# Billing Efficiency

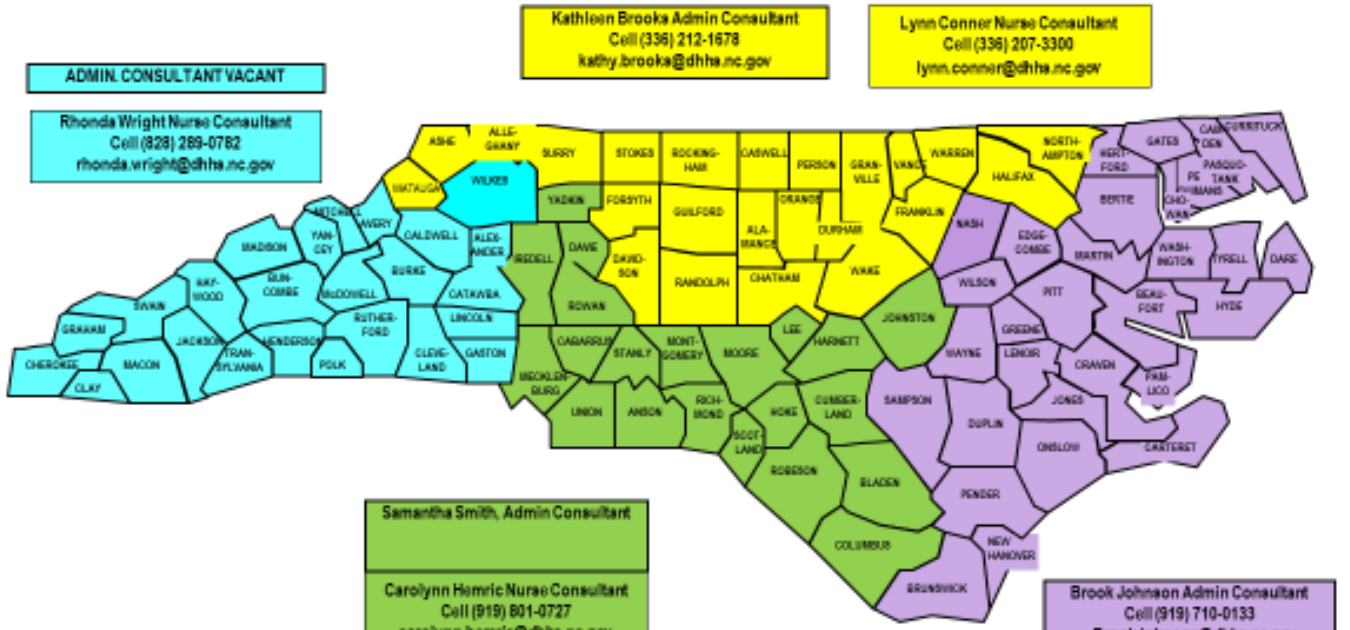
DPH PHNPDU LTAT CONSULTANTS

AUGUST 2019

## Local Technical Assistance and Training Branch

**Administrative and Nursing Consultants**

**Interim Map-revised 7/1/2019**

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# What is one tool I can use to improve Billing Efficiency?

The Coding and Billing Guide Document is a great resource and a quick guide to help answer questions.

https://publichealth.nc.gov/lhd/

# Coding and Billing Guidance Document

This document was developed to provide local health departments (LHD) with guidance and resources specific to public health coding and billing of services rendered. This information was developed using current program Agreement Addenda, Medicaid bulletins and Clinical Coverage Policies, and Current Procedural Terminology (CPT) and International Classification of Diseases or Diagnosis (ICD-10) code books. Although we have made every attempt to provide comprehensive and correct information, it is still advisable to contact your **program consultants** if this information is unclear or if you have specific questions.

# Here is what you will find in the Coding and Billing Guidance Document.

- **Documentation if you did it document it!**
- **New versus Established client**
- **Billing**
- **Standing Orders**
- **Sliding Fee Scale**
- **Establishing Fees**
- **ICD Coding Resources**
- **Program Specific Guidelines**

**And much more**

# Billing Tips & Tricks

prepared by Paula Jenkins, retired
New Hanover County Health Department

# In Network/ Credentialing

- IF YOU ARE NOT IN-NETWORK WITH AN INSURANCE COMPANY, YOU MAY RECEIVE A REDUCED RATE OR DENIED PAYMENT. (FOR EXAMPLE-BCBS PAYS THE PATIENT IF YOU ARE NOT IN-NETWORK)
- IF YOUR PROVIDERS ARE NOT CREDENTIALED…….YOU MAY NOT BE PAID.
- WHO IS RESPONSIBLE FOR THE CREDENTIALING PROCESS IN YOUR AGENCY?... … …SOMETIMES ITS THE PROVIDER OR MAY BE SOMEONE ASSIGNED TO BE RESPONSIBLE FOR CREDENTIALING.
- KEEP FILES ON EACH PROVIDER WITH ALL NEEDED INFORMATION
- CREATE A SPREADSHEET AND KEEP UPDATED WITH RE-CREDENTIALING DEADLINES FOR PROVIDERS.

