Principles of Revenue Cycle Management and Utilization Management

For Children's Providers

mctac THE MANAGED CARE TECHNICAL ASSISTANCE CENTER OF NEW YORK

Introduction & Housekeeping

Housekeeping:

- Slides will be posted at MCTAC.org after the last of these events
- Questions not addressed today will be:
  - Reviewed and incorporated into future trainings and presentations

Reminder: Information and timelines are current as of the date of the presentation

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Agenda/Objectives

I. Intro - 9:30AM

II. Revenue Cycle Management - 9:35-10:45AM

III. Break: 15 minutes

IV. Utilization Management - 11-12:15PM

V. Questions

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Children's Transition Timeline

2017

SYSTEM TRANSITION READINESS

Preparatory activities for children's system transition to include:

- Obtainment of NPI number
- Enrollment in NYS Medicaid Program
- Designation
- Contracting Fairs

JULY 1ST 2018

SPECIALTY BH BENEFITS TRANSITION TO MANAGED CARE

- Exemption from enrollment in managed care removed for children in all 1915(c) waivers
- Care Coordination services and staff fully transition to HH care management

JULY 1ST 2018

NEW SPA & ALIGNED HCBS SERVICES GO LIVE

- Six new Behavioral Health Children's Specialty Services available for children under 21 who meet medical necessity criteria
- Newly aligned children's HCBS services available through FFS and managed care
- Providers begin delivering services under new array

JANUARY 1ST 2019

VOLUNTARY FOSTER CARE TRANSITION & HCBS EXPANSION

- All children receiving foster care services will move into the managed care environment.
- Expansion of eligibility criteria for aligned children's HCBS to include children who meet Level of Need (LON)

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Revenue Cycle Management

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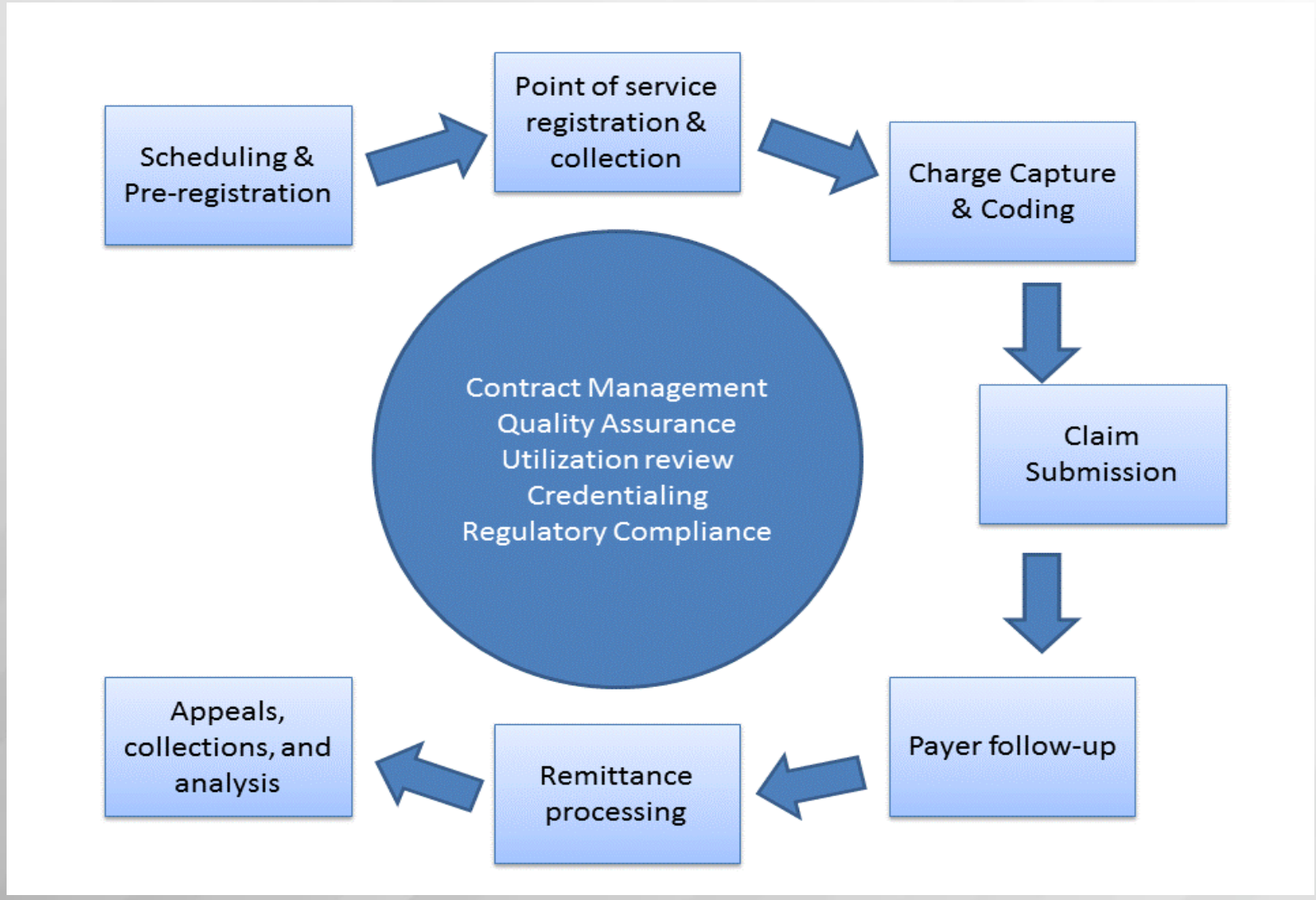
Revenue Cycle Defined

