Box – MUST be a Physical Address

- Zip Codes (anywhere on the claim form)
  - A full 9-digit format is required (12345–6789)
Electronic FQHC Medicare Claim Acceptance

- Loop 2300–CLM07
  - Provider Accept Assignment Code– ‘A’
- Loop 2300–CL101
  - Admission Type Code– ‘3’ (Elective)
    - 1–Emergency, 2–Urgent Care, 3–Elective, 4–Newborn, 5–Trauma Unit, and 9–Information Not Available
- Loop 2300–CL102
  - Admission Source Code– ‘2’ (Clinic/Physician Office)
- Loop 2300–CL103
  - Patient Status Code– ‘01’ (Discharge Self Care)