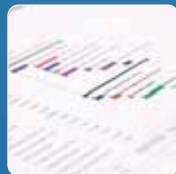


BILLING TRANSPARENCY: “SEE-THROUGH” PROCESSES IMPROVE EVERY STEP OF THE EMERGENCY MEDICINE BILLING CYCLE

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PHYSICIAN BILLING — PRACTICE MANAGEMENT

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There are many buzz words floating around the medical billing community, and “transparency” is no exception. But while it may seem that the term is self-explanatory, its meaning suggests that every participant in the billing cycle is allowed to see what is going on – from large-scale strategies to tiny details. On a large scale, a practice might consider total cash flow in a given time period, the status of claims, and quality measures. From a smaller standpoint, a practice might wonder about individual claims: their creation, history, validity, corrections, submissions, and reconciliation until payment, in order to understand the big picture.

In essence, billing transparency requires access to and explanation of every process within the billing cycle on a continuous and universal basis. This paper will look at each process within the emergency medicine billing cycle from the perspective of Medical Management Professionals, Inc. (MMP). What it will attempt to do is explain how each billing process can become more transparent, as well as establish the importance of process fluidity within the entire billing cycle, in an effort to improve a practice’s financial and operational health.

DATA INTEGRITY: WHERE IT ALL BEGINS

The revenue cycle involves patients, providers and payors and consists of the process required to schedule a medical service, provide that service and then bill and receive payment for same (Figure 1). At each step, inaccurate or incomplete information can infect the revenue cycle and lead to less than optimal reimbursement or no payment at all, which can be described as the opposite of billing transparency. Therefore, data integrity at the onset can ensure complete transparency in the entire billing cycle.

The starting point in the billing cycle is patient registration because the collection of key demographic patient information including name, Social Security number, and insurance coverage serves as the foundation for payment of services. It is critical that this information be accurate. Hospital-based practices face challenges when they must rely on data obtained during a sub-par registration process. Poor registration information results in denials, which requires more resources to track down proper data and resubmit a claim. In an emergency department (ED), it is imperative that a clean registration process is in place to obtain correct information at the time the patient presents. It is also important to verify this information each time the patient is seen face to face.

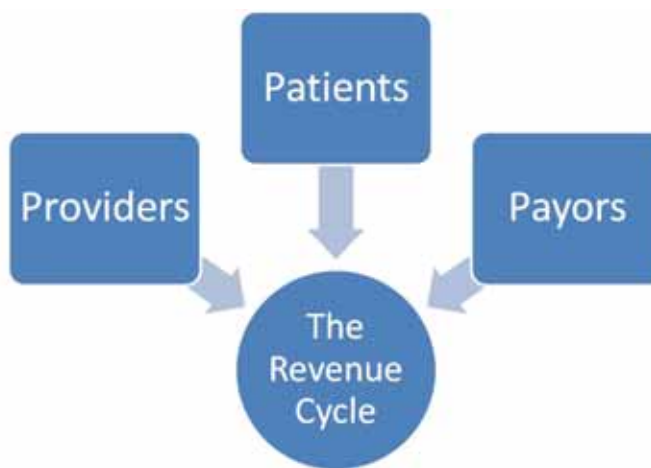


Figure 1 - Illustrates key parties involved in the revenue cycle.

Another area that can produce serious leakage in the revenue cycle is patient co-pays. Policies regarding co-pays vary among provider organizations. Some providers collect co-pays at the time of service. Others wait until the claim has been filed before billing the patient. Each approach has its benefits. Collecting at the time of service increases the likelihood the patient will pay, which in turn accelerates cash flow.

CODING: A WORKFLOW MANAGEMENT TASK

An always complex task within the billing cycle, correct coding assures that procedures are identified properly, filed and accepted by payors in order to receive payment. Savvy medical billing companies utilize software believed to provide advantages over the Natural Language Process (NLP) offerings. Coding workflow management software can often be an effective tool to enhance coding workflow, productivity, accuracy and compliance and is often developed with an eye toward leveraging human coding talent with the advantages of automation.