- All administrative and clinical functions that contribute to the capture, management, and collection of client service revenue. This describes the life cycle of a client account from creation to payment collection and resolution. The client account cycle is supported by a number of additional activities necessary to assure that all encounters are billable, meet regulatory requirements and revenue collection is maximized.

How is The Revenue Cycle Unique as an Organizational Process?

- Brings together workgroups and staff who do not work together in any other context
- Interdependencies exist across non- naturally occurring workgroups
- Revenue generation is the cornerstone of fiscal viability
- Inefficiencies, errors, and oversights can have a devastating impact
- Clinical priorities and fiscal/billing priorities are not always aligned


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

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Phases of the Revenue Cycle

- **Prior to Service**
  - Pre-registration including eligibility verification and authorization
  - Scheduling
- **During Services**
  - New client registration
  - Eligibility verification
  - Collection of fees
  - Charge capture and coding
- **Following Services**
  - Claims submission
  - Payer follow-up
  - Remittance processing and posting
- **Ongoing**
  - Analysis
  - Process improvement

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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
- Many payers have their own web portals or phone verification systems that can be used to verify eligibility

Authorization

- Some plans may require clinical authorizations that should be identified when verifying eligibility
- Each payer will have a unique process for securing authorizations
- Most authorizations will have visit limits that will need to be tracked

Prior to Service (continued)

Scheduling

- When possible scheduling should be centralized and electronic
- If an insurance plan requires specific staff credentials, care must be taken to schedule clients with providers that are reimbursable under the plan
- Efficiencies can be gained through “medical model” scheduling. In this model initial appointments are scheduled by front office staff, follow-up visits are set by front office staff based upon the clinicians instructions, and processes are put in place to “back fill” canceled visits.

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.
- Eligibility verification is also a service that can be provided by a billing clearinghouse.

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Charge Capture and Coding

Charge capture and coding

- Documenting the type and duration of the client encounter 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 basic charge. The proper selection of modifiers is critical to revenue maximization because in many instances they are associated with higher reimbursement rates.

Charge Capture and Coding (continued)

- If charge are not captured through the EHR/EMR then:
  - Staff should be provided with a Chargemaster that 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.

