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On the topic:
Maximizing a Healthy Revenue Cycle
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Maximizing a Healthy Revenue Cycle

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Revenue Cycle Management

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Revenue Cycle Management (RCM)

Revenue cycle management (RCM) is the financial process, utilizing medical billing software, that healthcare facilities use to track patient care episodes from registration and appointment scheduling to the final payment of a balance.

Components of RCM

Version 1
- Patient Access
- Population Health Management
- Patient Responsibility
- A/R Management
- Claims Management
- Charge Integrity

Version 2
- Patient Access
- Patient Registration
- Documentation/Coding
- Co-pay / Deductible
- A/R Management
- Denial Managements
- Cash Management
Revenue Cycle Management

- Patient Registration
- Reimbursement Systems
- Cash Management
  - Patient Centric
  - Practice Centric

Patient Registration

- Patient Identification
  - Personal Identity
  - Insurance Cards
    - Co – insurance
    - Deductibles
- Upfront Collections – ask for the money
- Cash Management -- Patient Centric
  Receipts – controlled / numbered / computerized
  Balance cash daily
Reimbursement Systems

- Fee Schedule Development and Analysis
- Managed Care Contracting
- Documentation and Coding
- Quality Measures
- Coding Compliance
- Physician Reimbursement Improvement

Fee Schedule Development

- Annually, CMS publishes a new fee schedule for Medicare Payments. We recommend setting your fees at three (3) times Medicare; we want our pricing above commercial insurance fee schedule.

- You can pull the Fee Schedule from CMS, or better yet, from your Medicare Area Contractor (MAC).

  HINT: NOT ALL CODES ARE IN THE SAME PLACE. LABORATORY FEE SCHEDULES ARE IN THE LABORATORY SECTION OF CMS PUBLICATIONS; AND OTHER CODES ARE FOUND ONLY IN THE MAC FEE SCHEDULES OR IN AN LCD.

  HINT: PURCHASING CODE BOOKS ANNUALLY ASSISTS IN RECOGNIZING THE RETIRED OR MODIFIED CODES.
Managed Care Contracting

• Four elements analysis and construction

1. Evaluation and Negotiation Checklist – copy of contract; fee schedule – know your stats – hospital / ER / Urgent Care admission rates

2. Managed Care Contract Review Checklist – know your stats – they may give them to you in quarterly review – Hospital / ER / Urgent Care admission rates – the lower the better

3. Managed Care Contact Analysis – what are they paying you – take the top 25 CPT compare reimbursement against Medicare

Managed Care Contracting

• Managed Care Contract Status Reports – Develop a grid for the staff, what needs authorizations, referrals, “carve out” testing

• HINT: PAY CLOSE ATTENTION TO THE “CARVE OUTS” AND THE APPEALS PROCESS; SOME COMPANIES HAVE VERY SHORT APPEALS PROCESS LIMITS.
Managed Care Contracting

• **HINT: PERIODICALLY ANALYZE YOUR PAYMENTS:**
  
  • Make a grid of your top 25 CPT codes and your top Payors. You can then compare your Payors and Target the ones not paying well for either renegotiation or dropping.

Documentation and Coding

• Documentation --
  
  • .... It WAS a way for you to communicate with yourself
  • .... It BECAME a way to communicate with your colleagues
  • .... It IS the way to communicate with Payors -- the only way they know you and your practice is through numbers

• Documentation Guidelines – either 1995 or 1997

• CPT and ICD -10 work together to paint the picture of the patient – CPT tells what was done; and ICD 10 supports why you did it. (Diagnoses codes supports Medical Necessity)
Quality Measures

- PQRS, HEDIS, GPRO, MACRA and MIPS are all measures which have an affect on the Reimbursement System, and most of them will have a negative impact if “thresholds” are not met.

- The introduction of MACRA and MIPS in 2017 has caused a great deal of angst for practices, but it is manageable.
  - MACRA is the law that introduced MIPS
  - MIPS is PQRS in a different coat....

Coding Compliance

- Three components of a Coding Compliance Plan:
  1. **Evaluation and Management Utilization Analysis** -- this analysis compares the physician to a national data base and will help you compare if the physician is “over/under” coding relative to their peers.
     - Note: the results of the analysis shows the practice is “different” than the peer group, and a chart review can validate the documentation supports the CPT code. DIFFERENT IS DIFFERENT, NOT WRONG.
  2. **Documentation Chart Review** -- Pre-billing review, establish time frame and thresholds for review.
  3. **Independent Physician Education** -- If the review shows “over/under” coding, then provide detailed education for the physician so that future errors do not occur.
Physician Reimbursement Improvement

- Annual Wellness Exams
- MIPS
- Transitional Care Management
- Chronic Care Management

Billing and Collection Processes

- Five major elements of the Billing Process:
  1. Claim Form errors
  2. Advanced Beneficiary Notice
  3. Non-physician Practitioners (Incident To billing)
  4. Place of Service
  5. Modifiers
Claim Form Errors

- **Clerical Errors** -- mainly discussion of the incorrect completion of the CMS 1500 form; not having the correct information in the right block -- for the most part these errors have been eliminated with electronic claims submission.

- **Patient Data** -- still a major source of claims rejections; Name, Sex, DOB, Incorrect Insurance Data --

- **Regulatory Errors** -- (LCD / NCD or payor rules) -- not having specific diagnoses when ordering testing, or knowing the specific guidelines for claims approval (e.g. Knee/Hip replacement).