- HTTP://WWW.CAQH.ORG/SOLUTIONS/CAQH-PROVIEW

# Electronic Billing

Check your edit report……were some claims kicked out of file – if so, research and find cause and resend……Medicaid and Insurance

Claims passed through submission to clearinghouse……did payor accept the claims…….check for report of claims accepted by payor…..example BCBS

**There are usually reports you can run for each file submitted …..accepted/rejected by clearinghouse and accepted/rejected by payor. These reports usually provide the reason for rejection. Take care of these immediately and rebill…….some insurances have a 90-day deadline for billing (BCBS, UHC, etc.)**

# Electronic Billing

NCTracks – you can see if rebilled claims paid/denied the following day if needed.

NCTracks – bill directly on-line for difficult claims or those close to deadline.

Insurances – bill directly on-line for difficult claims or those close to deadline.

# Billing Follow up

Payments were received…….but

Denied claims should be reviewed, researched and resubmitted immediately.  Get them corrected and rebilled asap.

Denied claims……..are you seeing patterns of denials……red flag should go up.  Are these data entry errors, coverage errors or NCTracks errors.  Identify as early as possible so corrections can be made or issue can be reported to NCTracks (via Consultants).

How to handle denied claims should be addressed in your policy.

Run your reports on a regular basis –this is important because you only have 90 days to bill in most circumstances (third party insurance).

Research claims showing at 31-60 and 61-90 days……..hopefully you will not see anything older than that.

Are there a number of claims with the same sent date? Are there claims with a "claimed" date but NCTracks did not receive?

Are there claims that paid but the payment did not post?

Are there denied claims that have not been worked?

# Aged Accounts Reports:
# IMPORTANT REPORT – RUN THIS OFTEN

# Regulations & Resources

Local Fee and Eligibility Policy (and others as they apply to billing/collections)

Consolidated Agreement

Medicaid Participation Agreement

Program Rules and Regulations

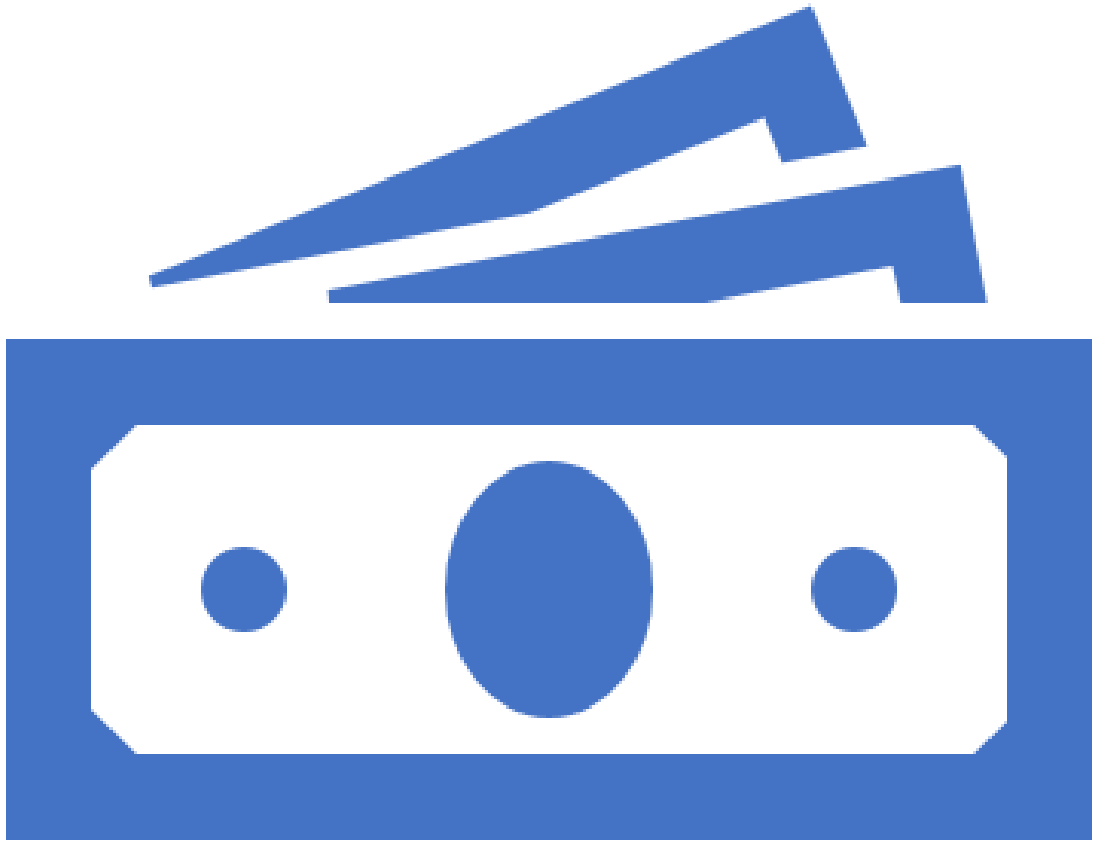
NC General Statues

NC Administrative Code

Coding and Billing Guide Document

Public Health Administrative Consultants

# Increase your revenue with In-house Audits



# Make sure you are getting paid for your services!

IN-HOUSE AUDIT WILL INCLUDE YOUR CLINICAL STAFF AND YOUR BILLING STAFF.

