HFMA - Northern California

Otani Consulting Group Inc. 21143 Hawthorne Blvd. #216 Torrance, CA 90503

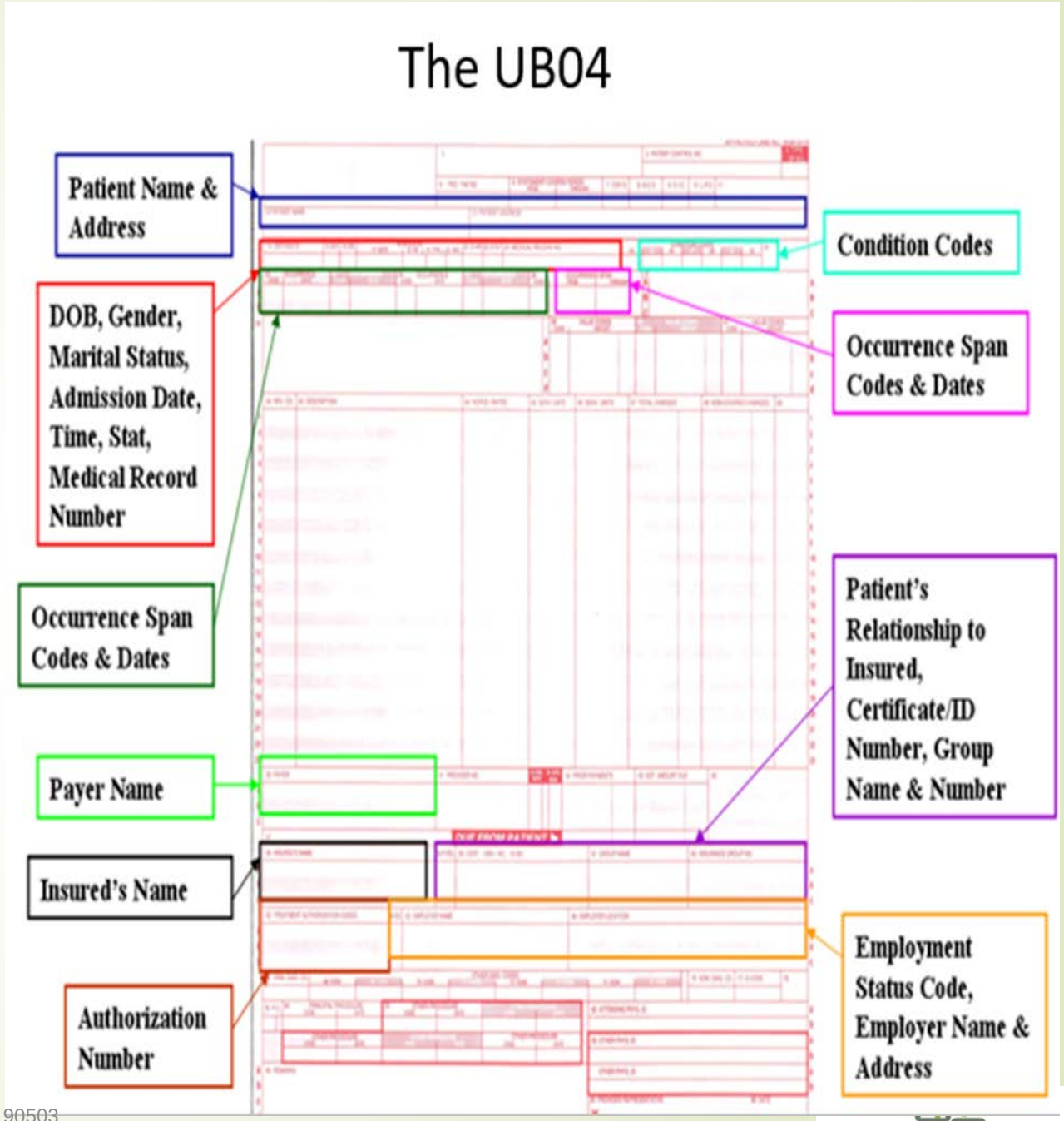
Module 3: Billing and Collections

- UB-04 Requirements and edits
- HIPAA Code Sets
- Reimbursement Methodologies
- Unnecessary Denials

UB04

- Understanding the UB04 and its impact on the Revenue Cycle process

- Patient Access staff captures most of the UB04 information during registration



Occurrence Codes

- Occurrence Codes are codes that alert the payor of how the claim will be paid or a need for additional information that will be needed to pay the claim.

