Clean Claims and Revenue Cycle Management (RCM)

General Overview and Refresher
Agenda

I. Revenue Cycle Management

II. Medicaid Managed Care Plan Network and Claiming Requirements

III. Submitting a Clean Claim
Revenue Cycle Management (RCM)
What is Revenue Cycle Management?

- Describes the life cycle of a client account and services provided from creation to payment collection and resolution.
- Includes all administrative, clinical, compliance, quality assurance and other functions that contribute to the capture, management, and collection of revenue.
How is the Revenue Cycle Unique as an Organizational Process?

- Brings together workgroups and staff who do not work together in any other context
- Develops interdependencies across administrative, clinical, compliance, quality assurance and other departments
- Revenue generation is the cornerstone of fiscal viability. Inefficiencies, errors, and oversights can have a devastating impact
- Works toward aligning clinical priorities and fiscal/billing priorities
Scheduling & Pre-registration → Point of service registration & collection → Charge Capture & Coding → Claim Submission → Payer follow-up → Remittance processing → Appeals, collections, and analysis

Contract Management
Quality Assurance
Utilization review
Credentialing
Regulatory Compliance
Phases of the Revenue Cycle

Prior to Service
- Eligibility & Verification
- Authorization
- Scheduling

During Service
- New Client Registration
- Eligibility & Verification
- Collection of Fees
- Charge Capture & Coding

Following Service
- Claims Submission
- Payer follow-up
- Remittance Processing & Posting

On-going
- Analysis
- Process Improvement
- Registration

For detailed information on each of the Revenue Cycle phases, go to the "resources" section of the slide deck
How Might RCM Address Operational Challenges?

- Clearly articulate, define, and measure performance standards
- Differentiate people problems from system problems
- Address people problems quickly and effectively
- Provide staff with the tools, information, and training they need to successfully carry out their tasks
How Might RCM Address Operational Challenges? (continued)

• Implement a quality improvement process and team to address system problems in order to:
  ▪ Bring together workgroups and staff
  ▪ Create tools
  ▪ Decide upon and measure against standards
  ▪ Document
  ▪ Address problems in a timely manner
  ▪ Communicate

• Assure that executive, clinical, and finance leadership are on the same page
Tools to Support RCM

A full-featured, properly implemented Electronic Health Record (EHR) that includes both documentation and billing within one system can bring significant efficiencies and accuracy to the revenue cycle process by...

- Providing electronic scheduling to maximize the use of provider capacity
- Efficiently evaluating insurance eligibility
- Tracking authorizations and alerting staff when they are approaching thresholds
- Providing behind the scenes management of charge capture and coding to eliminate errors, maximize revenue and minimize audit risk
- Catching and suspend claims that do not meet payer and documentation requirements minimizing audit risk
- Efficiently posting payments to maintain accurate client accounts
- Providing reports necessary to address staff, system, and payer performance issues
EHR Alternatives

Short of a fully functional EHR, here are some possibilities:

- Combination of systems i.e. an Electronic Medical Record (EMR; clinical documentation only) and a separate billing service

For billing alone (without electronic documentation):

- Outsourcing billing services
- Clearinghouse Services
- In house standalone billing systems
Medicaid Managed Care Plans (MMCP) Tips for Successful RCM

- Develop a good relationship with your clearinghouse vendor
- Review HIPAA requirements for electronic claim submissions
- Review and respond to clearinghouse reports (i.e. acceptance and denials)
- Promptly make corrections and submit the claim(s) to clearinghouse
- Quickly review and respond to payer remittance advices to allow time for corrections and appeals
MMCP Tips for Successful RCM (continued)

• Remember **timely filing** deadlines

• Review and update your 837i or UB-04 claim form. Make adjustments to ensure that the correct information is in each field to avoid delays/denial of payment

• Be mindful that claims forms often have pre-populated fields which worked for FFS but won’t work with MMCPs

• Sign up for Electronic Payments and Statements with each payer

• Know the unlicensed practitioner number for OMH, OASAS, and OCFS
Medicaid Managed Care Plan (MMCP)

Network and Claiming Requirements
MMCP Network Requirements

• MMCPs are held to specific network requirements. NYS monitors MMCP contracting regularly to ensure network requirements are met.

• A MMCP has the discretion to deny a claim from an out of network provider who does not have a single/case agreement.