## WHY?

TO MAKE SURE YOU **ARE** CODING CORRECTLY AND GETTING PAID FOR YOUR SERVICES.

# Form an in-house Audit Committee

Form a committee and have one person in Charge

Ask each clinic to send the committee head charts from their clinic. (Self-pay, Medicaid, Insurance, and Medicare). You determine the number you want to look at.

Have a team review the charts for clinical marks and billing to see if everything is being documented and billed correctly, paid correctly, and posted correctly.

Once the review is complete the committee will need to compile the data and write a report on the findings.

# What are some of the questions you should ask when auditing?

- WHAT IS THE FAMILY SIZE?
- LOOK AT THE TOTAL ANNUAL INCOME.
- WHAT IS THE PERCENTAGE OF PAY?
- ONCE THE REGISTRATION RECEIVED ALL THE ABOVE INFORMATION DID THE CLIENT/INTERVIEWER SIGN AND DATE THE INCOME DOCUMENTATION?
- WAS THE CORRECT DATE OF SERVICE KEYED INTO THE SYSTEM?
- WERE ALL SERVICES ENTERED AS INDICATED ON THE ENCOUNTER/ESUPERBILL IN THE SYSTEM?
- WAS ALL THE CPT CODES AND DIAGNOSIS  CODES CORRECT IN THE ENCOUNTER/ESUPERBILL?

# What are some of the questions you should ask when auditing?

- WAS THE SLIDING FEE SCALE APPLIED CORRECTLY?
- WAS THE CLIENT CHARGED APPROPRIATELY?
- DID THEY PAY? IF SO WAS IT POSTED TO THE CORRECT DATE? WAS THE AMOUNT POSTED CORRECTLY IN THE SYSTEM?
- DID YOU BILL CORRECTLY TO MEDICAID, MEDICARE, OR INSURANCE WITH THE CORRECT RATE?
- DID MEDICAID, MEDICARE, OR INSURANCE PAY OR DENY THE CLAIM?
- IF THE CLAIM DENIED DID YOU REBILL?
- WAS COPAYS TAKEN, WAS THE RA POSTED CORRECTLY?

# Once you have reviewed all your records you can compile the data for improvements.

Compile a report of your findings so you will understand what improvements are needed.

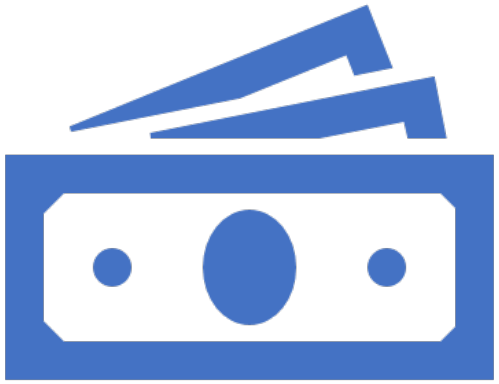
Once the committee has reviewed the finding they can come up with a improvement plan.

Who receives this plan?

| | | | | |
|---|---|---|---|---|
| The Health Director | The DON | The supervisors in each clinic | The billing supervisor | The finance officer |

The purpose of the In-house Audit is to catch any errors before they can get too big.  It will also improve your billing, revenue and coding.  This is a great way to train staff on how to make sure your billing is being keyed  correctly.  Audits should be performed every quarter.

# QUESTIONS



# Collecting Co-Pays and Applying Sliding Fee Scales.

REMEMBER! *FAMILY PLANNING CLIENTS* SHOULD NEVER PAY MORE THAN WHAT THEY OWE BASED ON THE SLIDING FEE SCALE.

# 5 STEPS FOR COLLECTING CO-PAYS AND APPLYING THE SLIDING FEE SCALE

1. Find out the client's income, family size and whether she/he has insurance.
2. Check the client's insurance eligibility and determine the client's co-pay amount based on her/his insurance plan.
3. Determine where the client's income puts her/him on the sliding fee scale.
4. If the co-pay is less than the client would pay on the sliding fee scale, she/he should pay the co-pay, and the agency should bill the insurance company the fee for the services. ***(Family Planning ONLY)***
5. If the co-pay is more than what the client would pay based on the sliding fee scale, the client pays what she/he would pay based on the sliding fee scale, and the agency should bill the insurance company the fee for the services. ***(Family Planning ONLY)***

**REMEMBER!** If the client requests confidential services, do not bill the insurance company, unless you have the client's written permission.

# Fee Setting in the Local Health Department

Fees for Health Department services are authorized under North Carolina 130A-39 (g), provided that 1) they are in accordance with a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners, and 2) they are not otherwise prohibited by law. Fees are based on the cost of providing the service.