- Common occurrence codes for Patient Access:
  - 01 – Auto Accident (date of accident)
  - 03 – Accident/TORT Liability (date of accident resulting in 3rd party action)
  - 04 – Accident/Employment Related (date of accident)
  - 05 – Other Accident
  - 11 – Onset of Symptoms/Illness (date patient became aware)
  - 18 – Date of Retirement
  - 19 – Date of Retirement Spouse

Most Commonly used Condition Codes

- 02 – Condition is employment related
- 05 – Lien has been filed
- 07 – Treatment of non terminal condition for a hospice patient
- 40 – Same Day transfer
- 44 – Inpatient admission changed to outpatient(CMS implications)

HIPAA Code Sets

Under HIPAA , hospitals have adopted specific code sets for diagnosis and procedures used in all transactions.

About code sets

Code sets classify medical:

- Diagnosis
- Procedures
- Diagnostic test
- Treatment
- Equipment and supplies

They inform diverse healthcare functions, from billing to tracking public health.

HIPAA Code Sets con't

Code sets outlined in HIPAA regulations include:

- ICD-10 – International Classification of Diseases, 10th edition
- Health Care Common Procedure Coding System (HCPCS)
- CPT – Current Procedure Terminology
- CDT – Code on Dental Procedures and Nomenclature
- NDC – National Drug Codes

Reimbursement Methodologies

- **Fee for Service** – Payment methodology that generally refers to an established maximum payment amount for a particular component of a service or an established percentage (sometimes 100%) of the maximum applicable to the Medicare program for the service. The state then generally pays the lesser of the provider's charge or this amount.
- **Cost based payment** - Payment methodology that typically requires a year-end settlement process or some documentation of actual cost is required to justify payment. Institutional providers may be paid using this methodology.
- **Prospective Payment** - Payment methodology where payment rates are generally based on historical cost, though year-end settlement or documentation of actual cost may not be required. Institutional providers may be paid using this methodology.

Reimbursement Methodologies

- **Percentage of Charge** - Payment methodology that uses a "percentage of charge" to reflect cost, typically using some documentation of a provider's historical cost to charge ratio. Institutional providers may be paid using this methodology.
- **Per Diem** - Payment methodology that makes payment for each day of care. Institutional providers such as nursing facilities may be paid using this methodology.
- **Per Discharge** - Payment methodology that makes a single payment for an episode of care, such as a hospitalization or a surgical procedure provided in a freestanding ambulatory surgery center or birth center. In some cases the payment includes all services and is "all-inclusive" or "global", and in others, certain ancillary services can be billed separately.
- **Diagnosis Related Groups (DRGs)** - Payment methodology often used to reimburse hospitals; the payment methodology establishes payment by the diagnosis of the patient, procedures performed and duration of stay. DRGs are the most common, but different DRG models in use across the states. Some states use the Medicare Severity DRGs (MS-DRGs); other states use All Patient DRGs (AP-DRGs) or All Patient Refined DRGs (APR-DRGs). Some states use "case-mix", the average acuity level of a hospital's patients compared to its peers, to adjust payment.

Unnecessary Denial caused by Lack of Communication

Real Cases

Hospice Admissions - Denial

- Hospice admissions are often overlooked due to lack of communication between patient access, financial counseling and care management
- Determine and or identify if the acute care visit is related to the hospice condition or not
- If the visit is related to the current hospice condition, the hospital needs obtain a hospice revocation letter from the hospice signed by the patient.
- If the letter is not received and/or signed by the patient, payment will be denied
- Patients that are on hospice waive all rights to Medicare payments for non hospice visits

Real Life Denial

- Patient in SubAcute
- Needed IVIG drugs
- Pt had trach and vent

Process

- Sub Acute received authorization for the drug administration
- Sub Acute contacted Nursing Supervisor
- Order from the doctor for Inpatient Admission
- Patient was discharged from Sub Acute and Admitted to the hospital ICU
- Drug was given
- Patient discharged from ICU after 8 hours
- Patient was admitted with a new account # to Sub Acute

Will we get paid?