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.
  - 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

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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
- **Clearinghouses can do a good job at scrubbing claims with technical errors but only an EMR with a billing component can evaluate claims for compliance with documentation requirements. An EMR 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.**

Denials

- Review each denied claim and determine the cause
- Some common denials are:
  - 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
- Adjudicate claims, correct errors and resubmit promptly
- Identify preventable denials and apply a quality improvement process to correct

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

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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

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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

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Ongoing (continued)

- 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
- 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.

How Might You Address the Operational Challenges?

- Clearly articulate measurable performance standards for all staff with involvement in the revenue cycle process
- Measure against these standards regularly and differentiate people problems from system problems
- Address people problems quickly and effectively

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How Might You Address The Operational Challenges?

- Provide staff with the tools and information they need to successfully carry out their tasks
- Implement a quality improvement process to address system problems.
- Assure that Executive, Clinical, and Finance leadership are on the same page and speak with a single voice regarding revenue and the critical role it plays in supporting the mission of the organization

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Tools to Support Revenue Cycle Management

A full featured properly implemented EHR/EMR with a strong billing component can bring significant efficiencies and accuracy to the revenue cycle process:

- Provide electronic scheduling to maximize the use of clinical capacity
- Efficiently evaluate insurance eligibility
- Track authorizations and alert staff when they are approaching thresholds
- Behind the scenes management of charge capture and coding to eliminate errors, maximize revenue and minimize audit risk
- Catch and suspend claims that do not meet payer and documentation requirements minimizing audit risk
- Efficiently post payments to maintain accurate client accounts
- Provide reports necessary to address staff, system, and payer performance issues

Tools to support RCM (continued)

Short of a fully functional EMR/EHR a strong Revenue Cycle Management system, here are some essentials:

- Outsourcing billing services is an option
- In house stand alone billing systems are available
- A combination of in house billing systems (either EMR/EHR or stand alone based) and a clearinghouse claims processer is a popular option.

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MCO 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
- Review and respond to payer provider remittance advices to allow time to make corrections and appeals
- Remember timely filing deadlines
- Review and update your 837i or UB-04 claim form and make adjustments to ensure correct information is in each field to avoid delay/denial of payment with managed care payers
- Be mindful that claims forms often have pre-populated fields which worked for FFS but won't work with MCO's
- Sign up for Electronic Payments and Statements with each payer
- Know about the unlicensed practitioner number for OMH and OASAS

Lessons Learned

- **Clearinghouse**
  - Plan
  - Providers
- **Providers should contact the Electronic Data Interchange (EDI) to assist in the remediation of rejected claims.**
- **Know the capabilities of the Electronic Health Record as it relates to receiving payments from multiple payers.**

Remember

CLAIMS TESTING

CLAIMS TESTING

CLAIMS TESTING

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Break
15 mins

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Utilization Management Overview

What is UM and Why Is It Important?

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What is Utilization Management?

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What is Utilization Management?

- A set of techniques used by Managed Care Organizations to manage health care costs by determining the appropriateness of care (level of care, intensity, duration) of services covered under an enrollee's plan
- Primary purpose is to ensure that services are medically necessary and cost-effective
- Maintains fidelity and integrity of service provisions

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What's The Difference?

Utilization Management

- Function performed by MCO as a payer

VS.

Utilization Review

- Regulatory requirement performed by provider that stipulates periodic re-examination of open cases

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Why do MCOs Conduct Utilization Management?

Role

- An integrated system that manages health services for an enrolled population.
- Puts processes in place to assist in determining whether identified services are medically necessary based on specific criteria.

Function

- Ensure individual receives the least restrictive care
- Confirm services provided are medically necessary
- Certify treatment is appropriate to diagnosis, member needs, and member wishes.
- Make certain payment rendered is for only those services that are “medically necessary.”
- Review for the appropriate length of care.

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What does Medical Necessity Mean?

- Is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
- Appropriate services and supplies are those that are neither more nor less than what the individual requires at a specific point in time.
- Medical necessity is the standard terminology that all health care professionals and entities will use in the review process when determining if medical care is appropriate and essential.