# Why do we charge fees?

The purpose of charging fees is to increase resources and use them to meet residents' needs in a fair and balanced way. Fees are necessary to help cover the full cost of providing recommended and needed health services. As much as possible, we set fee amounts based on the real cost of providing that service (calculated as direct costs plus indirect costs).

# Direct and Indirect Cost

**Direct Costs may include:**

- Salary and fringe -typically 75-80% of budget (or more)
- Supplies- band aids, table paper, forms, syringes, alcohol wipes, etc.
- Pharmaceuticals
- Travel
- Computer hardware & software

**Indirect Costs may include:**

- Facility costs (utilities, rent, insurance, cleaning contracts, etc)

# We Recommend

**Your agency needs to develop a pricing policy addressing establishment of usual and customary charges, applying income-based discounts, third party billing/reconciliation, Medicaid (physician administered drugs, fee for service drugs (340b), managed care, Medicaid as secondary payer).**

# *Do's and Don'ts*

**Do-** Set fees based on the cost to provide each service. You may use tools such as the Medicaid Cost Report, vendor rates (increased or decreased cost of supplies and services), personal costs. It is acceptable to inquire from surrounding county health departments as to their fee schedule to see if you are in the "ballpark".

Another tool you may use is the **"Workbook for Setting Fees"** located under the Policy & Procedure heading on the DPH/LTAT/LHD website.

https://publichealth.nc.gov/lhd/

**Do not-** take your current fees and add a percentage, such as 5%. This is not an acceptable method for fee setting.

**Do=** Document your methodology for setting your fees in a policy or procedure. In addition, be sure to retain any notes or minutes from your fee setting team meetings. These are required as documentation for Re-Accreditation.

**Do-** charge Medicaid your acquisition cost for all 340b drugs and devices

# QUESTIONS

# How Can We Increase our Revenue?

- Client Education
- Establish Expectations for Payment
- Explain the Need for Payment
- Develop a Payment Plan
- Follow Billing Policies
- Send Statements on a Regular Basis
- Credit/Debit Cards

# Collection of Revenue

**Make every reasonable effort to collect your cost in providing services**, for which Medicaid reimbursement is sought, through public or private third-party payors except where prohibited by Federal regulations or State law; however, no one shall be refused services solely because of an inability to pay.

# General Billing Information

Revenue Sources may include:

- Cash
- Check
- Major Credit Cards
- Medicaid
- Third Party Insurance
- Company Billing
- NC Debt Set-Off Clearinghouse (debt over $50.00)

# General Billing Information

- Medicaid is billed as the payer of last resort. Verification that Client is covered by Medicaid should be done at or before each visit. The health department bills Medicaid and accepts payment in full.

# General Billing Information

You can bill client for Non-Medicaid covered services, but you must inform the client that they will be responsible **PRIOR** to the service being performed.

If unable to determine Medicaid eligibility (not covered during period of service) then the client should be billed based on SFS.

If the client presents for services that are billable to insurance (BCBS-Immunizations, MNT), obtain all information necessary to submit a claim.

# Coding & Billing
# The Basics

# CPT & ICD-10: What's What?

**Correct CPT and ICD Must Be Used**

CPT codes = what you did

ICD-10 codes = why you did it

*ICD-10 codes **justify** CPT codes*

When you bill the incorrect CPT or ICD-10 code you will hold up your revenue.

To bill efficient you should review before you send to the payor.

# New vs Established

## New

- No care provided in last 3 years that requires History & Physical

  Includes billable Preventive and E&M visits

## Established

- In past 3 years, billed 99381-99387, 99391-99397 99211-99215
- Client can be New to a program but established with the agency

# The Encounter

Providers **may not** charge for an office visit unless they see the client face to face

Individual staff member's ID # or initials should be on the paper encounter form when a service is billed or reported. This is used to capture the number and type of services provided by each staff member.

Paper encounter forms may be very useful when cross-checking services provided to services billed. They are also needed by consultants performing coding & billing audits.

# What are Modifiers?

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers enable health care professionals to effectively respond to payment policy requirements established by other entities (Medicaid, Insurance, Medicare, etc)

# How do I know which modifier to use?

Any CPT coding book will include a section on modifiers. In addition the Coding & Billing Guidance Document prepared by DPH/LTAT/PHNPDU includes a chapter on modifiers.

Each modifier description provides details on when it is appropriate to use.

# Medicaid Specific Modifiers

**FP - Family Planning**

Use modifier FP to indicate that a service or procedure is related to Family Planning services.

**UD - 340-B Drug or Device**

Use modifier UD , in addition to FP, when billing Medicaid, as indication that the drug or device was purchased under a 340-B purchasing agreement.

**EP - Early & Periodic Health Screen**

Use modifier EP to identify early and periodic screens, and services provided in association with an early and periodic screen to NC Medicaid. This modifier is also used to identify preventive services such as vaccine administration.

**SL - State Supplied Vaccine**
Use modifier SL when reporting to Medicaid, as indication that the vaccine was state supplied.

**OB - Reportable Maternity Office Visits**
Use modifier OB to report or bill office visits with a $0.00 charge that are associated with a package code or OB global package code.

