

# Ohio RHC Practice Management Training March 5, 2014

**Slides for Morning Sessions:**

Managing Your RHC,  
Corporate Compliance, RHC Billing 101,  
Managing Your Accounts Receivable



# MANAGING YOUR RHC

OHIO RURAL HEALTH CLINIC  
PRACTICE MANAGEMENT TRAINING  
MARCH 5, 2014

# OBJECTIVES

- Participants will understand what makes good management; what is management & leadership?
- Participants will learn process to build a team within the practice.
    - Who are the players and what are their responsibilities?
    - Conducting Evaluations
  - Participants will understand how good management skills enhance the efficiency within the practice & patient care.

# WHAT IS MORALE?

- ▶ According to Miriam–Webster Dictionary:
  - Moral principles, teaching, or conduct
  - The mental and emotional condition of an individual or group with regard to the function or tasks at hand, a sense of common purpose with respect to a group.
  - The level of individual psychological well–being based on such factors as a sense of purpose and confidence in the future.

# WHAT IS MORALE?

- ▶ “A happy person is not a person in a certain set of circumstances, but rather a person with a certain set of attitudes”
  - Hugh Downs

# FACTS

- “An office staff with high morale doesn’t happen by accident.”

Mary Jo Welker MD



# FACTS

- ▶ No matter how boring or tedious the work may be, it can be made enjoyable with a positive environment.
- ▶ No matter how fun the work itself may be, it can be made miserable with a hostile environment.

# STATISTICS

- ▶ Left unchecked, poor morale can poison an entire office and even affect patient care.
- ▶ Good or bad, attitude flows from the top.
- ▶ 70% of your employees are **LESS** motivated today than they used to be.
- ▶ 80% of your employees **COULD** perform significantly better **IF THEY WANTED TO.**
- ▶ 50% of your employees only put enough effort into their work to **KEEP THEIR JOB.**

# GOOD OR BAD MORALE

- ▶ What do you see in your team?
- ▶ Do you have “**STAFF INFECTION**” in your practice?
- ▶ When staff morale is chronically low, employees suffer, providers suffer, and the practice suffers as patients leave to find a more pleasant health-care environment where people actually seem to enjoy their jobs.

# DANGER OF LOW MORALE

- ▶ Low morale is a **DANGER** in the medical office/clinic because it can lead to a whole set of issues hazardous to quality patient care.

# KEY SIGNS OF DECLINING MORALE

- ▶ Lack of attention to details concerning patient care.
- ▶ Missed deadlines.
- ▶ Minimal productivity.
- ▶ Negative attitude toward patients.
- ▶ Resentment of providers or co-workers/management.
- ▶ Talking ABOUT people rather than WITH people.
- ▶ Keeping secrets or withholding information.
- ▶ Constant snide remarks and bad attitude.
- ▶ Infects others.
- ▶ Negative impact on attempts to improve office morale.

# DO YOU HAVE A TOXIC EMPLOYEE?

- Trouble-maker.
- Naysayer
- Bad Apple
- Gloom and Doom
- Negative attitude and “Stinkin Thinkin”
  - These can drag high office morale down into the mud.

# WHAT TO DO WITH BAD MORALE!

- ▶ Identify the ringleaders.
- ▶ Hold them accountable.
- ▶ Work with them to help correct their attitude or WEED THEM OUT!
  - Discuss one on one.
  - Identify the extenuating circumstances.
    - Home problems, personality conflict with others, depression, etc.

# WHAT TO DO WITH BAD MORALE!

- ▶ Explain the problems that are being caused.
- ▶ Set up clear expectations.
- ▶ Monitor.
- ▶ DOCUMENT.

# HOW TO PROMOTE GOOD MORALE

- ▶ Most people will give back when they feel appreciated and cared for. This benefits everyone.
- ▶ Build a great foundation.
- ▶ Know the office deficiencies.
- ▶ Recognize the strengths and use them.
- ▶ Create a positive atmosphere.

# HOW TO PROMOTE GOOD MORALE

- ▶ KNOW YOUR TEAM
- ▶ Characteristics
- ▶ Goals
- ▶ Interests
- ▶ Work Styles

# HOW TO PROMOTE GOOD MORALE

- ▶ Grow an attitude of gratitude.
  - Staff need to feel appreciated.
  - EVERYONE is of value.
  - Encouragement and say Thank You.
- ▶ Hold regular office meetings:
  - Team
  - Build relationships
  - Company updates and news
  - Safe room.
  - Ownership

# HOW TO PROMOTE GOOD MORALE

- ▶ Define the mission.
- ▶ Solicit input.
- ▶ Specify roles.
- ▶ Acknowledge success.
- ▶ Foster Advancement.
- ▶ GOOD FOOD MOOD.

