Teamwork Leads to Getting Claims Paid

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Financial Disclosure

Both presenters acknowledge a financial interest in the subject matter of this presentation as an employee and independent contractor of Corcoran Consulting Group.

Challenges Today
- High deductibles
- Verifying benefits and coverage
- Collecting at time of service
- Denial management
- Refunds
- What's to come
  - ICD-10

Objectives
- Demonstrate the impact of collections issues on practice profitability
- Discuss how to improve collections at all levels
- Identify specific roles and responsibilities
- Review simple reporting and monitoring techniques
- Provide case studies of applied systems in actual practices

The Process

Check-in
Technician
Billing
Check-out
Doctor

The Revenue Cycle
- Contracting and Credentialing
- Patient registration
- Eligibility and benefits check
- Referral and Authorization
- Patient visit and coding and collection
- Data entry
- Claim submission
- Clearing house denial
- Payment posting
- Denial management
- Research aging
- Appeal
- Bill patient
- Collection agency
Front End

- First point of contact drives payment
  - Advise patient of their obligations
  - Notify them of required paperwork
  - Collect the correct insurance information
    - Are you in network?
    - Do they need a referral?
    - Do we have a claims address on the card?

Front End

- At check-in always get insurance card(s)
- Pre-certification and pre-authorization
- Check Eligibility and Benefits
  - Co-pay
  - Deductible
  - Current with plan
- Consider outsourcing
  - Navinet
  - eSolutions
  - Your current EDI vendor/clearing house

Doctor/Tech Responsible

- Chart and code correctly, chart notes must support the codes selected.
- Confirm that the services provided are authorized and covered
- Make sure the charge ticket is complete, link diagnosis codes to CPT codes, mark all services performed, indicate next step
- Review reports for accuracy

Check Out and Data Entry

- Collect patient responsible balances that were unknown at check-in (i.e., refraction)
- Proof the encounter form
- Locate missing tickets
- Confirm demographic data and insurance information
- Scrub the information

Billing

- Post charges and payments daily
- Scrub your claims before you transmit
- Transmit and print claims daily
- Fix transmission errors daily
- Work denials as soon as they arrive
- Payment posting – utilize electronic posting
- Use event driven billing for your patient statements

Examples
Upon checkout patient instructs office to bill vision plan despite the medical record showing a complaint and diagnosis that support a medical claim.

How could this have been avoided?

Vision vs Medical

Appointment Scheduling - Get clear information regarding reason for visit,

Front desk –

Obtain the one insurance the patient plans to use
Make sure it matches the reason for the visit
Verify eligibility for both vision and medical benefits

Vision vs Medical

Technician - Listen carefully patient’s reason(s) for visit. Do not copy over previous medical diagnosis as a reason for "recheck".

Checkout - Confirm insurance being billed and collect patient’s portion.

Vision vs Medical

Multiple Providers, Same Day

Patient presents for evaluation of floaters, OD, sudden onset this morning. General ophthalmologist examines and notes retinal tear, OD. Refers to retina specialist for same day evaluation and laser.

Retina specialist evaluates retina, confirms findings and proceeds with laser.

Both ophthalmologists bill for office visits.

Multiple Providers, Same Day

No issue with appointment scheduling
No issue with front desk check in

Problem: Medicare group practice rules limit this case to a single office visit. Only a single condition is being addressed.

Administration: Providers decide who bills for the exam and how each provider is compensated.

Global Period

CC: 2 week post CEIOL OD. Vision good, no pain.

SLE performed OU. Retina exam deferred.

Plan: Schedule cataract surgery OS

Billed 92014-24

Agree?
Global Period

No issue with appointment scheduling
No issue with front desk check in
Chief complaint is problematic.
• No separate payment for post-operative visits
• No billable reason for visit noted
• No indication for surgery left eye.
• Even if exam was billable, 92014 is not appropriate note containing SLE only

Minor Surgery Billing Rules

Your patient uses artificial tears for DES but is unhappy with the treatment. She asks for an alternative. You offer a trial of punctum plugs in the lower puncta and she agrees. The rest of the exam is unremarkable.