# Health Choice Specific Modifier

**TJ - Health Choice Early & Periodic Health Screen**

Use modifier TJ to identify early and periodic screens, and services provided in association with an early and periodic screen to NC Health Choice. This modifier is also used to identify preventive services such as vaccine administration.  Remember, the TJ modifier is not needed when providing FP services to a NCHC recipient.

# Modifier 24

**24– Complications of Pregnancy, Unrelated Issue:**

Append modifier 24-*Unrelated evaluation and management service by the same physician during the global period* to all E/M services that address the pregnancy complications or unrelated issues.

Modifier 24 is needed to alert the carrier that the E/M service(s) is unrelated to the global OB package. Bill after delivery

# Modifier 25

**25– Significant, Separately Identifiable E&M Service by Same Provider, or Other Qualified Health Care Professional, on Same day of Procedure or Other Service:**

The physician may need to indicate that the client's condition required a service above and beyond what is expected for other services provided on the same day.

The modifier 25 is attached to the E&M code, not the procedure code.

# Modifier 52 & 53

**52 & 53– Failed/Discontinued Procedure**

Use modifier -52 (Failed Procedure) to denote that you attempted insertion, but the procedure was incomplete due to anatomical factors (e.g. Stenosis) or -53 (Discontinued Procedure) to indicate that you had to stop because of concerns for client well-being (e.g. vaso-vagal, severe pain).

# Modifier 90

**90- Reference/Outside Lab**

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure should be identified by adding the modifier “90” to the CPT code for the laboratory test.

(e.g. LHD obtains sample but sends to outside laboratory for processing; in this case, the 90 modifier would be appended to the laboratory test)

# Modifier TC

**TC—Technical Component**

Use the TC modifier when **only** the procedure/test is being performed and not the interpretation of the test

# Modifier 59

Modifier 59 is used to identify procedures/services that are **commonly bundled together** but are appropriate to report separately under some circumstances.

A health care Physician or Advanced Practice Practitioner may need to use modifier 59 to indicate that a procedure or service was distinct or independent from other services performed on the same day.

This means a different location, different anatomical site, and/or a different session. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive

# X Series Modifiers

**XE – Separate Encounter:**

A service that is distinct because it occurred during a separate encounter.

**XS – Separate Structure:**

A service that is distinct because it was performed on a separate organ/structure.

**XP – Separate Practitioner:**
A service that is distinct because it was performed by a different practitioner.

**XU – Unusual Non-Overlapping Service:**

The use of a service that is distinct because it does not overlap usual components of the main service.

Utilizing X series modifiers will help with more accurate coding that better describes the procedural encounter.

X series modifiers are appropriate for NCCI procedure-to-procedure edits only.

# QUESTIONS

# Presumptive Eligibility Guidance

- Clients covered by third-party insurance carriers should also have a Presumptive Eligibility (PE) completed. The policy may be inadequate therefore, MPW could be considered as secondary coverage.

# Fill out Presumptive Eligibility Form

## Presumptive Eligibility Form, DMA-5032

PE FORM

Print Form

Patient Record # _____
Date Care Initiated _____

N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Eligible _____ Ineligible _____
Due Date_____

PRESUMPTIVE ELIGIBILITY DETERMINATION FORM FOR PREGNANCY – RELATED CARE

**Patient Information:** Address _____ (Street Address / City / State / Zip) County _____ Phone _____ E-Mail _____

**Household Members:**

| Line No. | HOUSEHOLD MEMBERS: NAME (First, MI, Last) | DATE OF BIRTH (mm/dd/yyyy) | RELATIONSHIP TO APPLICANT | SEX | RACE* (optional) | ETHNICITY** (optional) | SOCIAL SECURITY # (optional) | NC RESIDENT? (y/n) | TAX FILING STATUS: Will this person file federal income taxes for current year? | Claimed as tax dependent on current year's tax return? (y/n) | If tax dependent, who will claim? | Meet any tax exceptions? | Claim anyone not living in home? If so, who? |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | | | | |
| 2 | UNBORN CHILD | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |

*Asian = A  American Indian or Alaska Native = I  Native Hawaiian or other Pacific Islander = P  Caucasian or White = W  Black or African American = B  Unreported = U
**Not Hispanic/Latino = N  Hispanic Cuban = C  Hispanic Mexican = M  Hispanic Puerto Rican = P  Hispanic Other - H

**Financial Eligibility Information:**

| TOTAL COUNTABLE MONTHLY INCOME = $ | NUMBER IN HOUSEHOLD: | POVERTY INCOME LEVEL: $ |
|---|---|---|

**Health Insurance Information (optional):**

| Company Name | Policy Holder's Name | Policy Number | Group Number | Insurance Type(s) | Policy Begin Date |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

I attest that I am pregnant with _____ fetus(es). I understand that this is a temporary determination of my eligibility for Medicaid and that if I do not file an official application for Medicaid by the last day of the month following the month this form is signed my eligibility will stop on that date. I also understand that I am eligible only for outpatient prenatal care related to my pregnancy. I certify that I have provided true and accurate information about my household, income, and state residency.