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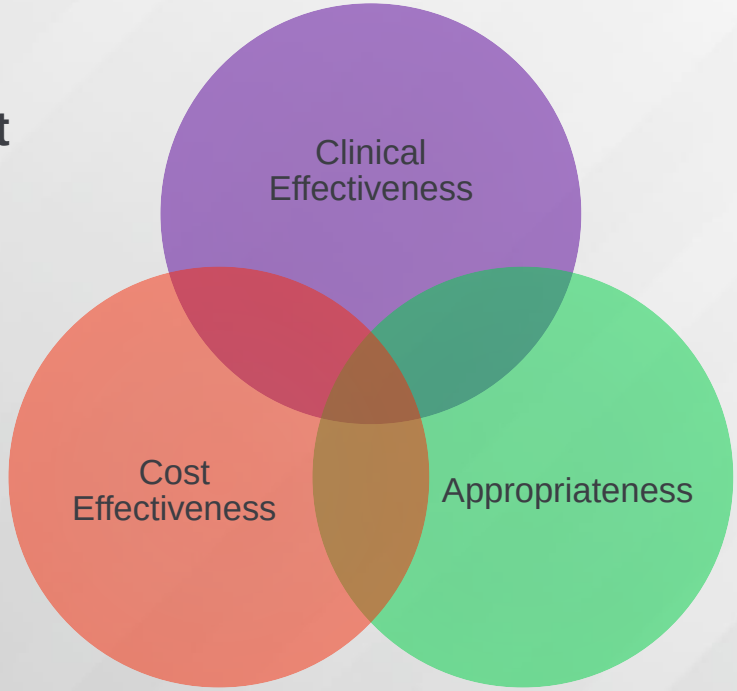
Medical Necessity Principles

Consistent Management of:

- **Clinical effectiveness - Treatment of illness, injury, disease or symptom must be proven to be clinically effective.**
- **Appropriateness - Type, frequency, extent and duration of services must be appropriate for the individual enrollee.**
- **Cost effectiveness - Services must not be more costly than alternative services that are just as likely to produce equivalent therapeutic and diagnostic results.**



All Components are needed for authorization

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What does Medical Necessity Mean?

- **New York State Department of Health requires the following definition of Medically Necessary:**
  - Medically necessary means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. (N.Y. Soc. Serv. Law, § 365-a).

Types of Reviews?

UM will occur at different points in the healthcare delivery cycle:

- **Prior authorization:** provider must request permission from the MCO before delivering a service in order to receive payment
- **Concurrent review:** occurs during an ongoing course of treatment (such as inpatient hospital admission) to ensure that such treatment remains appropriate
- **Discharge Review:** For inpatient, this review occurs prior to discharge to assure that plans are in place for a safe and supported re-entry into the community
- **Retrospective review:** review that takes place, on an individual or aggregate basis, after the service is provided

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Utilization Management Process

1) **Prior to calling the MCO**
   - ✓ Review Level of Care (LOC) criteria for the service being requested/discussed
   - ✓ Review the specific information regarding the individual (presenting problem, current symptoms, medications, recent treatment) and formulate a rationale for the requested service(s) and anticipated service units
2) **Contact the MCO representative**
   - ✓ Provide patient name, Date of Birth (DOB), Medicaid number (CIN) and your name, facility name and contact number
   - ✓ Identify the start date for treatment being requested
   - ✓ Request the services and number of service units (days, visits, etc.) necessary to deliver these services
   - ✓ Present rationale for request

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Utilization Management Process

3) **Discuss planned treatment changes (if any) and anticipated service units.**

4) **Always include overview of the long term treatment/support plan (including discharge planning steps if the individual is in an inpatient setting)**

- ✓ Communication with treatment providers (new, existing)
- ✓ Family meetings
- ✓ Medications (new, existing, changes)
- ✓ Patient involvement (family driven, youth guided, person centered approach)
- ✓ If inpatient, discharge plans: to home, transfer to another facility, etc..

Utilization Management Process

5) **Obtain decision from MCO, document and schedule next review if necessary**

- ✓ If adverse decision:
  - ✚ request rationale
  - ✚ request alternative services
  - ✚ consider MD to MD review
  - ✚ appeal

When Parties Disagree?