Advanced Beneficiary Notice

- The ABN is a written notice you must issue to a Fee-for-Service beneficiary before furnishing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of Medical Necessity.1

- The ABN is required to be on the CMS form: **Advanced Beneficiary Notice of Noncoverage (ABN), Form CMS – R - 131.**

- ABN’s must be filled out correctly, there are guidelines on what to do if the patient refuses to sign, when to offer an ABN, and how frequently the ABN can be used.

- **NOTE:** **MAKE SURE YOU REFRESH YOUR COPIES**

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1CMS, ABN Booklet, ICN00626, October 2016
ABN References

*ABN Forms and Instructions, Rules, and Financial Liability Protections*

- ABN Questions Revised [ABN_ODF@cms.hhs.gov](mailto:ABN_ODF@cms.hhs.gov)
- General Information
  - [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html) on the CMS website
- “Medicare Claims Processing Manual” (Publication 100-04), Chapter 1, Section 60.4.1, located at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf) and

Non-Physician Practitioners (Incident To Billing)

- “Incident to” billing is complicated by three factors:
  1. State Regulations – Medical Practice Act, Nurse Practice Act
  2. Location of the Services Provided (billing Place of Service)
  3. Provider or facility Guidelines

- Scope of Practice Hierarchy
  - Level 1 – State Regulations
  - Level 2 – Provider or Facility Guidelines
  - Level 3 – CMS Billing (and Documentation) Requirements
  - Level 4 – Non-Medicare CMS Billing Requirements (Commercial)
Place of Service

**HINT:** AT THE HOSPITAL DOES NOT MEAN IN THE HOSPITAL: AND IN THE HOSPITAL DOES NOT ALWAYS MEAN AN INPATIENT

Place of Service has become more difficult for the physician office staff, as the location and definition of A PATIENT have important differentiations.

- In-patient vs. Observation
- LTAC vs. Rehabilitation vs. Skilled Nursing
- Nursing Home
- Home Health in a facility

Modifiers

- Modifiers have always been important; however the changes proposed and implemented have made even the simplest modifier placement questionable.

- When to use modifier 25, or 59 have long been topics of discussion with CMS having “special” newsletters regarding its use.

- Annual education or documentation reviews by the billing staff are increasingly more important and becoming almost mandatory to ensure a smoothly run Claims processing.
Claims Management

• Timely Submission
• Claims Validation

Timely Submission

I am sure that everyone is well aware of timely submission of claims, so we won’t belabor the point. However, think about timely resubmissions; RFI, disputed claims etc.

Our recommendation is to have no more than 5 days accumulated claims for submission.

• Computing Days to Bill
  • Total Claims $ to be billed /Average $ per Day
Claims Validation

Claims validation is usually a simple process, and is the first step in getting “clean” claims --
• The four steps are simply stated (it may be more complex than this, but these are the rudimentary four steps):
  1. To Clearinghouse
  2. From Clearinghouse
  3. To FI
  4. From FI

Accounts Receivable Management

• Generally the largest Asset of the Medical Practice
• Generally the least understood part of the Medical Practice
• Generally the most Ignored part of the Medical Practice
A/R Management

- We have broken this into only three sections:
  1. Claims Denial
  2. Posting
  3. Accounts Receivable Analysis

Denials

- One of the most overlooked aspects of A/R Management; usually denials fall into four broad categories:
  1. Requests for Information
  2. Non-covered services
  3. Medical Necessity
  4. Unspecified ICD – 10 – CM Codes

- RECOMMENDATION: Establish a Systematic EOB Review, determine if there are patterns/trends and work to correct those.

- RECOMMENDATION: Establish a Systematic Denial and Appeals Review (are your appeals being denied, is there a pattern/trend)
Denials and Appeals

• Review them ALL

• Appeal them ALL

Posting

• Post Daily...

• Posting keeps the account current and will then keep accurate Accounts Receivable and Patient / Insurance Balances.
Accounts Receivable Analysis

• “Look Behind” the numbers:
  • A/R by date of Service
  • A/R by date of Billing
  • A/R by Payor – What Payor is paying slowly, what does the contract say about timely payment?
  • Highest Payor A/R and why?
  • Patient Balances – how many, how much?
  • Value A/R and Balances – how much could we collect

Accounts Receivable Analysis

• Looking Behind the numbers –
  • The reviewer should look at the balances, but are there trends to these accounts, why have they gotten to this point (30, 60 or 90 days), are we bumping up against “timely filing”.

  • If we can identify trends, then can we correct the issues so that we don’t have a continuing problem.

  • Keep in mind a cleanup of A/R will be a short term infusion of cash, but getting paid on time and fully will increase the cash flow of the practice.
Cash Management

- Patient Centric
  - Collecting Co-pays, deductibles and outstanding balances at the time of service.
    - Set collection goals for staff
    - Give "prizes" for best collector

- Practice Centric
  - The whole process of managing cash is sometimes not the manager’s responsibility, but the manager can help cash a number of ways:
    - Make sure that Vendor Invoices are processed for payment timely (late fees can take quite a toll on the practice)
    - Evaluate Bank Fees
    - Make sure that your “getting what you pay for” (cable bills, telephone bills, IT services, billing services (carve out capitation payments), etc.}

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