The federal government requires the State to provide information about your language preference. Please help us by providing the language you prefer to speak (circle one) English Spanish Other Specify_____)

_____ Application Date  _____ Applicant's Signature

_____ Provider Name/NPI #  _____ Completed by (print):  _____ Title  _____ Signature/Date

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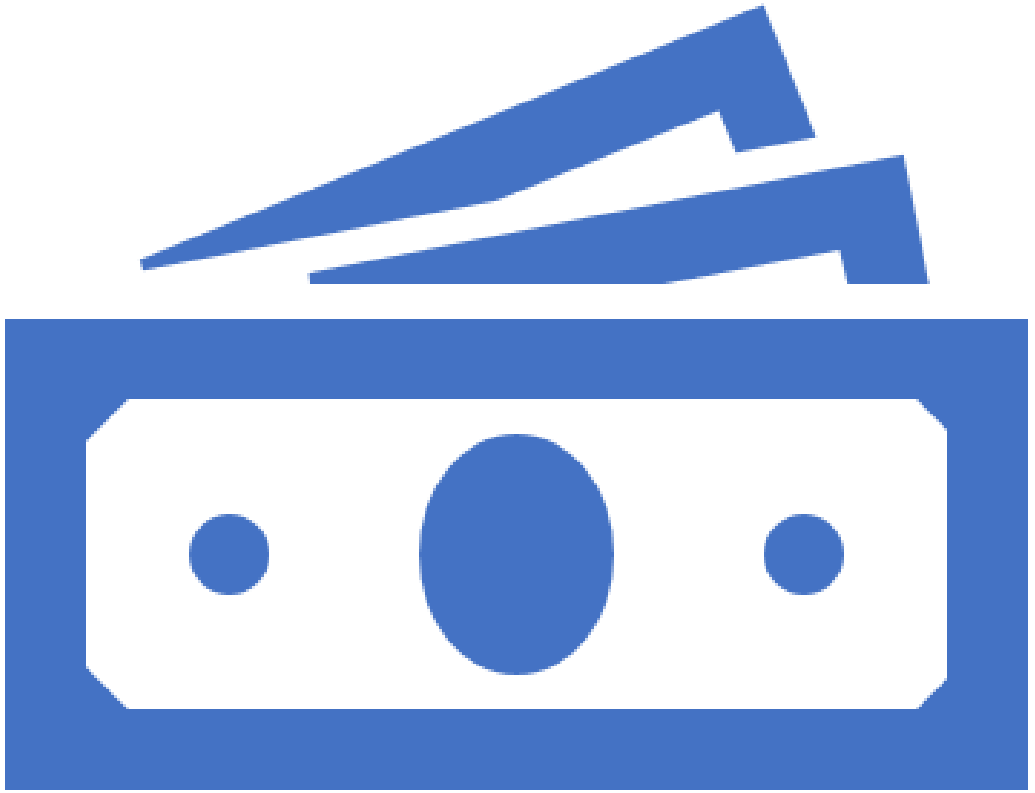


# Computing Income

Use **Gross** Income or for **self-employed income after business expenses**.

**Weekly** = pay x 52

**Biweekly** = pay x 26

**Twice a month** = pay x 24

# Computing Income

**Continuously employed** (worked that last 12 months) can use the regular formula.

*In general, gross income includes:*

**Salaries, wages, commissions, fees, tips, overtime pay**

Earnings from self-employment (Net income after business expenses)

Investment income, stocks, bonds savings account interest

Periodic trust fund payments

Unemployment compensation

Alimony

*In general, gross income includes:*

Child support ***(cannot count for Family Planning)***

Military allotments including re-enlistment bonuses, jump pay, uniform allowance, and cash allowances such as Family Subsistence Supplemental Allowance (FSSA).

Social Security benefits

Supplemental Security Income (**SSI**)

Veteran's Administration benefits

Retirement and pension payments (**1099-R forms**)

Workers Compensation

*In general, gross income includes:*

Education stipends (Payment for services rendered)

All other sources of **cash** income except those specifically excluded.

**Regular monetary contributions from individuals not living in the household.**

Prize winnings, Christmas bonuses.

Income Verification Letter

Stipends (payment for services rendered)

# *Exceptions:* Gross Family income does not include except those non-cash income or payment/benefits from federal programs/acts including.

- Military housing benefits (on base or off base)
- Value of in-kind benefits
- Reimbursement from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
- Payment to volunteers under Title I (VISTA) and Title II (RSVP), foster grandparents, and others of Domestic Volunteer Service Act of 1973
- **Payment under the Low Income Energy Assistance Act**
- Student financial assistance/Scholarships (payment for tuition, books, other school related items/services)
- Value of any child care payments made under section 402(g)(1)(E) Social Security Act
- Value of food/clothing from non-resident (food bank, church, other charitable organization, relative or friend)
- **Assistance to child or families for Free Lunch and Food Stamps**
- VA Disability Benefits (Added 2-3-17)
- Payments received under the Job Training Partnership Act

# Computing Income

If the client is **not employed or has changed jobs in the last 12 months**, use the **Irregular Income Formula** or **Six Month Formula**.