▶ “IT IS YOUR ATTITUDE, NOT YOUR APTITUDE, THAT DETERMINES YOUR ALTITUDE.”

▪ Zig Zigler

# LEADERSHIP AND A GOOD TEAM

- Leadership is about the future
  - “Leader” implies that someone is taking others to a destination beyond the here and now.
- Leadership is influence.
  - Are you happy with YOUR Performance?
  - What are YOUR Goals?
  - What is YOUR affect on the staff?
  - How effective are YOU to inspire and influence?
    - Good influence is NOT heavy fisted tactics.

# LEADERSHIP AND A GOOD TEAM

- ▶ Make sure the employees understand the mission/vision.
- ▶ Provide strong employee orientation.
- ▶ Hire the RIGHT people for the RIGHT Job.
- ▶ COMMUNICATE effectively.
- ▶ Be flexible.
- ▶ Provide training.
- ▶ Give recognition/express appreciation.

# LEADERSHIP AND A GOOD TEAM

- ▶ Be able to confront change and LEAD the team through the changes. Be the change agent.
  - Know what needs to change.
  - Know the staff and how they deal with change.
  - Know how the staff accepts change.
  - Utilize the strengths of the staff to deal with change.

# LEADERSHIP AND A GOOD TEAM

- ▶ Colin Powell states:
  - “Find ways to reach down and touch everyone in a unit. Make individuals feel important and part of something larger than themselves.”

# HOW TO BUILD A GOOD TEAM

- ▶ The team must have a committed leader.
- ▶ Team members must all play some vital part of the project/work.
- ▶ The team must be united in the purpose and goals.
- ▶ The team must have a focus.
- ▶ Team members need to be in the right position.
- ▶ NO member of the team is less important than another, or more important than another.

# HOW TO BUILD A GOOD TEAM

- ▶ A team strategically trains and plans.
- ▶ Serving the team is more important than the position.
- ▶ Team members must show respect for each other.
- ▶ A team is only as strong as it is disciplined.
- ▶ Effective teams realize that failure may be a step toward success.
- ▶ **COMMUNICATION IS CRUCIAL.**

# HOW TO BUILD A GOOD TEAM

- ▶ Great teams exhibit sincerity, transparency, and vulnerability.
- ▶ The team needs to be focused in the same direction.
- ▶ Non-participatory team members could and should be removed.

# WHO ARE THE PLAYERS?

- ▶ WHAT ARE THEIR RESPONSIBILITIES?
  - Manager
  - Medical Director
  - Providers
  - Clinical Support Staff
  - Business Support Staff

# EVALUATIONS

- ▶ Job Descriptions
- ▶ Evaluations
- ▶ Merit
- ▶ Percentage
- ▶ Discipline
- ▶ Documentation

# KNOW THIS

You are really something, do you know that?  
And in spite of whatever may happen in your day,  
you are going to stay that way; trying and giving  
and living in the best way you know how.  
So keep your spirits up, and keep things in  
perspective.

IT IS GOING TO BE OK





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# CORPORATE COMPLIANCE

OHIO RURAL HEALTH CLINIC  
PRACTICE MANAGEMENT TRAINING  
MARCH 5, 2014

# OBJECTIVES

- ▶ Participants will understand what Corporate Compliance is within the practice.
- ▶ Participants will review the audit and assessment process for corporate compliance in the practice.
- ▶ Participants will gain knowledge in the design and implementation of a corporate compliance process for the practice.

# WHAT IS CORPORATE COMPLIANCE?

- ▶ Corporate compliance is a set of policies or rules and regulations which business institutions follow in order to overcome management problems. These instructions help in maintaining a healthy and suitable work environment for every employee. However the main challenge is implementing these regulations and involves the following steps:
- ▶ Corporate compliance is an integral part of best practices and must be taken seriously to maintain a good working environment.

# STEP 1

- ▶ There is need for an audit or assessment to assist in identifying the laws and regulations governing the organization. For example, there will be need to provide healthcare services for employees in an organization. There can be implementation of new rules and regulations such as those protecting against sexual harassment ethics, financial statements, equal opportunity / fair hiring practices, environmental preservation and smoking to protect workers. However, this depends on the scope and nature of the business.