**MMCPs must allow a provider to continue to treat an enrollee on an out-of-network basis for up to 24 months following the implementation date by providing a single case agreement.**
Single Case Agreement

- Single Case Agreements (SCA) may be executed between a MMCP and a provider when an out of network provider has been approved by a MMCP to deliver specific services to a specific MMCP enrollee.

- MMCPs must execute SCAs with non-participating providers to meet clinical needs of children when in-network services are not available.
Claim Submission

• MMCPs and providers must adhere to the rules in the billing and coding manuals.
• MMCPs shall support both paper and electronic submission of claims.
• MMCPs shall offer its providers an electronic payment option including a web-based claim submission system.
Clean Claims
Important

Please note this guidance applies to outpatient/ambulatory services only
Billing Requirements

• Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by first typing in “24” followed immediately with the appropriate four-digit rate code.

• Every claim submitted will require at least:
  - 837i (electronic) or UB-04 (paper) claim format;
  - Rate code;
  - Valid CPT code(s);
  - CPT code modifiers (as needed); and
  - Units of service
Timely Payment

- Insurance Law § 3224-a requires insurers and health maintenance organizations to pay undisputed claims within 45 days after the insurer receives the claim, or within 30 days if the claim is transmitted electronically.
Credentialing

• When credentialing, MMCPs shall accept state licenses/designation, operation and certifications in place of, and not in addition to, any MMCP credentialing process for individual employees, subcontractors or agents of such providers.

• MMCPs can still collect and accept program integrity related information from providers.

• MMCPs shall require that such providers not employ or contract with any employee, subcontractor or agent who has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.
Tips for Submitting Clean Claims

- Claims are submitted using standard, CMS defined/approved templates.
- Most businesses find it most economical and efficient to bill electronically. Electronic claims are submitted using an 837.
- 837s are standardized so that they can feed data directly into a database in a 1:1 transfer.
- It is very important that you enter appropriate data in each field.
  - For example, just as you would not enter a procedure code in the surname field on a paper claim, you should also make sure that the same happens in electronic format.
Tips for Submitting Clean Claims (continued)

• You have the option to procure/build your own claiming software or contract with a billing vendor.
  ▪ Procurement will require upfront funds.
  ▪ Billing vendors typically charge a percentage of total revenue or a flat rate per claim.

• You typically receive payment more quickly when billing electronically using an 837, because the claim can usually be reviewed by a system instead of a person.
Tips for Submitting Clean Claims (continued)

• If you choose to submit paper claims, the claim needs to be reviewed by a person, which typically takes longer.
  - Furthermore, if the claim is not “clean” (if there are errors or missing information) it will need to be returned to you via mail, corrected by hand, and re-submitted manually before payment can be made.

• Although paper and electronic claim forms are standardized, certain fields might vary from plan to plan.
  - For example: One plan might require a piece of information that is optional at another plan. Or, the specific definition of a field might vary from plan to plan.
Important Billing Fields

This section of the presentation will emphasize fields that have very specific rules or fields that can often be the cause of denials.

Please refer to the MCTAC Billing tool for information regarding completing all fields of the UB-04.
FL 04

Type of Bill – Four Digit Alphanumeric Code

1\textsuperscript{st} Digit
- 0 (Leading 0)

2\textsuperscript{nd} Digit
- Identifies the type of facility

3\textsuperscript{rd} Digit
- Identifies type of care

4\textsuperscript{th} Digit
- The sequence of this bill, referred to as “frequency”

REQUIRED
See following slides for Code Set
FL 04

1\textsuperscript{st} Digit

0 (leading 0)
Identifies the type of Facility

1. Hospital
2. Skilled Nursing
3. Home Health Facility (Includes Home Health PPS claims, for which CMS determines whether the services are paid from the Part A Trust Fund or the Part B Trust Fund.)
4. Religious Nonmedical (Hospital)
5. Reserved
6. Intermediate Care (not used for Medicare)
7. Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8. Special facility or hospital ASC surgery (requires special information in second digit below).
9. Reserved
Bill Classification (Except Clinics and Special Facilities)

1. Inpatient (Part A)
2. Inpatient (Part B) - (For HHA non PPS claims, Includes HHA visits under a Part B plan of
3. Outpatient (For non-PPS HHAs, includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment). For home health agencies paid under PPS, CMS determines from which Trust Fund, Part A or Part B. Therefore, there is no need to indicate Part A or Part B on the bill.
Bill Classification (*Except Clinics and Special Facilities*)

4. Other (Part B) - Includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for “nonpatients,” and referenced diagnostic services. For HHAs under PPS, indicates an osteoporosis claim. NOTE: 24X is discontinued effective 10/1/05.