No payment for ICU level of care

- Since the drug was authorized in SubAcute, we will be paid for the drug
- All other services will be denied that may have occurred during the admission

Process to ensure appropriate level of care and payment

- Sub Acute needs to get authorization for the drug administration
- Case Management should be notified prior to order and transfer
- Patient Access needs to be notified of the appropriate patient status for admission based on the physician order
- Patient will be registered as order by the physician
- Patient will be placed on bed hold or leave of absence (LOA) in Sub Acute
- After drug administration, patient will be transferred back to Sub Acute and with the previous SubAcute encounter number
- Billing will append the appropriate modifier to identify to the payer that the patient transferred from 1 unit to the other without being discharge.

Real Life Denial #2

- Patient comes in via ER
- Request for Inpatient admission entered into the system but never validated/acknowledged or accepted by admitting or attending physician
- Patient type is changed by admitting to inpatient status
- Patient is in a bed for 3 days and discharged
- No inpatient order on the encounter

- How should this encounter be handled? Billed as inpatient or outpatient

Sample Denial Letters

[redacted] Hospital
Attn: Inpatient Utilization Review Department
[redacted]
Los Angeles,CA 90059-3026

Tracking #: 6920290 **Member Name:** [redacted] Diaz
RE: Notice of Non-Payment for Inpatient Hospitalization

Dear Inpatient Utilization Review Department:

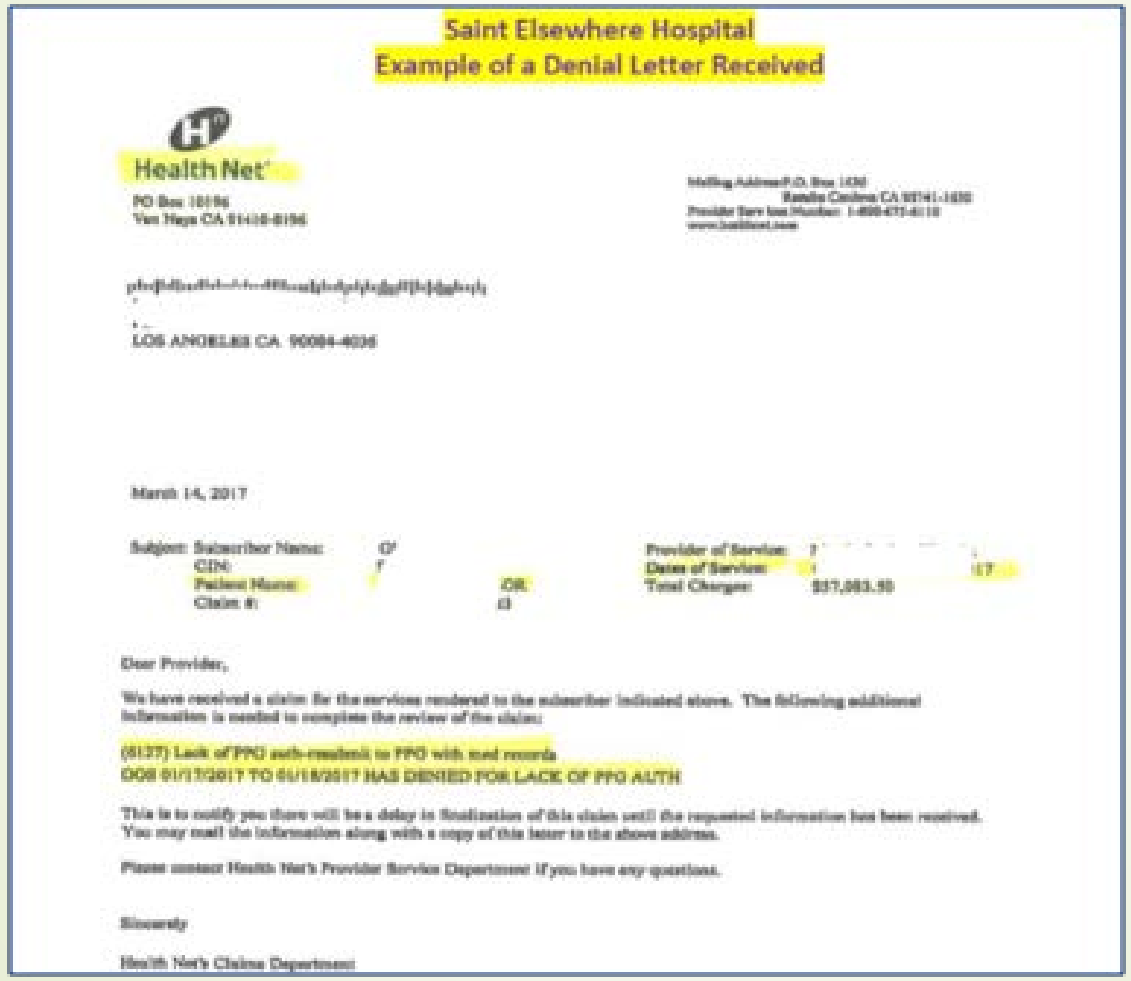
This letter is to inform you that [redacted] Diaz's hospitalization referenced below has been reviewed by [redacted] Group's Medical Director.