Dealing with Denials: Appeal and Grievance Process

1) **What if your organization cannot support the decision of the MCO?**
   - Conflict Resolution (both external and internal)
   - Are there liability issues in not providing a service, even if the MCO denies payment?

2) **If the respective clinicians do not agree on a plan of action, the next step is to formally submit an expedited appeal. Mandated timeframes guide this process for both the facility making the appeal as well as the MCO and must be adhered to.**

3) **The next steps in the appeal process is the Standard Appeal or External Appeal.**

When Parties Disagree?

Dealing with Denials: Appeal and Grievance Process

Each Managed Care Organization may have specific guidelines for initiating any of these options. They will all be similar but it is important for you to become familiar with the process for each MCO you work with.

Medicaid Managed Care Provider Guide

https://www.emedny.org/ProviderManuals/ManagedCare/index.aspx

Note: More on Appeal and Grievance in January

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A reminder:
The Member Bill of Rights...

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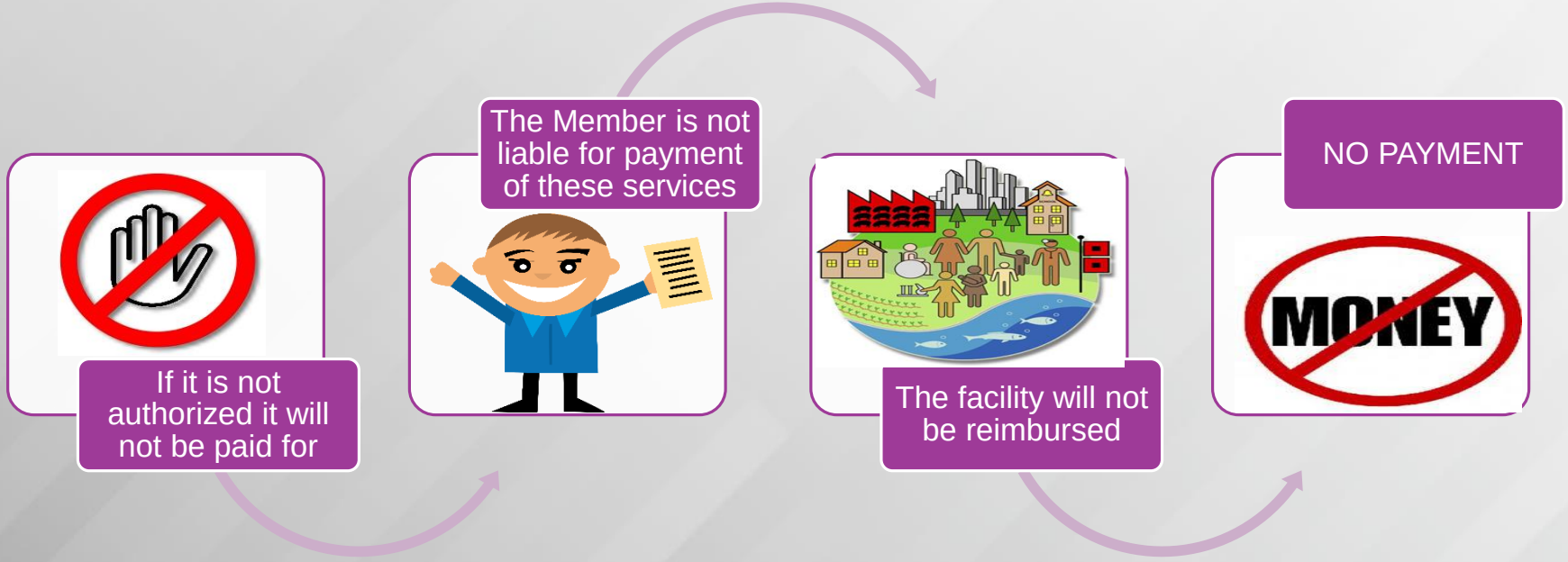
Utilization Management and Payment for Services

In a nutshell



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Role of Agency in UM Process…

Secure the optimal care for your clients…

Utilization Management Expectations

Medicaid Managed Care Transformation

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NYS State UM Expectations

- The State has provided guidelines for Utilization Management practices for the Behavioral Health Benefit Administration of the Medicaid Managed Care Program.
- Plans will use Medical Necessity Criteria (MNC) to determine appropriateness of new and ongoing services for Specialty BH services.
- Family Driven, Youth Guided, and Person Centered approaches will be the expectation when providing services.