5. Intermediate Care - Level I

6. Intermediate Care - Level II

7. Reserved for national assignment (discontinued effective 10/1/05).

8. Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).

9. Reserved for National Assignment
Bill Classification (*clinics only when 7 is used as a second digit*)

1. Rural Health Clinic (RHC)
2. Hospital Based or Independent Renal Dialysis Facility
3. Free Standing Provider-Based Federally Qualified Health Center (FQHC)
4. Other Rehabilitation Facility (ORF)
5. Comprehensive Outpatient Rehabilitation Facility (CORF)
6. Community Mental Health Center (CMHC)
7. Reserved for National Assignment
8. Reserved for National Assignment
9. OTHER
Bill Classification (*special facility only*)

1. Hospice (Nonhospital Based)
2. Hospice (Hospital Based)
3. Ambulatory Surgical Center Services to Hospital Outpatients
4. Free Standing Birthing Center
5. Critical Access Hospital
6. Reserved for National Assignment
7. Reserved for National Assignment
8. Reserved for National Assignment
9. OTHER
4th Digit

1. Admit Through Discharge Claim
2. Interim-First Claim
3. Interim-Continuing Claims
4. Interim-Last Claim
5. Late Charge Only
6. Replacement of Prior Claim
7. Void/Cancel of a Prior Claim
8. Final Claim for a Home Health PPS Episode
a – d) Value Code

a – d) Value Code Amount

Providers will enter the rate code in the header of the claim as a value code. This is done in the value code field by entering “24” followed immediately with the appropriate four digit rate code.

Based on licensure or certification, programs submit one claim per rate code per day, per week, or per month.

REQUIRED - Please note:

- **For Excellus** (MMC, HARP, Essential Plan, and CHP), Empire Blue Cross Blue Shield HealthPlus & BlueCross BlueShield of WNY – Value Code must be followed by “00”
- **For United** – Value Code must be followed by “00” on the paper claim only; *not the electronic submission*. That include value code “24” under CODE
- **Emblem Health/Beacon** situationally requires
Revenue codes REQUIRED

Note: revenue codes must be 4 digits with leading 0.
CPT/HCPC/Procedure Code

Modifiers go in the same field as the procedure code. This field allows five digits for the procedure code and another 8 digits for modifiers, up to 4 modifier codes can be included with the procedure code. (See billing manuals for required modifiers)

REQUIRED

Please note: Emblem Health/Beacon requires situationally
NPI
Agency/Program NPI REQUIRED

For CFTSS and Children’s Aligned HCBS: all designated agencies must obtain an NPI number and link that number, when enrolling as a Medicaid Provider Agency in order to submit claims for reimbursement.

For more information view state guidance.
Principal Diagnosis Code: For claims which may not be directly related to a diagnosis, but for which a valid code is required to comply with the Implementation Guide, such as Child Care, Managed Care, and Waiver Services, NYS DOH will accept ICD-10 code R69 – Illness, unspecified.

REQUIRED

*Please note: For United use F99 – mental disorder not otherwise specified*

For OTP Services: To facilitate claiming it is recommended these programs use ICD-10 for the entire week.

a – q) Other Diagnosis and POA Indicator

NOT REQUIRED
Attending Provider NPI and Qual

Attending Provider – Last Name/First Name

REQUIRED

If the individual licensed practitioner is Medicaid enrollable* they must enroll and use their individual NPI number on claims. If the individual practitioner is unlicensed or not a licensed enrollable Medicaid practitioner* the OMH (02249154), OASAS (02249145), or OCFS (05448682) unlicensed practitioner ID may be used.

* There are certain licensed/credentialed practitioners that cannot become a Medicaid provider: Licensed Master Social Worker (LMSW), Licensed Marriage and Family Therapist, Licensed MH Counselor, Licensed Creative Arts Therapist, Applied Behavioral Analyst, Credentialed Alcohol and Substance Abuse Counselor (CASAC), and Peer.
For Electronic/EDI Claims: When submitting claims utilizing an unlicensed practitioner ID as Attending, providers will submit the NM1 Attending Provider Loop 2310A as follows:

- NM108 and NM109 will be blank/not sent
- REF Attending Provider Secondary Information will be added
- REF01 G2
- REF02 the OASAS, OMH or OCFS unlicensed practitioner ID
  - (example: REF*G2*02249145~)
Other Provider NPI and Qual

Other Provider Last Name/First Name

REQUIRED

for referring provider information, with exception of Emblem Health/Beacon where is situationally required (e.g. referring physician) and Excellus which does not require for Mental Health Providers
ACT – Agency’s NPI should be used

Children and Adult HCBS – Agency’s program NPI

Children and Family Treatment and Support Services - the NPI of the LPHA who made the recommendation for services should be used if the individual is an enrollable practitioner type. If the LPHA is a practitioner type that cannot enroll in Medicaid*, the NPI number of the agency must be used.

