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Optimize Your Revenue Cycle Operations

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Learning Objectives

- Review receivables process to ensure charge capture, documentation and billing of all possible covered items and/or services
- Track and Trend revenue cycle metrics to measure performance, improve operations and optimize reimbursement.
- Medi-Cal Billing, WRAP Rates and Payments - Optimize

AGENDA

- Revenue Cycle Improvements-
  - Patient Access and Charge Capture
  - Billing Processes
  - Collections and Payment Posting
  - Capturing and Billing for Possible Covered items and/or services
- Receivables Monitoring
  - Benchmarking Metrics
  - Industry Best Practice
  - Quality Assurance Audits
- Medi-Cal Billing
  - Charges and Edits
  - WRAP Rates
  - Upcoming Proposed State Plan Amendment (SPA)

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Part 1 – Revenue Cycle Improvement

Charge Capture, Patient Access, Billing and Collections

Patient Access & Charge Capture – Best Practice

- Pre-Register Patients – evening scheduling hours
- Pre-Verify Insurance Patients
  - Electronic verification tool(s)
  - Batch submissions monthly for Medicaid
  - Month to month transition –beware managed care plan movement
- Front End Edits
- Real-Time charges / Online charge entry
- Point of Service Collections/Co-pays
- Attend Schedule = Reconcile visits daily

Billing Processes

- Electronic scrubber edits and set-up
- Track billable visits, daily billed, unbilled
- Track your clean claims rate
- Know your new vs. established patient*
  - Established Pt PPS rate = Base Payment X GAF
  - New Pt PPS rate – Base Payment X GAF X 1.346
- Bill second visit in same day if documented and appropriate (Modifier -59)
- Ensure billing for IPPEs and AWVs
- Bill WRAP for Medi-Cal

BUILD PAYMENT CODE EDITS IN SCRUBBER

- FQHC payment codes G0466, G0467, and G0468 must be reported with revenue code 052X or 0519
- FQHC payment codes G0469 and G0470 must be reported with revenue code 0900 or 0519
- Each FQHC payment code (G0466 – G0470) must have a corresponding service line with a HCPCS code that describes the qualifying visit (Complete listing of the qualifying visit codes on CMS FQHC PPS website)

Collections & Payment Posting

- Monitor Aging
- Staffing Productivity
- Documentation of Account/Encounter notes
- Electronic Remittance Posting
- Automated Denials Capture, Management and Tracking
- Limits for Appeals and Resubmissions

Capturing and Billing For All Possible Covered Items and Services-PPS -Medicare

- Regular Visits – New Vs. Established = PPS Rate
  - New patient to organization not seen last 3 years (34% higher rate)
- Mental Health Services Visit – separately payable same day as PPS visit – No modifier needed
  - 2nd Visit in the same day for different DX, reason – payable w/modifier -59
  - Influenza (G0008) and Pneumococcal (G0009) Vaccines - must be reported, but not separately payable. Reimbursed on Cost Report

Preventive Services - Medicare

- Separately Payable if Billed on a different day than other PPS visit:
  - Diabetes Self-Management Services “DMST” (G0108) **C**
  - Medical Nutrition Services “MNT” (97802)
  - Initial Physical Preventative Examinations “IPPEs” (G0402)
  - Annual Wellness Visits (G0438 and G0439)
  - Hepatitis B Vaccine (G0010)
  - Screening Pelvic and Clinical Breast Exam (G0101)
  - Screening PAP Smear (Q0091)
  - Prostate Cancer Screening (G0102) **C**
  - Glaucoma Screening (G0117 and G0118) **C**
  - Lung Cancer Screening Using LDCT (G0296)

C = Coinsurance Applies

The Calculation of Coinsurance

Set up Table of most common scenarios to calculate your coinsurance. For example:

- **Medical Visit Payment Code –** Charge is $200, PPS rate is $175
  - Established Patient G0467 – Lesser of PPS rate or charge x 20% = $35
  - New Patient G0466 – Lesser of PPS rate or charge x 1.346 x 20% = $47.11

- **Mental Health Services –** Charge is $150, PPS rate is $175
  - Established Patient G0470 – Lesser of PPS Rate or Charge x 20% = $30
  - New Patient G0469 - Lesser of PPS rate or charge x 1.346 x 20% = $40.38