# STEP 2

- ▶ Ensure compliance with legal counsel and requirements. This helps in identifying those changes in practices or policies needed to improve compliance at every level of the organization. There may be need to audit the organizations' clinical, business and financial relationships to achieve best practices, compliance and risk management. There will be need to emphasize compliance with documentation, billing and coding practices especially in government sponsored organizations.

# STEP 3

- ▶ Designing and implementing a corporate compliance program is the third step to achieving corporate compliance. This means that healthcare and business organizations must ensure compliance and best practices to deliver standard services and quality. There may be need to adopt the “phased-in” approach to achieve corporate compliance. This means improvement internally before focusing on external issues. A corporate compliance program helps in achieving this without compromising any risk management and avoiding healthcare fraud through false claims.

# STEP 4

- ▶ Knowledge about the Corporate Compliance Principles is very important before implementing them. Business organizations and healthcare facilities must get familiar with the principles involved to ensure best practices at every level. The process of introducing some principles without disturbing standard processes may be tasking and challenging. Executive managers therefore must be informed of the strategies and principles before they are introduced.

▶ **HOW DOES THIS  
AFFECT MY RHC?**



# 7 BASIC ELEMENTS OF AN EFFECTIVE COMPLIANCE PROGRAM

- ▶ Implementation of written Policy/Procedures and standards of conduct.
- ▶ Designation of compliance officer and committee.
- ▶ Effective training and education.
- ▶ Effective Communication.
- ▶ Enforcement/discipline
- ▶ Internal auditing and monitoring
- ▶ Response to detected errors

# COMPLIANCE PROGRAM

- ▶ Your compliance program must be unique and customized for your organization.
  - Prevention, Prevention, Prevention
  - Rapid correction of problems
  - Compliance with ALL rules, laws, regulations and statutes
  - Compliance imbedded at every level in every job
  - Management actively involved and knowledgeable
  - Education at every level in the organization
  - Implementation of “best practice” standards



# COMPLIANCE PROGRAM

- Discipline and enforcement
- Ongoing risk assessments
- What you “knew or should have known”
- ▶ Just because you have a written compliance plan does not mean you have compliance.
  - It is not a full written book
  - It is not a check off list
  - Whatever you do within the structure of the clinic needs to be addressed.

# COMPLIANCE PROGRAM

- ▶ What needs to be addressed?
  - People
  - Regulations
  - Procedures
  - Providers
  - Services
  - Systems
  - Payors

# COMPLIANCE PROGRAM

- ▶ Will you do everything you said you would?
- ▶ Can you do everything you said you would?
- ▶ Are you doing EVERY single thing your plan says you are doing?
  - How do you know and can you prove it?

# COMPLIANCE PROGRAM

- ▶ Rely on prevention, not reaction
- ▶ Constantly changing and adapting.
- ▶ Don't assume what is written is working.

# TYPICAL VIOLATIONS

- ▶ Duration of problem
- ▶ Why not found?
- ▶ You can manage what you don't know about.
- ▶ Policies/Procedures are not carried out
- ▶ Monitoring for compliance is not effective

# WHO SHOULD BE IN CHARGE OF COMPLIANCE?

- ▶ Pays attention all the time
- ▶ Can they draw a line in the sand and stick to it?
- ▶ Should be a leader and a team player
- ▶ Right is more important than being liked
- ▶ Can work independent

# WHERE DO I FIND CURRENT INFORMATION FOR COMPLIANCE?

- ▶ [oig.hhs.gov/](http://oig.hhs.gov/)
- ▶ [cms.hhs.gov/](http://cms.hhs.gov/)



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# RHC BILLING 101

OHIO RURAL HEALTH CLINIC  
PRACTICE MANAGEMENT TRAINING  
MARCH 5, 2014

# OBJECTIVES

- Participants will understand the billing differences between Provider Based and Independent RHC Technical billing.
- Participants will understand how to appropriately bill professional and technical components.
- Participants will understand the challenges of RHC billing and managing the Accounts Receivable.

# WHAT IS A RHC?

- A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.