RE: Hospital Stay from 10/27/2016 to 10/28/2016 at:
[redacted] Hospital

After Medical Director Review of available clinical information from [redacted] Hospital, it has been determined that **inpatient care on/from 10/27/2016 to 10/28/2016 will not be covered for the following reason:**

DOES NOT MEET INPATIENT CRITERIA
Your request for approval of a continued inpatient stay for member admitted to [redacted] Hospital has been reviewed by our Medical Director.
The requested bed day(s) of 10/27/2016 to 10/28/2016 is denied because the clinical information showed that the patient did not meet the criteria per MCG M-100 for Chronic Obstructive Pulmonary Disease. Patient did not meet Acute Inpatient Care Admission Criteria.
Hospital may resubmit for observation.

Sample Denial Letters



Saint Elsewhere Hospital
Example of a Denial Letter Received

Health Net

PO Box 10196
Van Nuys CA 91410-8196

Mailing Address P.O. Box 1436
Rancho Cordova CA 95741-1436
Provider Serv ice Number: 1-800-675-6610
www.healthnet.com

LOS ANGELES CA 90084-4036

March 14, 2017

Subject: Subscriber Name:
CIN:
Patient Name:
Claim #:

OR

Provider of Service:
Dates of Service:
Total Charges: $57,083.50

Dear Provider,

We have received a claim for the services rendered to the subscriber indicated above. The following additional information is needed to complete the review of the claim:

(6127) Lack of PPO auth-resubmit to PPO with med records
DOS 01/17/2017 TO 01/18/2017 HAS DENIED FOR LACK OF PPO AUTH