MMP uses a proprietary software called MMPact® Coding Optimize, which assists professional coders and allows them to hone their craft, sub-specialize, and increase productivity. The end results validate data sufficiency and integrity within the billing

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system. Leveraging human talent with technology is often the best way to ensure complete transparency in coding. Adding to that, a management reporting tool that allows coders and administrators to oversee quality assurance can track work in process while also identifying backlogs and exceptions, and monitoring coder productivity.

Coding can also be extremely specific. For example, emergency medicine coding can be very subjective and can present administrators with significant challenges in making sure that coding is accurate, compliant and complete. It is imperative to have skilled ED coding resources.

CHARGE RECONCILIATION: CLAIMS GENERATION THAT PRODUCES PAYMENT

Making sure that all ED charts produce payable claims is a central objective of the billing cycle. A reconciliation of charts and procedures-to-charges is one of the best ways to confirm that an accurate number of claims has been generated. Creating special emphasis around the education of all parties involved in the charge capture and documentation process will not only improve the process, but will also provide proactive feedback on coding trends.

To ensure that all ED reports are captured, an electronic log of emergency room charts should be obtained on a regular basis. Electronic reconciliation of all reports received can be compared to the log of procedures performed in this respect. If a charge is not in the billing system, the report should be obtained from the hospital. The goal is to assure that reports are submitted consistently so that any issues may be rectified.

CLAIMS MANAGEMENT: CLEARINGHOUSES PROVIDE MAXIMUM FUNCTIONALITY

Electronic clearinghouse functionality that includes standard insurance company issued edits as well as the ability to customize internal edits for review before going to the insurance company is critical to a healthy claims management system.

A clearinghouse allows the submission of claims in daily batches with real-time claim by claim edit and resubmission to the carriers in the click of a button (Figure 2). In many instances claims can be corrected online with the electronic vendor and resubmitted real-time to the carrier. Many clearinghouses have a queue that highlights outstanding verifications and then follows up directly with the payor to ensure verification.



Figure 2 - Illustrates ease of clearinghouse functionality and offerings.

Having the ability to run an eligibility and verification report for most carriers is also helpful, since it allows access to the eligibility system with the patient’s identification number. This gives a billing company or in-house administrator the opportunity to run all self pay accounts against a database of payors to verify current coverage, which also assists in focusing collection efforts for self pay accounts.

Depending on the carrier, there are typically both electronic and paper options, whereby claims are uploaded and sent daily in either electronic or paper format. Electronic clearinghouse functionality allows standard insurance company issued edits as well as the ability to customize internal edits for review before going to the insurance company.

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PAYMENT POSTING: TRACKING IS REQUIRED

Payments can be posted by using manual or electronic remittance methods. For optimum turnaround, remittances that are posted electronically are typically faster. If an 835 file (e.g., health care payment and remittance advice) is not available or the format is not acceptable (e.g., it is not in a line item format) payments can also be posted manually by payment posters. It is important that all payments be posted by line item.

In addition to this portion of the billing cycle, reimbursement tracking can match electronic claims with the electronic remits received from payors to identify not only underpayments, but also inappropriate denial and/or bundling of services that are not within the payors published medical policy and/or “black box” edits. This process easily captures information by payor so that underpayments can be tracked in bulk and easily sent in spreadsheet form to the payor for re-adjudication.

If a primary payment is posted and the patient has secondary insurance, the secondary claims can be transferred automatically by Medicare to secondary carriers that accept electronic crossover claims or are generated electronically (where the carrier will accept an electronic EOB). For those that do not accept crossover or electronic claims, a paper claim can typically be generated and submitted.

All EOBs, electronic and paper, should be attached to the patient’s account at the time of payment posting because these EOBs are usually viewed in account inquiry. Alternatively, access to electronic 835 files can also be made available on the Web.

DENIAL MANAGEMENT: RESOLVE ISSUES FROM BOTH ENDS

Reducing the possibility of claim rejections and denials by addressing root problems like inaccurate demographic data and improper diagnostic coding ahead of time is the best strategy for successfully managing the emergency department revenue cycle. It is important to develop a comprehensive back-end system that can identify and resolve denials that occur. A denial can be triggered at any point throughout the billing process, and it is important that a practice track its denials from the front-end, during coding or during claim adjudication (Figure 3). Detailed denial information and tracking is a major part of what it means to have a transparent billing system.