# INDEPENDENT VS PROVIDER BASED

- Independent RHC are generally private
  - Professional billing is submitted under CLINIC Part A number.
  - Technical billing is submitted under CLINIC Part B number. This can be billed under the group, but each provider must be credentialed with Medicare Part B if they are seeing patients.
- Provider based RHC is owned and directed by the hospital, nursing facility, or home health agency.
  - Professional billing is submitted under CLINIC Part A number
  - Technical billing is submitted under HOSPITAL Part A number

# RHC LOCATIONS

- The clinic (office)
- Home visit (the home of the patient)
- Nursing Home
- Scene of an accident

# RHC ENCOUNTER

- Encounters with (1) more than one health professional; and (2) multiple encounters with the same health professional which takes place on the same day and at the same location, constitutes a single visit. *Exceptions will be addressed later in presentation.*
- The term “visit” is defined as a face-to-face encounter between the patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting nurse, clinical psychologist, or clinical social worker during which an RHC service is rendered.

# RHC ENCOUNTERS ARE NOT

- Non medical necessity services
- Non covered services
  - Lab tests/results only
  - Dressing change
  - Refill of prescriptions
  - Administration of injection only
- Completion of claim forms
- Care plan oversight
- 99211 is NOT an RHC encounter. If the provider is billing this level they are most likely undercoding

# SLIDING FEE PROCESS

- If this process is offered in your clinic setting you must:
  - Post in the patient area that the service is offered
  - Offer to all patients
  - Have an application system in place with policy
  - Understand the process
  - Be current in the poverty guidelines and their application for use.

**COMMERCIAL  
AND OHIO  
MEDICAID RHC  
BILLING**



# NON MEDICARE/NON MEDICAID

- You will submit your commercial, workers comp, and auto claims as you always have. These are submitted on 1500 claim forms.
- You will bill your self pay services as you always have through your statement services.
- You may still turn accounts over to collections
  - Have a process
  - Have policy

# MEDICAID SPECIFICS

- ▶ Place of Service 72

**MEDICARE**

**RHC BILLING**



# BILLING GUIDELINES

- All billing is subject to CMS guidelines.
- Be certain that your credentialing/enrollment processes are correct and current.
- Be sure that each provider's NPI numbers are attached to the services rendered and that the NPPES website has current information.
- Be sure that the clinic NPI number has the correct taxonomy codes including Rural Health Clinic.
- Midlevel providers need to have their own Medicare Part B billing numbers
- Know your carriers and if the midlevel needs to bill under the supervising physician or if they can be credentialed as a provider

# REVENUE CODES

- The following Revenue Codes are used for Medicare Part A billing on the UB 04 format:
  - 0521 Clinic visit at RHC by qualified provider
  - 0522 Home visit by RHC provider
  - 0524 Visit by RHC provider to a Part A SNF bed
  - 0525 Visit by RHC provider to a SNF, NF or other residential facility (non-Part A)
  - 0527 Visiting Nurse service in home health shortage area
  - 0528 Visit by RHC provider to other non-RHC site (scene of accident)
  - Revenue code 0900 from both RHCs and FQHCs when billing for services subject to the Medicare outpatient mental health treatment limitation, and revenue code 0780 when billing for the telehealth originating site facility fee.

# COMINGLING

- Commingling is being paid twice from Medicare for the same service(s) and is considered fraud.
- Since you are billing incident-to-services with the professional component to Medicare Part A as an RHC you cannot bill the same incident-to-services to Medicare Part B to receive a second payment

# NON RURAL HEALTH SERVICES

- These services are billed to:
  - Medicare Part B as FFS (fee for service) for Independent RHC
  - Medicare Part A under the main entity for Provider-Based
    - Diagnostic testing (technical component)
    - X-ray
    - EKG
    - Laboratory services
  - Medicare Part B for both Independent or Provider Based
    - Professional services done in the hospital

# MEDICARE PART A BILLING

- File in the UB 04 format
- Type of bill 711 for RHC and 771 for FQHC
- Enter actual charges, NOT THE ENCOUNTER RATE.
  - The charges must be rolled into 1 line item with the correct revenue code EXCEPT for G0402, G0438, G0439
- Co-insurance/deductible is based on the total charge of professional services rendered.
- Bill only one Medicare encounter per day for services rendered in the clinic
- Must have a medically-necessary diagnosis
- A mental health visit AND an RHC encounter are payable on the same day.
- Timely filing limits have changed to one year from the date of service.