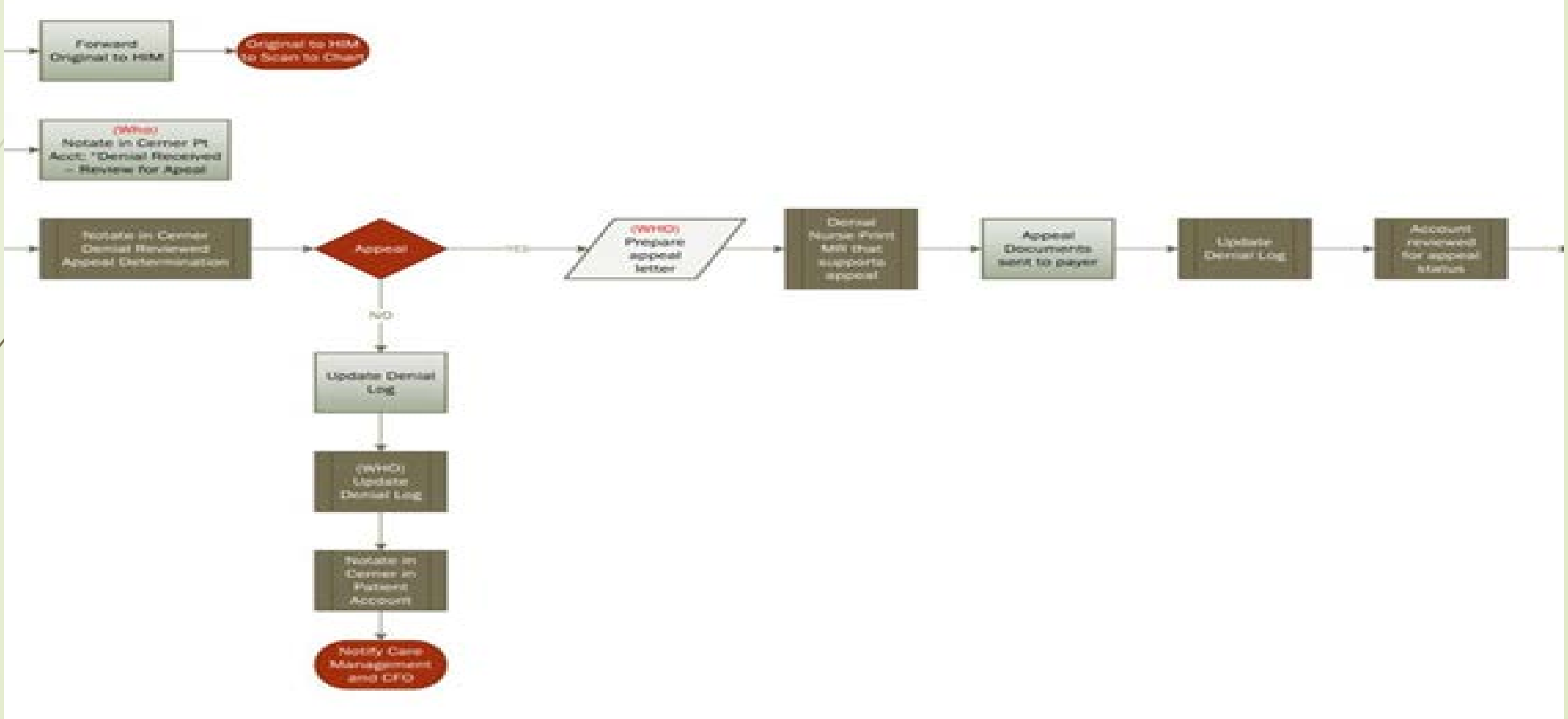
This is to notify you there will be a delay in finalization of this claim until the requested information has been received. You may mail the information along with a copy of this letter to the above address.

Please contact Health Net's Provider Service Department if you have any questions.

Sincerely

Health Net's Claims Department

Denial Workflow



Revenue Trends to Look For

- Payer trends the business office should review:
  - Take-backs from government payers – notify management immediately
  - Consistent underpayments from a particular payer – notify management
  - Multiple denials from a payer with the same denial code
  - Review AR to ensure all adjustments and payments are posted
  - Review DNFB/ATB for accounts that are not a net to net down prior to month-end
  - Look for payer activity changes
  - Request from payer for multiple refunds

Revenue Cycle Team

- Establishing a Revenue Cycle team will aid in:
  - Creating processes as a team
    - Authorization Denials – Updated Case Management Coordinator position and duties, develop and implement processes
    - High DNFB – Refocused workload during vacations, realigned Case Mgmt. focus on authorizations
  - Increase collaboration and communication amongst the Revenue Cycle key players
  - Prevent/Decrease unnecessary denials
  - Avoid finger pointing
  - Avoid reviewing statistics for statistical purposes
  - Allow for timely billing and collections
  - Increased Revenue

Revenue Cycle Key Players

- Revenue Cycle Director
- Business office managers
- Chart Auditor
- Director of Population Health
- Patient Access
- CDI
- IT
- Compliance as needed(for regulatory guidance)
- Department Heads as needed

Sample Revenue Cycle Agenda

[redacted] Hospital

Revenue Cycle Meeting – Agenda

2:30- 4:00pm – Council room A

Attendees: [redacted]

Operations – Patient Business Services

A/R status/Review	AC/[redacted]
Collections	
Conifer Assignments	
5/29 Action Plan w/NPI and Tax ID status update	
Med Assets CDM Review/Update Process	Paul/[redacted]

Operations – Patient Access

OTC – POS Collections	Selina [redacted]

HIMs/Coding Update

	Leslie [redacted]
Coding – Status	
Department update	

IT Update

System update schedule	Eric [redacted]
Status of vendor file set up/transfers	

Resources

- www.hfma.org
- https://www.cms.gov/

Thank You

- Contact Information:
  - Lynn Otani
    lynn.otani@otaniconsulting.com
  - AC James
    ac.james@otaniconsulting.com
  - Michelle Way
    michelle.way@otaniconsulting.com

OTANI CONSULTING GROUP, INC.