PROS – the LPHA who makes the recommendation for PROS
Common Errors/Mistakes

1. Incorrect rate code (where applicable)
2. Authorizations not obtained (when required)
3. Total charges less than Medicaid rate
4. Type of bill for resubmission/rebilling
5. Modifiers are missing or wrong
6. Site/Program is not credentialed or on file
7. Eligibility – Member is not part of plan
8. Diagnosis
9. Timely Filing
10. Incorrect Client Information
11. Wrong Procedure Code or Place of Service
What To Do When Things Go Wrong?

1. Review internally

2. Gather information/data and be specific such as
   - Is this issue specific to a program/service?
   - When did it start?
   - What do you think the issue/problem is?
   - Review the 277CA the “Claims Acknowledgement Report”: The 277CA acknowledges all accepted or rejected claims in the 837 file. This is prior to adjudication.
   - Review the 835, the “835 Health Care Payment / Advice”, also known as the Electronic Remittance Advice (ERA), which provides information for the payee regarding claims in their final status, including information about the payee, the payer, the payment amount, and any payment identifying information.
What To Do When Things Go Wrong?

(continued)

3. Try to determine if it’s internal process/set up issue or external

4. Review Billing Manual and Integrated Billing Guidelines to make sure you are meeting billing requirements

5. Review

6. Matrix – Managed Care Information

7. Contact Managed Care Organization

8. Provide data/information
Tools

• **Managed Care Plan Matrix** – comprehensive resource for MMCP contact information relevant to adults and children

• **Billing Tool** – Children System specific updates – coming soon!
Questions and complaints related to billing, payment, or claims should be directed to the following list:

Specific to Medicaid Managed Care and for any type of provider/service:
Managedcarecomplaint@health.ny.gov

Specific to a mental health provider/service:
OMH-Managed-Care@omh.ny.gov

Specific to a substance use disorder provider/service:
PICM@oasas.ny.gov

Specific to an OPWDD provider/service:
Central.Operations@opwdd.ny.gov

Specific to an OCFS provider/service:
OCFS-Managed-Care@ocfs.ny.gov

General provider enrollment questions:
providerenrollment@health.ny.gov
Questions and Discussion

Please send questions to: mctac.info@nyu.edu

Logistical questions usually receive a response in 1 business day or less.

Longer & more complicated questions can take longer.

We appreciate your interest and patience!

Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access resources.
Resources
Billing Manuals

• New York State Children’s Health and Behavioral Health Services Billing and Coding Manual

• New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual

• New York Medicaid Program 29-I Health Facility Billing Guidance
More information on the Revenue Cycle Process
Phases of the Revenue Cycle

Prior to Service
- Eligibility & Verification
- Authorization
- Scheduling

During Service
- New Client Registration
- Eligibility & Verification
- Collection of Fees
- Charge Capture & Coding

Following Service
- Claims Submission
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On-going
- Analysis
- Process Improvement
- Registration
Prior to Service

Eligibility verification

• When possible insurance eligibility and benefit verification should take place before the initial visit and checked regularly after that.

• Staff should have a working knowledge of the most commonly seen insurance plans and coverage options.
Prior to Service

Authorization

• Some plans may require authorizations that should be identified when verifying eligibility
• Each payer will have a unique process for securing authorizations
• Most authorizations will have timeframes and visit limits that will need to be tracked
Prior to Service

Scheduling

• When possible scheduling should be centralized and electronic
• If an insurance plan requires staff to have specific credentials to deliver a reimbursable service, care should be taken to ensure the client is scheduled with an approved provider in order to be reimbursed for the service.
During Service

New client registration

• Efficiently collect information necessary to establish a new client record including basic demographics, financial information, and financial agreements.

• Clients need to be made aware of fee policies and any payment responsibility they may have.