# BILLING OFFICE VISITS

- Established Patient
- New Patient
- Independent RHC submits the encounter under the CLINIC Medicare Part A number on the UB form
- Provider Based RHC submits the encounter under the CLINIC Medicare Part A number on the UB form

# LABORATORY

- All Independent RHC lab services are billed to Medicare Part B using the clinic Medicare Part B number and filed in the 1500 claim format.
- Use CLIA waived modifiers QW on Part B claims.
- All Provider Based RHC lab services are billed to Medicare Part A using the hospital Medicare Part A number and filed in the UB 04 format.

# LABORATORY

- ▶ Venipuncture issues with CMS

# MEDICARE EKG

- The professional component (interp and report) 93010 is bundled into the RHC encounter and billed inclusive on the UB form to Medicare Part A for both Independent and Provider Based RHC.
- The technical component 93005 is billed as fee for service to Medicare Part B 1500 claim format using the clinic Medicare Part B number for the Independent RHC and to Medicare Part A UB 04 claim format using the hospital Medicare Part A for the Provider Based RHC.

# RADIOLOGY

- The professional component is bundled into the RHC encounter.
  - Know if the professional piece is contracted by a radiologist not included in the RHC.
  - Know if the contracted radiologist is billing for the reading.
- For Independent RHC the technical component is billed as fee for service to Medicare Part B on a 1500 claim form using the clinic Medicare Part B number.

# INJECTIONS

- Injections and immunizations are only billed to Medicare and Medicare HMOs if there is a valid face-to-face encounter with an approved provider.
- If you have a face-to-face encounter within 30 days prior or after the date of the injection/immunization, you may bundle the injection/immunization service into the encounter and bill to Medicare and Medicare HMOs.

# PROCEDURES

- Procedures performed on the same day as an RHC encounter will be bundled and ONE RATE will be paid for the entire encounter.

# FLU/PNEUMOVAX

- These injections are covered under the RHC program.
- Regular Medicare services are NOT to be billed on a claim.
- A log needs to be kept for these injections and they are submitted on the cost report. They will be paid at annual cost report reconciliation.
  - Date of service
  - Patient name
  - Patient Medicare Number
- Medicare HMOs are to be billed on a HCFA 1500 with the administration code. Use Medicare billing CPT codes for Flu/pneumo. (G code series)

# WELCOME TO MEDICARE

- This is payable once per lifetime
- The service must be rendered within twelve months of the patient becoming eligible for Medicare or if they are enrolled in Medicare and they have NOT had their welcome visit.
- The co-insurance/deductible are not applicable to this service
- Only one payment is made for this RHC encounter.

# WELCOME TO MEDICARE

- For an Independent RHC all diagnostic screenings are billed to Medicare Part B.
- Codes G0402 must be billed on their own claim line and must have the CPT code on the UB04 claim form. If other services are performed on the same day and they meet the requirement of separately identifiable face-to-face encounter, they will be bundled together on their own line item separate from the G codes listed and they will not need CPT codes on the UB 04 form but will be in the revenue line item.
  - G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
  -

# ANNUAL WELLNESS VISIT

- ▶ Annual wellness is NOT a physical.
- ▶ Medicare DOES NOT pay for the wellness exam, ie, 99397
- ▶ G0439  
Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit

# ANNUAL WELLNESS VISIT

- ▶ The initial annual wellness visit (AWV) includes taking the patient's history; compiling a list of the patient's current providers; taking the patient's vital signs, including height and weight; reviewing the patient's risk factor for depression; identifying any cognitive impairment; reviewing the patient's functional ability and level of safety (based on observation or screening questions); setting up a written patient screening schedule; compiling a list of risk factors, and furnishing personalized health services and referrals, as necessary. Subsequent annual wellness visits (AWV) include updating the patient's medical and family history, updating the current provider list, obtaining the patient's vital signs and weight, identifying cognitive impairment, updating the screening schedule, updating the risk factors list, and providing personalized health advice to the patient.

# ANNUAL WELLNESS VISIT

- G0438 Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit
- G0439 Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
- G0438, G0439 must be billed on their own claim line and must have the CPT code on the UB04 claim form. If other services are performed on the same day and they meet the requirement of separately identifiable face-to-face encounter, they will be bundled together on their own line item separate from the G codes listed and they will not need CPT codes on the UB 04 form but will be in the revenue line item.

# IN PATIENT HOSPITAL SERVICES

- Independent RHC In-Patient services are billed to Medicare Part B on a 1500 claim form

# NURSING HOME SERVICES

- Nursing home services (including SNF) are billed to Medicare Part A on a UB form.