Figure 3 - Illustrates front-end and back-end denial management functions.

Having the capability of comparing denials such as bundling and medical necessity to published payor “black box” edits and medical policy adds greater accuracy to a denial management system. In order to assist in the re-adjudication of claims, practices can generate trend data by payor and submit inappropriate denials for bundling or misinterpreted medical policy in a single spreadsheet that contains all the necessary information the payor needs. This approach is a significant improvement over a historical “manual” process resulting in more timely identification of denial issues and payment resolution.

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A rules-based system can automate many of the functions associated with A/R follow-up, claims submission, collection letter generation, etc. (Figure 4). For instance, all outstanding claims with no payment or denial can be automatically resubmitted based on payor pre-defined parameters. When claims are still outstanding after being resubmitted, they can automatically be placed in a work queue for follow-up with the payor.

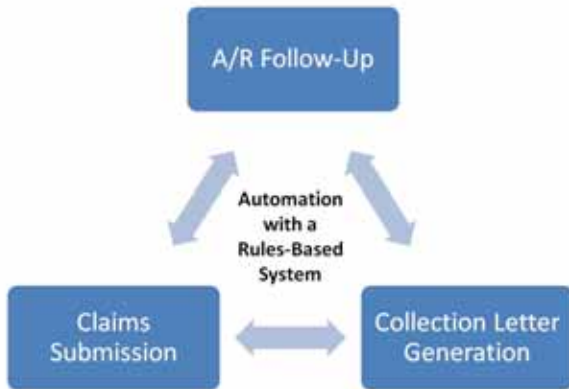


Figure 4 - Illustrates automated functions of a rules-based denial management system.

Follow-up with carriers for claims status and expected payment date should be handled via payor websites and when necessary, over the phone. Similar to denials, the no response/unpaid claims queue enables immediate, real-time data to effectively manage no response/unpaid claims.

Based on research and thorough follow-up, if an insurance claim is still outstanding, it can then be rotated to patient responsibility, and a new follow-up cycle begins for the self pay financial class. A billing company or in-house administrator can and should work directly with practice leaders to develop financial policies that consider the practice's specific payor mix, demographic mix and economic factors in its locale. Whatever the case, keeping abreast of where the denial is within the system maintains optimum transparency throughout the process.

REIMBURSEMENT TRACKING: TAKE CARE FOR CORRECT PAYMENT

Effective reimbursement tracking allows the user to set up managed care plans by contract, payment criteria and carve outs. This information drives specialized functions in the payment posting and reporting modules in order to showcase correct allowable calculations and to ensure that payors are complying with agreed-upon payment amounts. A truly effective system handles fee-for-service, percentage discounts, allowables set by specific fee schedules or by RVU's, and capitation tracking (Figure 5).

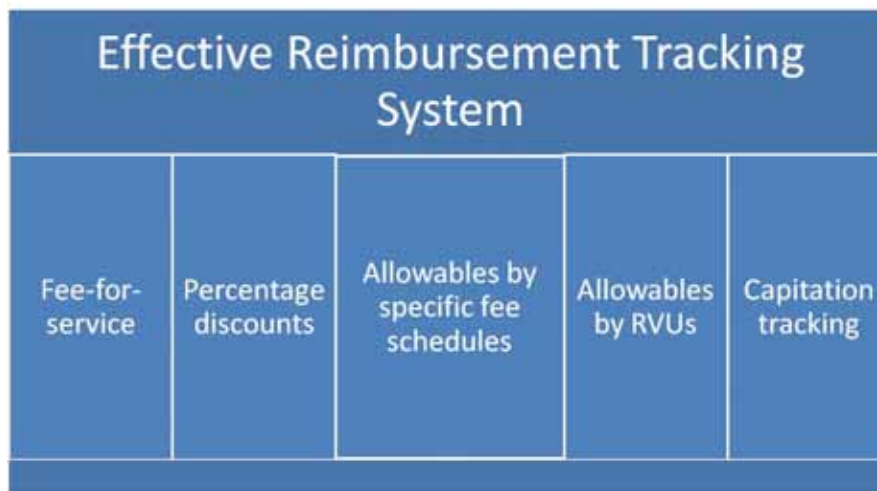


Figure 5 - Illustrates the elements that comprise an effective reimbursement tracking system.