NYS State UM Expectations

- **The Plan's UM system shall follow national and state standards and guidelines, promote quality of care, and adhere to standards of care, including protocols that address the following:**
  - Review of clinical assessment information, treatment planning, concurrent review, and treatment progress
  - Promotion of recovery principles
  - Promotion of relapse/crisis prevention planning

Medicaid Managed Care Organization Children's System Transformation Requirements and Standards

Final published July 2017

See section 3.8 on Utilization Management, pp. 50-56

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf

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More about the OASAS LOCADTR…

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LOCADTR: Background

- **Transition to Managed Care Carve In**
  - Want to ensure access to care
  - Need tool for provider-patient-plan communication
  - Tool aligned with NY treatment system

- **Goals**
  - Reliable/valid/credible
  - Include collective understanding of level determination
  - Placement in least restrictive yet appropriate setting
  - Simplified and expedient administration

https://www.oasas.ny.gov/treatment/health/locadtr/index.cfm

LOCADTR

- **Reflects OASAS clinical judgment about the appropriate level of care**
  - Based on ASAM
  - Tailored to NY:
    - Policy to increase MAT for opioids
    - Residential redesign
  - Required for MMC services
    - OASAS would like to extend beyond Medicaid
- **Training Needs:**
  - Diverse workforce:
    - Designed for someone with SUD clinical background
    - Eventually will be used by other providers
  - Working with managed care to develop workflow

LOC Principles

- Treatment should occur in the least restrictive setting that is likely to be successful.
- Resources may be added to increase the likelihood that the client can succeed in a lower level of care including care coordination through a health home, peer or other support services.
- Failure at an outpatient level of care, by itself, should not necessarily lead to a higher level of care.
- Access to a higher level of care that is needed should not be denied because the client has not failed at a lower level of care.

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What We Want in a Tool

- Speed- Able to be completed in minutes
- Relevance- Includes Levels of Care known and understood in New York
- Reliability- Predictability and accurately recommends the best level of care
- Credibility- Plans and providers accept the tool and agree that there is evidence to support the tool, face validity and empirical support
- Clinical Support- Provides information to clinicians to support level of care decisions to payers and auditors

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LOCADTR: Online Tool

- **Health Commerce System:**
  - The LOCADTR is a web-based application
  - Currently found on the Department of Health-Health Commerce System (HCS)
  - Users need to have a health commerce account with a user name and password

- **Online tool offers an opportunity for streamlined conversations with Plans:**
  - Plans will have access to LOCADTR
  - Ability to speak the same language to help with conversations with managed care plans