# FINANCIAL INFORMATION



# MEDICARE COPAYS/DEDUCTIBLES

- The effect on payment is an increase in the charge, and in the co-insurance.
- RHC services deductible is based on billed charges. Non-covered expenses do not count toward the deductible.
- The cost for incident-to-services are included in the cost report, but they are not payable on the claims.
- **EXAMPLE:** The patient has an office visit for \$65.00 and an injection for \$40.00. There will be one line item of \$105.00 on the UB form with revenue code of 521. The patient (or secondary) will be responsible for \$21.00 which is the 20% co-insurance

# PAYMENT POSTING

- Medicare will pay 80% of the RHC encounter rate.
- The patient/co-insurance will be responsible for 20% of the charge.

# MEDICARE SECONDARY PAYER

- Collect patient health insurance or coverage information at EACH patient visit.
- Tools can be found on the CMS website:
  - <http://www.cms.gov/manuals/downloads/msp105c03.pdf>
- Bill the primary payer before billing Medicare, as required by the Social Security Act.

# SECONDARY BILLING AFTER MEDICARE

- 20% of charges may not be equal to 20% of the encounter rate (if the charges are not equal to the encounter rate)
- Coinsurance is established on the 20% of the allowed amount.
- Do not write off the account with primary payer to \$0.00. Bill the patient/secondary 20%.

# MEDICARE BAD DEBT

- RHCs are allowed to claim bad debts in accordance with 42 CFR 413.80. RHCs may claim unpaid deductible. The RHC must establish that reasonable efforts were made to collect these co-insurance amounts in order to receive payment for bad debts. If the RHC co-insurance or deductible is waived, the clinic may not claim bad debt amounts for which it assumed the beneficiary's liability.
- Reasonable attempts must be made to attempt to collect the bad debt. Trail to show statements/billing in a routine pattern for 120 days.
- Only services rendered during RHC effectiveness qualify to be written off for Medicare Bad Debt.
- Medicare Bad Debt is reported in the year it was written off.
- Any denials by Medicaid as secondary payer as long as claim was actually billed and denied
- Documented charity write-offs

# OTHER REPORTS



# OTHER REPORTS

- Credit Balance Reports
  - Due 30 days after the end of each fiscal quarter
  - Report over-payments from Medicare
  - No payments will be made if you do not complete this report
- CMS billing audit reports
  - CMS may ask for 25 patients specific billing for a date of service and the office notes to support the billing.
  - An adjudicator reviews and decides if the service was a medical necessity.
  - Monies can be taken back by Medicare. There is an appeal process through the adjudicator.

# QUESTIONS / ANSWERS





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# TAKING CONTROL OF YOUR ACCOUNTS RECEIVABLE

OHIO RURAL HEALTH CLINIC  
PRACTICE MANAGEMENT TRAINING  
MARCH 5, 2014

# OBJECTIVES

- ▶ Learn to understand aged AR
- ▶ Learn to work AR
  - Get the old stuff paid
- ▶ Learn to manage AR
  - Where do we go from here?

# ACCOUNTS RECEIVABLE

- ▶ Accounts Receivable are unpaid payments/charges that are owed to you by the patients and/or insurance companies.
- ▶ Accounts Receivable reports are a vital tool to use to measure the success of collections within the office.
- ▶ AR reports are a roadmap to show the path the office is taking in regards to its finances



# ACCOUNTS RECEIVABLE

- ▶ Do you have an awareness of your Accounts Receivable?
  - The amount outstanding
  - Due from Patients responsibility
  - Due from Primary Insurances
  - Due from Secondary/Tertiary Insurances

# ACCOUNTS RECEIVABLE

- ▶ Do you know your payer mix?
- ▶ RHC has a difference between Medicare/Medicaid and commercial claims
- ▶ RHC Medicare/Medicaid has the rate.
- ▶ Commercial claims has FFS or contracted amount.
- ▶ Do you know the difference?

# MANAGING YOUR AR

# MANAGING YOUR AR

- ▶ Correct management of Accounts Receivable begins at the time of registration.
- ▶ Confirm the demographics
- ▶ Validate the insurance coverage
  - Inform the patient of services not covered by their carrier (EX: not all BC contracts cover flu injections, some commercials do not)
- ▶ Collect the Copay and past due balances

# MANAGING YOUR AR

- ▶ Have effective communication between billing office and front desk.
- ▶ Review financials before placing the reminder call. Inform patient of expected payment due.