• Important to check eligibility
Eligibility Verification

• Medicaid Fee for service and Medicaid Managed care verifications can be done by:
  - Telephone
  - VeriFone Vx570
  - ePACES
  - Batch upload (270)

• The most efficient means to verify Medicaid eligibility is the electronic transmission of a 270 directly from the billing component of your EMR/EHR or billing software. A 271 will be returned to your billing system which should create a variance report for reconciliation.
During Service

Charge capture and coding

• Documenting the type and duration of service provided and transforming that into a data set necessary to support a clean claim.

 Whenever possible charge capture should be standardized. One of the approaches is to develop and implement a Chargemaster.

 EHR/EMR setup should make it easy to identify when a modifier should be applied to the base rate. The proper selection of modifiers is critical to revenue maximization because in many instances they are associated with higher reimbursement rates.
During Service

Charge Capture and Coding (continued)

- If the charge is not captured through the EHR/EMR then:
  - Staff should be provided with a Chargemaster they can use to cross walk from the service they provided to the proper billing code.
  - An efficient process must be in place to record, verify, and accurately report services provided to be entered into the billing program.
  - Care must be taken to assure that minimum duration standards are met and that the CPT code for the transaction matches the start and end time on the clinical documentation.
During Service

Improper or Inaccurate Coding

• Improper or inaccurate coding carries a significant risk of disallowance upon subsequent audit

  - Strong quality assurance programs must be in place to assure codes are correct and supported by the clinical documentation.

  - It is essential that staff understand the billing rules that guide their practice and documentation.
After Services

Claim submission

• Submission of billable fees to the insurance company via the required universal claim form.

☐ Claim data can be submitted directly to the payer or through a clearinghouse

☐ Processes must be in place to “scrub” claims to assure that they are clean.
After Services

Claim submission

• Some common tests should be:
  □ Was the claim formatted correctly and are all required data elements present
  □ Was the service of the required duration for the code
  □ Was the documentation completed properly:
    ◦ Progress note was completed
    ◦ Service was on the treatment plan
    ◦ Treatment plan was up to date
• Claims should be submitted as soon as feasible
Improper Claiming

- Improper claiming can be very costly
  - Each claim that is rejected due to improper formatting must be “touched” and resubmitted
  - Claims that are submitted without adherence to documentation regulations create a huge risk for disallowance upon audit
After Services

Capturing Errors

• EMR/EHR can suspend claims and alert staff to errors that renders the claim unbillable and support quality improvement efforts and regulatory compliance.

• If there is no EMR scrubbing of claims it is essential that there is an active Quality Assurance process that identifies improper claims and voids them when necessary.

• Clearinghouses can do a good job at scrubbing claims with technical errors but only an EMR/EHR with a billing component can evaluate claims for compliance with documentation requirements.
Denials

• Review denials on a regular basis
• Review each denied claim and determine the cause
• Adjudicate claims, correct errors and resubmit promptly
• Identify preventable denials and apply a quality improvement process to correct the issue
Examples of Common Denials

- Claim was submitted after the allowable time period
- Visit was not authorized
- Client was not eligible
- Provider was not credentialed
- Claim had incorrect client or provider data
- Provider technical error
- Payer technical error
After Services

Not Just Denials:

• **Not Billed**
  - Due to EHR/EMR billing rules, claims might be held back. These are not denials
  - Clearinghouse can also hold claims back due to their rules

• **Rejection**
  - Due to numerous errors, claims might not be processed (never get to the payer) at all and fall into rejection category, for example, wrong ID or Name on the claim.

• **Pending**
  - Sometimes the payer, including Medicaid, will Pend the claim due to missing information or further reviews internally
Remittance Process and Posting
• Posting and applying payments and adjustments to client accounts and posting payments in aggregate amounts to the General Ledger
  - Post payments in a timely fashion
  - Compare payments received to amounts billed and reconcile differences
  - Review adjustments made by the payer to individual claim. Appeal adjustments when warranted
Ongoing

Analysis

• Review and evaluate the effectiveness of your revenue cycle management and the performance of your payers.

  - Create an analysis standard metrics to identify issues and processes that may need improvement
  - Quantify issues related to payers and discuss with your customer service representatives
Some standard metrics

- Collection ratio: a total collected to total billed reviewed by payer and payer class
- Aged accounts receivable: Dollar value of accounts receivables tracked by amount of time they have been outstanding:
  - Less than 30 days
  - 30 – 60 days
  - 60 – 90 days
  - 90 – 120 days
Ongoing

- Standard metrics continued
  - Denial report – percentage and amount of claims denied by reason, clinician, and payer
  - Percentage of claims paid upon initial submission

Process improvement

- Formalized process using your analytics to identify problems, create solutions, implement change, and measure the results.