LOCADTR Assessment Layers

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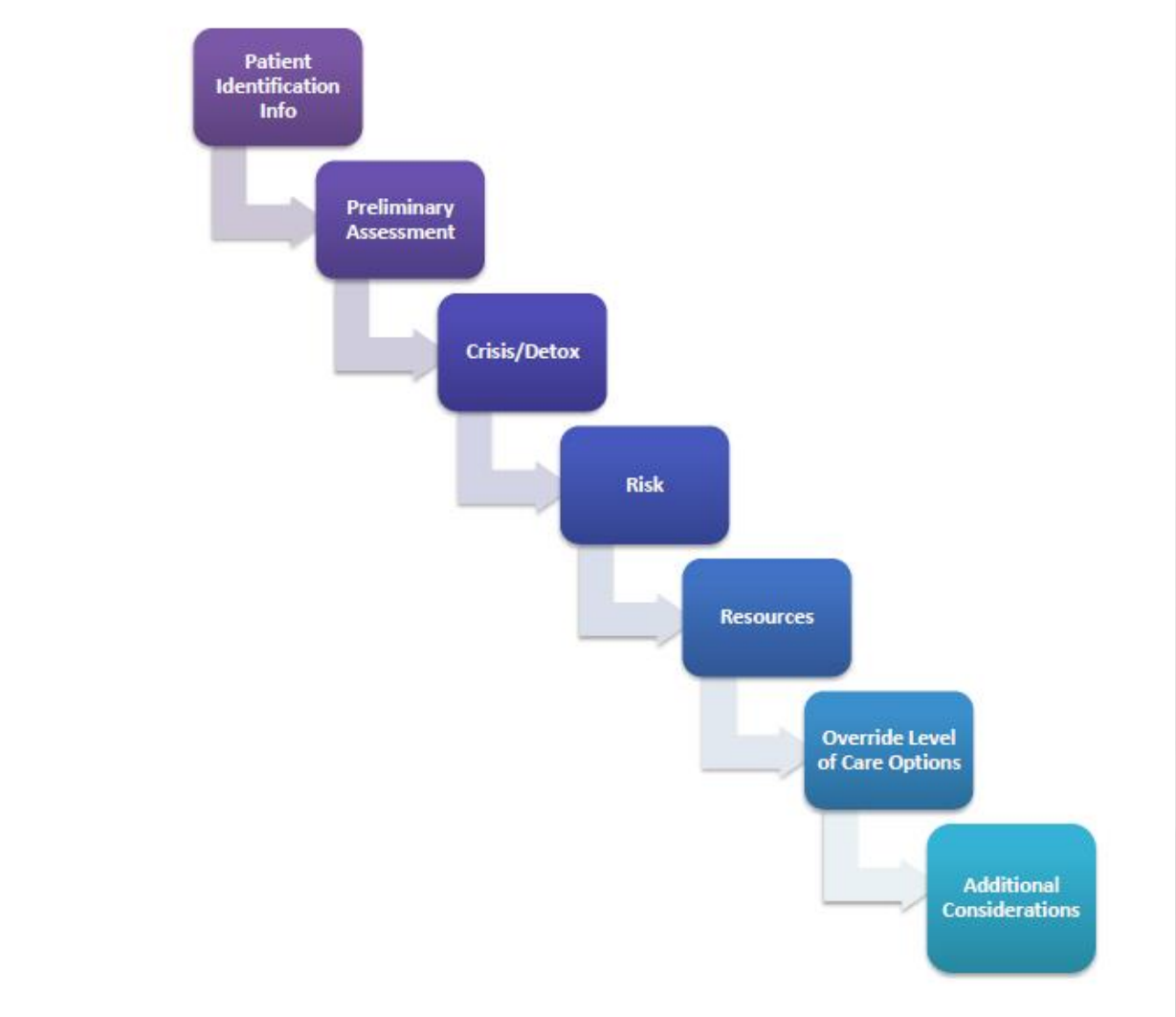
LOCADTR Schematic



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Strategies for Maximizing Utilization Management Outcomes

What Can Providers Do Today To Prepare For UM?

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Top 10 things to consider

1. Understand medical necessity criteria per service
2. Documentation integrity (i.e., dx and tx must match)
3. Examine level of intensity per service, identify outliers
4. Reference EBTs/Best Practices
5. Be able to provide a concise clinical presentation demonstrating how level requested is needed and will be used.

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Top 10 things to consider

6. Proactively staff cases of concern/high risk and have practical, individualized crisis plans that are up to date
7. Participate in any MCO workgroups
8. Have fully functional IT systems for reports and tracking
9. Be prepared for appeals, & know how to staff a case
10. Bump up any concerns!