# MANAGING YOUR AR

- ▶ Charge/Data Entry responsibility
  - Support staff
  - Provider staff (some systems have the providers doing charge entry)
- ▶ Know your office procedures
- ▶ Make sure the encounter form/superbill is complete and accurate
- ▶ Review the encounter form/superbill
  - Confirm what you are processing

# MANAGING YOUR AR

- ▶ Charge/data entry
  - Know your coding
  - Clean claim processing
    - Use the 4<sup>th</sup> and 5<sup>th</sup> digit for diagnosis
    - Use proper modifiers
    - Know your carrier guidelines
  - **BE PREPARED FOR ICD 10 ON OCTOBER 1, 2014**

# MANAGING YOUR AR

- ▶ Do you have a plan of attack?
  - Policies in place?
  - Set schedule for working AR
  - Keeping Management informed
  - Work by carrier?
    - Set schedule
    - Minimum of monthly review of claims
    - Work claims at the time of processing the EOB

# Managing Your AR

- ▶ Working the EOB
- ▶ Electronic posting vs. Manual posting
  - Review to make sure all monies have posted
  - Review to take care of rejections
  - Know what the carriers will and will not cover
  - Check the claim for needed codes
    - Correct CPT?
    - Correct ICD-9-CM? Proper digits?
    - Correct modifiers (if applicable)

# MANAGING YOUR AR

- ▶ WORK THE REJECTIONS
- ▶ DON'T JUST WRITE THEM OFF
- ▶ MAKE SURE THE WRITE OFF IS LEGITIMATE
- ▶ KNOW WHAT CAN BE TRANSFERRED TO PATIENT RESPONSIBILITY

# MANAGING YOUR AR

- ▶ ABN use
- ▶ Non covered services
- ▶ Part of the service covered and a remaining charge not considered on the claim for payment. Did the claim need a modifier? (Ex: In some states BC may pay for injection and not the Office Visit if the OV does not have the proper modifier) **KNOW YOUR CARRIERS GUIDELINES**

# MANAGING YOUR AR

- ▶ Know your payer mix
- ▶ Build a rapport with your carriers
  - Call the carrier for explanation
  - Do they need more documentation?
- ▶ Know how to appeal a claim
  - Challenge the carrier
  - Have your supporting documentation
    - Have the provider assist you

# ACCOUNTS RECEIVABLE

- ▶ What are your days in AR?
- ▶ Tracking your AR days allows you to determine the effectiveness of your billing and collections process.
- ▶ If your AR days are higher than average, you need to determine the source of the problem.

# ACCOUNTS RECEIVABLE

- ▶ What is acceptable Days out in AR?
  - If under 65 days: Good Job!
  - If over 65 days: Preview process. Taking too long
  - If over 80 days: PANIC. You are losing money. But it is easy to improve.

# MEDICARE PART A

# MEDICARE PART A

- ▶ Are you sending to the correct FI?
  - Have you kept up with the MAC jurisdiction?
  - Have you done proper enrollment paperwork?
- ▶ Refile claim
  - First step of correction.
  - Only refile claim once and then begin the work process

# MEDICARE PART A

## ▶ IVR

- Utilize the IVR system to check on the status of the claim.
  - Charges applied to deductible?
  - Covered service?
  - Has it been denied?
    - Make corrections on claim as necessary.
    - Move to patient balance if allowed
- ▶ Know the timely filing limits

# MEDICARE PART B

- ▶ Are claims going to correct FI?
- ▶ Refile claim
- ▶ Use IVR system
- ▶ Know your timely filing limits

# MEDICARE PART B

- ▶ Independent RHC
  - Do you have the CLIA certification?
  - Are you maximizing the coding?
- ▶ Provider Based RHC
  - Are the proper components being broken out from Professional and Technical? (if applicable)
  - Don't lose out on the small stuff. Sometimes the billing office spends the time collecting on the large hospital balance and neglects the small clinic balance.

# MEDICAID

- ▶ Bill the claim. Don't just write it off.
- ▶ Wait for the rejection to do the write off.
  - This gives supporting documentation to billing staff decision making on the claim
- ▶ Don't forget the secondary amount balance
  - Especially deductibles and large copays
  - Bill for all services at least once.

