“Understanding the Billing Claim Cycle”

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Webinar content

Basic Concepts

Claims Generation & Transmission

Claims Processing

Claims Adjudication

Billing Claim Cycle
Target Audience

This webinar is intended for organizations:

• Which are currently using paper for documenting and/or billing
• Which have a very limited or no billing experience at all
• Require to have a basic understanding of the claim processing
Basic Concepts
Basic Concepts

• **EBS**: Electronic Billing System
  - Software used ONLY for claim processing. Usually includes some demographics, billing and reporting capabilities

• **EMR**: Electronic Medical Record
  - Software which allows ONLY case documentation for medical or behavioral healthcare. It does not have billing functionalities

• **EHR**: Electronic Health Record
  - Software which allows case documentation and billing, all integrated within the same system
Basic Concepts

- **HMO**: Health Maintenance Organization
  - e.g., Oxford Health
  - Users should go to a designated network of providers
  - Users are only responsible for co-payment

- **PPO**: Preferred Provider Organization
  - Users can choose providers In-the-Network or Out-of-the-Network
  - If chosen In-the-Network: Users are only responsible for co-payment
  - If chosen Out-of-the-Network: Users should pay a percentage
Basic Concepts

• **POS: Point of Service**
  • Similar to PPO
  • Except that users are usually required for:
    • Co-payment
    • Co-Insurance: where the plans pays a percentage and the difference is paid by the user

• **Indemnity:**
  • There is NO-Network
  • Users can choose any provider, anywhere
  • Plans pays a percentage – User pays the difference
Basic Concepts

• **NF (No Fault):** Medical services due to automobile accident

• **WC (Worker Compensation):** Compensation after being hurt at work

• **Regular Medicaid or Straight Medicaid:**
  Government insurance for who needs financial assistance (adults and children)

• **Medicaid Managed Care Organizations:**
  Commercial/Private Insurance Carriers which had been outsourced by Medicaid to handle specific services.
Basic Concepts

- **Fee schedule**: Approved conditions by CMS which regulates healthcare services and payment
- **CPT (Current Procedure Terminology)**: Procedures and service codes
- **ICD10**: Diagnosis code (R69 only code for ALL HCBS services)
- **Rate code**: Amount of reimbursement for the service
- **Modifier**: Conditional details of the Procedural Code which might affect the Rate Code (e.g., Onsite vs Offsite; Individual vs Group)
Basic Concepts

• **HCFA1500/CMS1500**
  - Health Care Financial Administration Form 1500 or CMS1500: Center for Medicaid/Medicare Services Form 1500
  - Paper forms used for submit claims
  - Used for professional staff only

• **UB04:**
  - Paper form used for submit claims
  - Used by Organizations

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<tr>
<td>Professional Services</td>
<td>HCFA1500 or CMS1500</td>
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<td>UB04</td>
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Claims Generation & Transmission
Service delivery

- Service is delivered
- Service is documented
- Service is approved for claim

Claims generation

- Claim Batch is created
- Claim Batch File
- Claim Batch Report

Claims Transmission to the Payer

- Claims Scrubbing
- Claims Transmitted to Payer
- Claims Transmission Report
Basic concepts about claims....

• **Claim batch:**
  • Process that allows to consolidate multiple claims into a claim batch which will be ready to be sent for transmission

• **Claim batch file:**
  • Text file which consolidates multiple claims and transmitted to the payer.

• **Claim batch report:**
  • Detailed report of the data or information that is contained into the Claim Batch File
Claims Scrubbing and Transmission

• **Claims Scrubbing:**
  - Internal process in the software which reviews the claims in order to reduce errors before transmitting to the payer

• **Transmission Report:**
  - List ALL claims: Transmitted and Rejected

In theory the total number of the Claim Batch Report *should be equal* to the Transmission Report.

If not matched it is due to Claims Scrubbing
Claim transmission to the Payer

• **Two modalities:**
  - Payer direct
  - Clearinghouse: Intermediate organization which receives transmitted claim files and forward them to the proper payer

• **Clearinghouses:**
  - Some carriers only accept claims from a clearinghouse
  - Clearinghouses do additional scrubbing utilizing Correct Coding Initiative (CCI) Edits
  - CCI gets into more details of the rules for the claims. Internal scrubbing usually focuses on data existing in the claim (missing or not)

With the warning alerts we have somewhat eliminating the need of the CCI
Claim transmission to the Payer

• More about Clearinghouses:
  • Not free
  • Reports are usually generated within 24 hours after transmission
  • Reports included accepted and rejected claims
  • If rejected it always indicates error (e.g., incorrect diagnosis or modifier) or where to look
Claims Processing by Payer
837i is received from Provider → Additional Scrubbing → Payment Determination → Claim Remit File

Claims Processing by Payer
Claims processing by Payer

• Receives Claims Batch File (837i)
  • Transmitted by software or clearinghouse
  • Uploaded into the carrier’s system:

• Performs additional claims scrubbing:
  • e.g.: Policy Number (17 versus 71)

• Processes valid claims
  • Takes claims information
  • Determine if payable or not
    • If Payable determine amount
    • If not payable, provides explanation of why is not payable
Claims processing by Payer

• Generates report of results
  • Process approximately takes 15 to 20 days from the time of transmission to the time of receiving response from the carrier (range 7-30 days)
  • Usually response is electronic and it is called Claim Remit File or Explanation of Benefits (EOB)
  • After being received by provider software results are being posted to the individual chart. This is called automatic posting or auto-post
How to read the Claim Remit File/EOB IF claim is PAID

• Member Identification
• Charges: Fees for services provided
• Approved: Fee amount that the carrier is willing to pay
• Payment: Net payment paid by the carrier (direct deposit; check)
• Co-Insurance: Percentage of the approved amount that the member should paid. Usually applies for providers out of the network
• Patient Responsibility: Dollar amount that the member should pay to the provider
• Co-pay: Fixed amount that the member should pay. Usually applies for providers within the network

For HCBS Customers: The last three above will be blank
How to read the Claim Remit File/EOB IF claim is REJECTED

• In addition to the information of previous slide
• Denial Reason Code (DRC):
  • Coded in alpha or numeric which explains why the claims was not being paid
  • For example: Code 18 (Duplicate claim)
  • DRC for Straight Medicaid/Medicare are standardized
  • DRC for Commercial/Medicaid MCOs are not standardized
How to APPEAL a rejected Claim

• Deadline for appeals differs by each carrier/payer
• Proceed to appeal no later than 30 days after the date of rejection
• Method:
  • Written letter plus attachments
  • It should be sent via regular mail
  • DO not send via email for HIPAA Regulations
Claims Adjudication
Closing the claim cycle

• **Auto post payment:**
  • Remit file is instantaneously uploaded into each individual electronic chart

• **What should be the balance?**
  • When Payment Balance equals ZERO then claims payment is closed
  • One penny difference does not close the claim and leads the organization to **Write Offs**

• **Write Offs**
  • Organizational decision to reduce or charge the patient from remaining balances.
  • The agency can charge the patient only what the carrier has indicated in the column of Patient Responsibility
How do I follow up on my claims?

• **Balance Report:**
  - At the end of each day is important to run a report of all charges, adjustments and payments
  - We suggest you match the payment total with the deposit total

• **Account Receivables (AR) Report**
  - Lists status of balance of pending payments

• **Age Trial balance Report**
  - Same AR report but with the additional information of how long the balance has existed
  - e.g., <30 days; 30-60 days; 60-90 days; >90 days
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Many thanks for your attendance !!!