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UM Strategies: Prepare Your Agency Staff

- Understand any requirements or qualifications for staff delivering the services and address any gaps in staff preparedness
  - For example: Family and Youth Peer Support Services
- Review and fully understand Level of Care admission, continuing stay and discharge criteria
- Understand MCO expectations for the review process
- Understand and embrace the MCO language tied to UM
- Practice reviews with Case Studies to gain comfort with the process

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UM Strategies: Effective Agency Practices

- Develop internal workflows with responsibilities clearly designated for staff members
- Develop population level reporting strategies to identify outliers by program by staff and client level
- Routinely monitor the quality of the service being provided and look for improvement opportunities.
- Seek feedback (degree of satisfaction) from those individuals receiving the services

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UM Strategies: Effective Staffing for UM

The Agency's Utilization Management staff member:

- Is a member of the treatment team and a part of the conversation
- Effectively communicates MCO concerns to the team
- Understands MCO terminology, treatment volume caps and effectively communicates with the MCO.
- Understands the treatment being provided and is not just extracting information from a client note or record
- Is familiar with all covered services under the Plan: OMH/OASAS Inpatient, Outpatient, clinic, PROS, HCBS, etc..
- Well informed of treatment modalities being utilized including medications
- Tracks the success of the individual in the service being provided and can articulate the success to the MCO
- Able to articulate the long term services plan developed to move the individual towards recovery and how the current service supports the long term plan.

MCO Tips for Successful UM

- **Make sure front line staff making the calls and submitting the documentation are as aware of regulations as supervisors**
- **Remember that the member ID card may not broadcast that the member is on Medicaid; Providers should attend MCO orientations to become more familiar with each Plan's Medicaid name, logo or other identifying feature and know how to contact that specific MCO for member authentication and/or service authorization**
- **Identify yourself as a Provider, in any communication with MCO:**
  - Caller/Sender name
  - Name of treating Provider/Facility
  - Provider Tax ID #
  - Address
- **Expedite a member authentication with this 2-point PHI validation process:**
  - Option 1:
    - Subscriber/Medicaid ID #; AND ONE of the following:
    - Member's full DOB (month/day/year)
    - SSN (last 4 digits suffice)
    - Address; or
    - Full phone #
  - Option 2:
    - Member's full DOB (month/day/year); AND ONE of the following:
    - Subscriber/Medicaid or Member ID
    - SSN (last 4 digits suffice)
    - Address; or
    - Full phone #

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Future Trainings

- SPA and HCBS Rates and Codes
- SPA and HCBS In-Depth Service Specific Implementation Support
- Billing Rules and Manual
- Utilization Management, Medical Necessity, Prior Authorization/Concurrent Review Criteria for Specialty Children's Services

- Want additional training? MCTAC+ focuses on providing individualized and hands-on training and technical assistance to BH providers throughout NYS on the successful transition to Medicaid Managed Care. This includes topics such as the Children's System Transformation.

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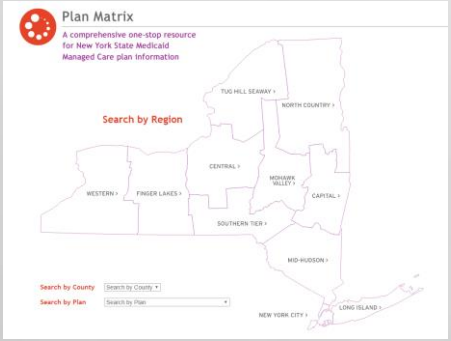
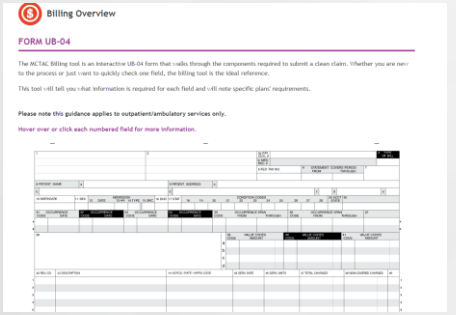
Tools



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



- **Billing Tool** – Children System specific updates –coming soon!

- **Output to Outcomes Database** – access to standardized outcome measurement tools and metrics (database) designed to facilitate and improve use of evidence based practices.

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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

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