If third-party payments are posted to the billing system for which a fee schedule or other discounted reimbursement structure is in place, the system can alert the payment poster if an incorrect payment is received, and a report can be generated that details those accounts paid outside the reimbursements set in the billing system for the third-party. These lists can be researched with the carrier for adjudication.

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In addition, many emergency department practices have recently been barraged by "silent PPO's." A "silent PPO" is a third-party that asks for a discount off the charge amount without truly having a signed contract with the practice that provides for the discounted arrangement. In many situations, the adjustment is taken and the practice loses money. Having an ability to identify each third-party with whom the client contracts is important in identifying whether the third-party should be treated as general commercial insurance. If no allowable schedule is present, the user should then be prompted not to take a discount.

If an error has been identified, an appeal letter should be automatically generated for review and processing after a comparison of all 837 files (e.g., health claims and equivalent encounter information) to the 835 files is made for both fee schedule accuracy and appropriateness of any processed clinical edits. For a greater chance of reimbursement, the appeal letter should possess copies of contract language and the explanation of benefits.

It is then important to track the response and success of each appeal in order to report the payors that are paying incorrectly as well as how long it is taking to appeal and be paid appropriately. This information can also play a role in contract negotiations (Figure 6).



Figure 6 - Illustrates steps for a greater chance of reimbursement.

ELIGIBILITY VERIFICATION: ELIMINATING CLAIMS DENIALS REQUIRES MAINTENANCE

Eligibility verification serves the purpose of eliminating claim denials, claim re-submittals and unpaid patient balances in accounts receivable. Similar to co-pays, eligibility verification allows for fewer patient statements, zero claim denials due to lack of health coverage and far fewer claim re-submittals. If conducted regularly, it helps reduce the patient revenue cycle, minimizes delays and denials, and improves collections by reducing write-offs. Emergency medicine practices can estimate and collect the patient portion of a service up front in an effort to balance account receivables at zero, ideally.

Insurance companies regularly make policy changes and updates to their health plans. Therefore, it is inevitable for a practice or medical billing company to verify if the patient is covered under a new plan to achieve acceptance of the claim on the first submission, whereas non-verification leads to several discomforts like rework, decreased patient satisfaction and increased errors other than causing delays and denials.

Checking patient insurance eligibility on every new patient and on patients who have not been seen in a while or whose insurance has changed can constitute major changes in a practice's month-end balance sheet and cash-flow. Practices can do this by contacting primary and secondary payors via telephone or authorized online insurance portals to clarify information, including member ID, group ID, coverage period, co-pay amount and other benefits information (Figure 7).



Figure 7 - Illustrates how practices can verify patient insurance for major changes in month-end balances and cash flow.

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Once information is obtained, updating the system is the most important aspect of eligibility verification since it assures that a patient’s information is correct moving forward. Good communication is also essential for reimbursement success and speaking with the patient about updated information is usually a good first and last step to the process.

ANALYTICS: SHOWCASE WHAT HAS BEEN TRANSPARENT

Reports can address all functional areas in the practice including reports by client, provider, payor, specialty, claims, denial codes, charges, payments, adjustments, contractual and staff productivity reporting (Figure 8).



Figure 8 - Illustrates areas of data and information that can be funneled into on-demand reports.

With on-demand reporting, a practice can run reports anytime by specifying a start and stop date to include in the data. Additionally, reports should have technical capabilities with output to Excel Pivot Tables for drill-down and data manipulation. An ad hoc report writer can offer report generation from drop-down filters with data choices that can be detailed, summarized, reported month to month or year to date. For data manipulation, all reports can then automatically be exported into standard formats such as MS-Excel or Rich Text Format.

Many reports do not require custom programming and can be produced using standard reporting options. Such reports can accumulate information for time frames varying from daily to monthly to yearly. User-defined breakpoints for distinct customization can provide subtotals and grand totals.