Separately Reimbursable Services

- Chronic Care Management Services – Separately payable note: code change to G0511 as of 1/1/18
- Collaborative Care Model – Separately payable as of 1/1/18 with code G0512
- Hospital Inpatient Visit Billing – Separately payable, ensure visits captured

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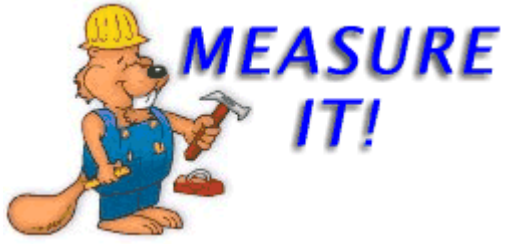
Part 2 – KPIs and Benchmarking Your Receivables Performance Measurement

Receivables Monitoring

“If you Can’t Measure it……”?

Benchmarking Metrics:



- UNBILLED
- AR Days
- AR % Over 90 Days
- AR % Over Year
- Denials

RECEIVABLES MONITORING BEST PRACTICE METRICS

- Unbilled =<5 days
  - Days to Enter Charge <2 days
  - Days to bill to Payer <3days
- Cash Collected = 100% Net Revenue
- AR Days = <50
- AR Greater than 90 Days =<15%
- AR Greater than 365 days = <2%
- Denials = <2% net revenue

Receivables Monitoring – Sample Dashboard

Revenue Cycle Metrics	Industry Best Practice	Current Month	Variance
Monthly Revenue	Not Applicable	$10,000,000	
Cash Received	100% of Net Revenue	$ 3,000,000	
DOS to Charge Entry	< 2 Days	1	-1
Charge Entry to Bill	< 3 Days	2	-2
AR Days	<50 AR Days	65	+15
AR Dollars	Not Applicable	$50,000,000	
% AR over 90 Days	<15%	30%	+15
% AR over 365 Days	<2%	10%	+8
Clean Claims Rate	>95%	99%	+4
# Claims Submitted	Check to visit volume	15,000	
# Claims Unbilled	Remaining unbilled	1,000	
Denials %	<2% of Net Revenue	10%	+8

*Based on HFMA and MGMA Best Practice Guidelines

Out of Range – Action Needed

Need to research and monitor –not at average, but within acceptable range

Within Industry Standard or at Best Practice

Recommended Sample Audit Monthly

1. Conduct data analytics/mining to judgmentally select 10 paid claims for each of the following payers:
    - Medicare
    - Medicaid
    - Top Commercial/Contract Payer
    - MA Advantage
    - Self-Pay w/Sliding Scale

2. Ensure mix of visit types – e.g. new patients, established patients, with and without mental health visits, dental visits as well as preventive services claims.
3. Create Excel Spreadsheet and input formulas to calculate expected reimbursement for various visit types & combinations per payer.
4. Add actual reimbursement from payer.
5. Add formula & field to calculate variance.

OR

USE System-Generated Variance in HIS/EHR/AR Computer System Module

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Part 3– Medi- Cal Specific TIPS

Billing Codes, WRAP and Upcoming State Plan Amendments for FQHCs

Medi-Cal Billing Charges and Edits

Billing:

- Bill encounters (e.g. T1015) for regular PPS payments with payment amount set to interim rate.
- CPT service lines below the encounter visit code should be billed with zero charges, but charges should be captured.

Examples of Bill Scrubber EDITS:

- No more that 2 visits per day – one medical and one dental
- WRAP billing – flag accounts for codes 02,18,19 and 20 to ensure proper modifiers (e.g. T1015 needs modifier SE)

WRAP Rates

Establish WRAP rates soon as possible

- Default rate is $25
- Set Wrap rate close to total PPS rate to avoid over/underpayments
- Bill for only FQ Medi-cal Billable Visits
- Re-establish WRAP rates as needed (e.g. Contract rate changes, PPS rate changes)

WHY?

- Reconciliation Reports are due 150 days after FYE
- State has 3 years from date of receipt to settle up reconciliation variances
- Avoid surprise large payback amounts or large additional payment checks

Upcoming Proposed State Plan Amendments

If approved by CMS, will be retroactive to 1/1/18

- Implementation of Productivity Requirements:
  - Physicians 3,200 visits/year
  - PA/NP 2,600 visits/year
- Restriction on adjustments to PPS reimbursement rate
-
- Addition of Marriage Counselors and Family Therapists as qualified FQHC providers
- Elimination of authorization requirements for allergy injections

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Questions?

Any new approaches?

Comments?

Suggestions?

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