**Unemployed today** = last 6 months income + projected unemployment (if applicable) or zero if client wont' receive unemployment. If no unemployment compensation – ask how the client is going to support themselves

# Computing Income

**Employed today but unemployed last 6 months** – Did the client receive unemployment the last 6 months? In no, record as zero and then project 6 months forward at current income. This will give you income for the client for a 12-month period.

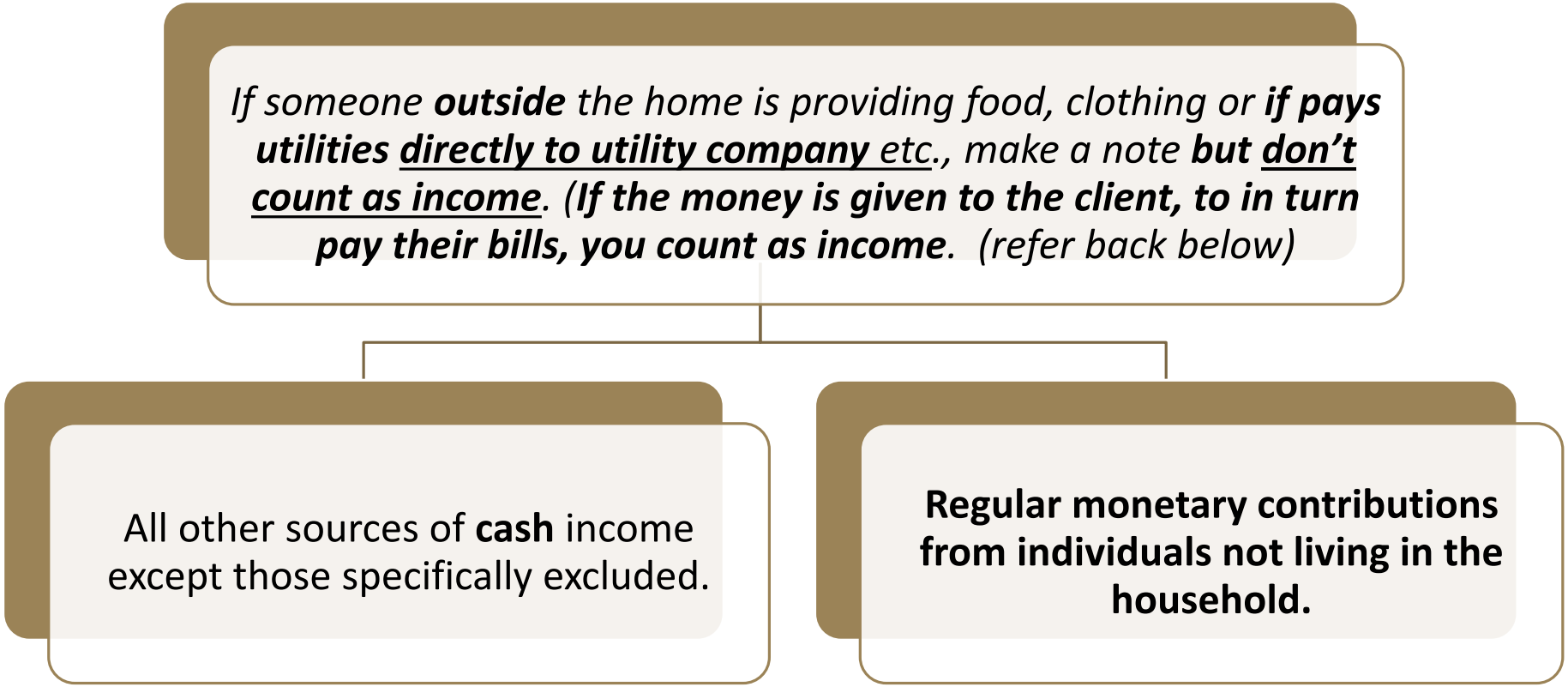
# Computing Income

If a client states they have **no income or a very low income**:

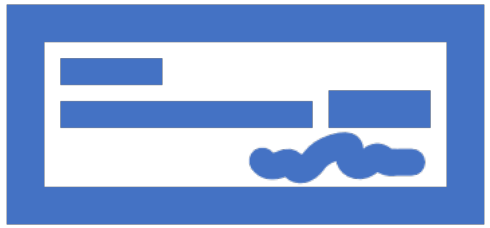
Ask the client if they have worked in the last year? If yes, when was their last day? Refer to Six Month Formula

Ask what the client pays for: shelter, rent, food, etc. Compare HH income to the Sliding Fee Scale to see in income at or below federal poverty. Is there more money going out than coming in? **Use the Expense Worksheet and scan into EMR**