The use of dashboards can also showcase key performance areas that are real-time and user-defined, often from drop down menus. Dashboard data is easily updated on a desktop and can be configured to a company, department, and/or on an individual level.

Tracking PQRS data elements is a critical area of reporting and would include flags for PQRS eligible procedures as a reminder to the coder to append the PQRS codes. The claims management portion of the billing system often has automated edits to facilitate completeness of PQRS reporting. Running reports from a clearinghouse and/or our billing system to check PQRS compliance can give practices a heads-up on incentives they may receive.

QUALITY ASSURANCE: A SCIENTIFIC APPROACH KEEPS ERRORS AT BAY

Quarterly coding reviews, annual claim submission reviews and random compliance/HIPAA privacy and security billing center reviews are recommended for quality assurance. These coding quality assurance (QA) reviews should be performed per coder by individuals schooled in compliance or holding current coding certifications.

For optimum results, quality assurance samples can be selected in such a manner that coders do not know in advance which charges will be reviewed and the review will be performed on a retrospective basis, (i.e., billing of the services has already occurred). The sampling method can consist of a query/request by the auditor of the appropriate amount of records from specified dates of service (DOS). If the coder utilizes an automated coding workflow tool, the auditor can gain access to the coder’s records and retrieve the appropriate amount of records from the requested dates of service spread amongst providers, locations, and procedure class. If the coder utilizes paper records, the auditor can request the appropriate number of records, spread amongst providers, locations, or procedure class for the specific DOS from the coding supervisor or office manager as appropriate.

Quality assurance samples that are selected over time will represent the full range of services performed by a coder. For example, if a coder routinely codes both emergency medicine and radiology services, both specialties would be represented in the QA sample. If a coder routinely codes for two pathology clients, both would be represented in the sample, as well as varying modalities, locations, and providers.

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Error rates for ICD-9-CM diagnosis coding and CPT®/HCPCS procedure coding should be calculated separately and then combined for an overall error rate.

Audits are also a critical element within a successful quality assurance program. The charge capture audit can be a useful safeguard for periodically assessing the department’s efficacy in producing appropriate claims for emergency medicine services.

THE SUM OF THE PARTS

To quote Oscar Wilde, “you know more than you think you know, just as you know less than you want to know.” While a practice and its leaders may possess a great deal of knowledge about the emergency medicine billing cycle and the processes that comprise it, they may not know the specifics within each process relating to their practice’s specific data and claims status, as examples. In today’s unforgiving healthcare climate, practices can no longer afford to “not know.” Billing processes that are compartmentalized and lack fluidity can create holes in an emergency medicine practice’s revenue and money can be lost without a practice even knowing about it. By achieving billing process transparency and overseeing every step, practices can better expedite error identification and resolution, resulting in reduced over- and under-payments, improved regulatory compliance and increased revenue.

Carrie MoneyMaker is an operations manager with Medical Management Professionals, Inc. (MMP) in its East region. She currently works with hospital-based radiology practices and their joint ventures in the Mid Atlantic area and possesses 16 years of professional healthcare experience including clinical work, program and practice management and billing and operational revenue cycle management. Ms. MoneyMaker obtained a Bachelor of Science in Respiratory Therapy from Salisbury University. She is a member of the Radiology Business Management Association (RBMA) and serves on MMP’s Radiology Specialty Committee and the EHR subcommittee.

Lee Ann Kennedy is a senior operations manager with Medical Management Professionals, Inc. (MMP) in its East region. She has more than 24 years of physician practice management and billing operations experience with specific focus to emergency medicine practices in the past 11 years. Ms. Kennedy is a graduate of Middle Tennessee State University. She began her career with MMP in September 2000.

About MMP

Medical Management Professionals, Inc. (MMP) was founded in 1993 and is a provider of billing and practice management services to emergency medicine physicians. It currently serves more than 70 emergency medicine practices with more than 1000 emergency physicians combined. MMP’s flexible solutions range from billing-only services to full-practice management services. For more information about MMP, visit www.cbizmmp.com.

For additional information please call **1.877.541.9690** or email emergency@cbizmmp.com