Billed
920xx-25
68761-E2
68761-E4

Minor Surgery Billing Rules

No issue with appointment scheduling
No issue with front desk check in
No issue with charting

Billing Issues
• No unrelated, billable exam
• Exam performed to determine the need for surgery
• Bill for procedure only

Cosmetic Denial

Patient is schedule for a bilateral blepharoplasty. Surgery Scheduling contacts payer for verification of benefits and pre-certification requirements. Verbally told no pre-cert needed. Surgery is performed and claim is denied as cosmetic.

How could this have been avoided?

Pre-certification/Authorization 1

HMO Established patient returns after 2 weeks with dry eye complaint. Authorization is for 99213. Doctor briefly examines the patient and inserts plugs in RLL and LLL (68761). Insurance denies 68761 and pays visit.

How could this have been avoided?

Cosmetic Denial

Clinic/Surgery Scheduling – perform all necessary testing, chart supports functional diagnosis, pre-certification obtained in writing prior to surgery regardless of what the insurance rep may tell you, get ABN or Notice of Exclusion signed
Check out – confirm ABN/Notice of Exclusion is signed prior to surgery being performed
Billing – know the payer policy and keep clinic updated
Pre-certification/Authorization 1

**Front Office** - After first visit, request authorization for 68761-50 just in case. The 2015 National Medicare rate for 68761-50 is $223.65 vs. $72.94 for 99213

**Clinic** - Chart does not support separate exam code. If 68761 is not highlighted on encounter form, stop and request authorization before proceeding

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Pre-certification/Authorization 2

**New patient’s HMO insurance approved CPT 92004 for today’s visit.** Doctor examines the patient and removes a foreign body (65222). Insurance pays for office visit and denies FB removal.

How could this have been avoided?

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Appointment scheduling - confirm/obtain authorization before visit. Add information to appointment to print on encounter form

Front desk check – confirm authorization and highlight approved codes on encounter form

Clinic – if add-on, stop and get approval/auth or reschedule if non urgent, add 25 modifier to exam

Check out – collect patient portion

Billing – confirm authorization number is attached to claim

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Billed with wrong doctor

**Credentialing** – new doctor joined the practice but his Medicare ID number is still pending.

Clinic – Dr. A sees the patient, Dr. B reviews the chart and signs off

Billing - Claim is filed under Dr. B

Agree?

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Billed with wrong doctor

**Appointment** – Don’t make appointment until you receive notice of application processing, hold claims until final

Title 42, Section 424.535 (a)(7):

§ 424.535 Revocation of enrollment and billing privileges in the Medicare program.

(a) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier’s Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(7) Misuse of billing number. The provider or supplier knowingly sells to or allows another individual or entity to use its billing number.

Now what?

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Place of Service

**Data Entry** - you have a new employee entering surgeries into your practice management system and she select place of service office (POS 11) instead of ambulatory surgical center (POS 24) over a 3 month period

Now what?
**Place of Service**

**Billing** – Identify those procedures that were overpaid (i.e., YAG 66821, Bleph 15823) vs. those that need just need POS corrected (CEIOL 66984)

Attempt to submit a reopening for those claims that were not overpaid correcting the POS.

Submit a voluntary refund for the overpayment (the difference only) on the other claims. This may or may not be accepted.

**Surprise Bill**

**Appointment scheduling** - scheduled patient for office visit with Dr. Retina

**Front desk check in** - gets patient’s ID card, they are Medicare only

**Clinic** – doctor performs an OCT and intravitreal injection with expensive anti-VEGF drug

**Check out** – attempts to collect 20% but patient is irate and refuses to pay

How could this been avoided?

**Clean Claim**

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

**Surprise Bill**

**Front desk check in** - gets patient’s ID card, they are Medicare only - advise patient they will be responsible for 20%, can give estimate at this time

**Clinic** – prior to test advise patient of out of pocket and confirm they want to proceed

**Optimize Collections**

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

**Adjust and Prevent**

- All practice employees have the ability to positively or negatively impact collections
- Submit Clean claims
- Verify insurance eligibility
- Collect patient responsible balances at time of service
- Use of ABNs when appropriate
- Internal auditing and modify your process when its not working
- Training and continual monitoring
- Use the Resources
More help…

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

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