# Computing Income

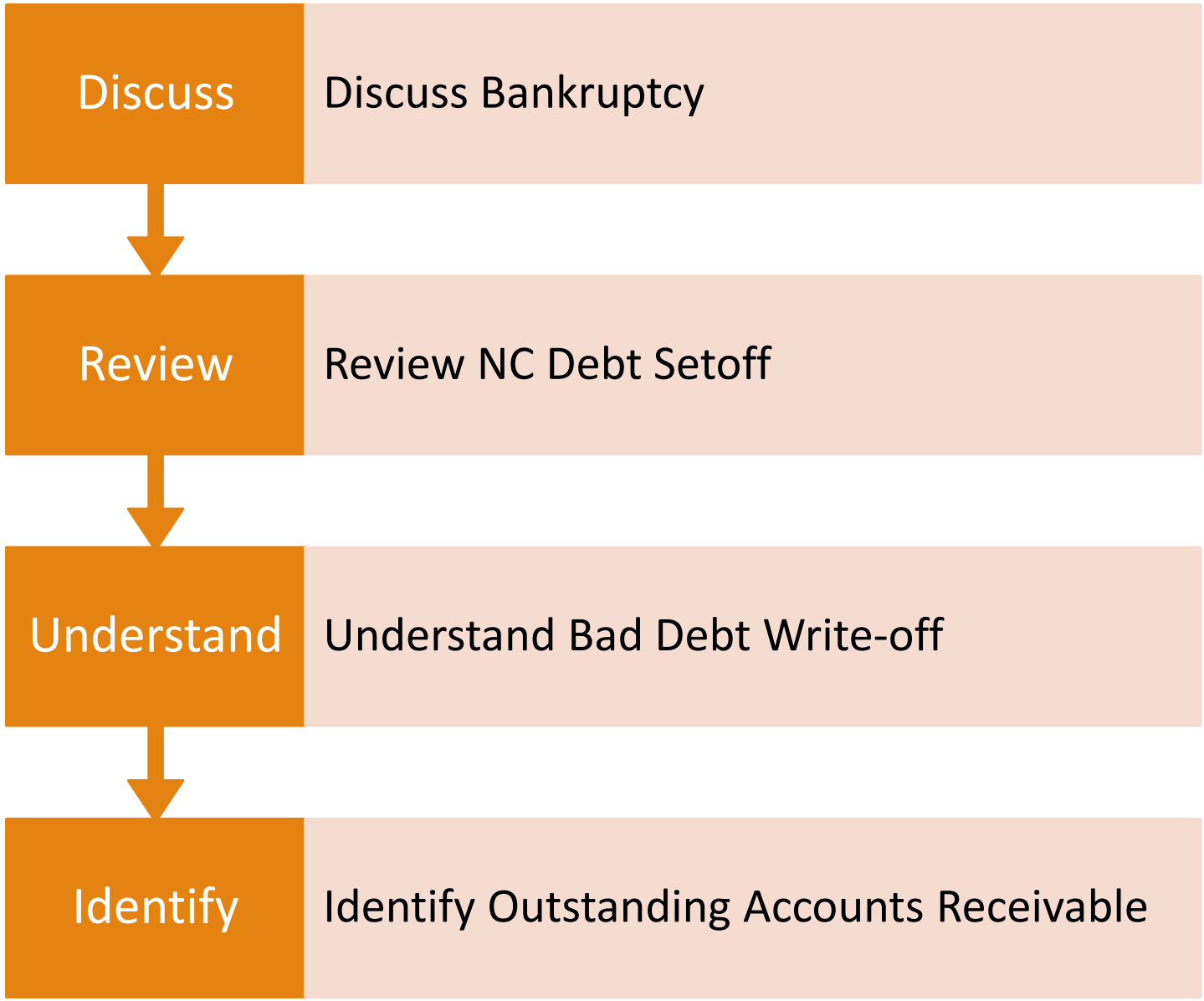


# QUESTIONS



# Managing Outstanding Accounts Receivable

# We will Discuss:



# Bankruptcy

- Legal notification from Bankruptcy court
- No further collection of outstanding account unless payment schedule is set up by Bankruptcy court
- Note or flag on patient's account
- Account may be written off if mandated by court
- Patient may volunteer to pay
- Additional visits are charged

# Identifying Outstanding Accounts

## Aged Accounts Receivable Report

- Medicaid
- Insurance
- Patient Pay-When was the last visit?-When was the last payment?
  - You should run reports in your system monthly to identify outstanding Accounts.
  - Once you have identified outstanding accounts you will need to work them.

# NC Debt Setoff Clearing House

North Carolina General Statutes Chapter 105A:  Setoff Debt Collection Act

NC Income Tax Refund or Lottery (over $600.00)

Mandated Fees (charged to individual)

Requires Name and SSN/ITIN

- Not a breach of confidentiality since debt is listed as county, not Health Department

Requires Local Policy

# Requirements for Debt Submission

Must have SS# or ITIN

Debt Must be at least 90 Days Old

Amount Must be at least $50.00

Must Give Proper Notice of the Debt to the Debtor

Must Give Rights of Appeal to Debtor

http://www.ncsetoff.org

# NC Debt Setoff

Debt Can Remain on File with NC DOR Until Paid

Balances are NOT REMOVED from the Patient's Ledger

Transfer the Balance to NC Debt Setoff Guarantor

# QUESTIONS