# COMMERCIAL CARRIERS

- ▶ Know the guidelines for each carrier
  - What is covered and what is not covered
  - What can you bill as patient responsibility?
- ▶ Are you under a signed contract?
  - Know and understand the terms of the contract?
- ▶ Is this a management care program?
  - Will you receive a set rate?
  - At what point does the visit get processed and written off?

# WORK COMP/AUTO

- ▶ Paper claims
- ▶ Make sure the authorization processing claim number is on the claim
- ▶ Attach notes to support the claim
  - This expedites the processing of the claim
  - Don't wait for the carrier to request notes

# SECONDARY CLAIMS

- ▶ Don't ignore these
  - Not always a large balance, but still revenue to be received
  - Don't write off until the EOB states the rejection
- ▶ Maximize the claim reimbursement

**SELF PAY**

# SELF PAY

- ▶ Medical practices can be among the worst when it comes to getting/collecting their money.
- ▶ The office may be known to send the same bill five times with no repercussions for non-payment.
- ▶ Patients don't pay because they figure that no one really expects them to.

# SELF PAY

## CHANGE THE THINKING

- ▶ Set a firm policy in place.
- ▶ Communicate the policy to the patients in advance.
- ▶ Follow through with the policy. The message will get out.
- ▶ You have the right to expect payment.
- ▶ You have the right to turn an account over to collections. Work with the provider on this—the patient may have shared with the provider if there are issues of why payment is not happening.

# ACCOUNTS RECEIVABLE

- ▶ What about the Mission Statement?
- ▶ There is a difference between the **ability** to pay and the **refusal** to pay.
  - If someone is truly unable to pay, work with them, give options, etc.
  - If someone truly refuses to pay---continue with the collection process.

# SELF PAY

- ▶ Consider using Payment Plans and have the patient sign the plan.
  - Set up the plan so that the patient is not adding more charges each month than they are paying.
  - Set the payment plan for the PAST DUE and instruct patient that they **MUST** keep current responsibilities up to date.
  - Monitor to make sure the payment plans are being kept.

# SELF PAY

- ▶ Sliding Fee Scale
  - Consider implementing
  - Monitor and maintain current sliding fee applications. Develop the system so that this is updated on a yearly basis with current patient data, financials, etc.
  - Have the policy in place and make sure staff understand the policy and how to implement and maintain the patient accounts

# SELF PAY

## ▶ Payment Coupons

- Develop a policy that states the usage of the payment coupons and the minimum balance owed for setting up this type of payment plan with the patient.
- The patient receives a coupon book just like a car/house payment book. Give them envelopes for mailing, etc
- Some software systems will print these for you. See if your software system allows this option and utilize it.
- Make pre-made payment coupon books and complete as needed.

# SELF PAY

- ▶ ABC Medical Office, Payment Coupon
- ▶ Name: \_\_\_\_\_ Date: \_\_\_\_\_
- ▶ Account No: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_
- ▶ Payment Amount: \_\_\_\_\_

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\*This payment plan is for the original amount due of \$\_\_\_\_\_. All other balances since the date of contract are not included in this arrangement.



# SELF PAY

- ▶ RHC must show the attempt of collecting in order to use the Medicare Bad Debt on Cost Reporting.
- ▶ Keep your trail of attempts made to collect
- ▶ RHC Medicare accounts must be handled as all other financial accounts in order to place on the bad debt report.
- ▶ Log your Medicare Bad Debt efficiently

# SELF PAY

- ▶ **Future Services in the clinic**
  - You may reschedule a visit as long as there is no health risk to the patient.
    - You are NOT denying care---only rescheduling the appointment.

# What Causes Low Collections?

- ▶ When are outpatient and inpatient charges entered into the billing system with respect of the date of service (lag time?)
  - Do you have the appropriate number of staff to keep up with the data entry and working of the claims?

# What Causes Low Collections?

- ▶ When did you last review your fee schedule?
- ▶ Do the billers flag management when a procedure is considered/allowed at 100%?

# What Causes Low Collections?

- ▶ What is your payer mix?
  - Has your payer mix shifted towards payers with lower allowance schedules?
  - Are there services that your payers have stopped consideration for payment?
  - Have you updated/re-negotiated your contract?

# What Causes Low Collections?

- ▶ What is the percent of claims that are denied during the first submission?
  - Identify the 5 major denials
    - Coding
    - Incorrect/incomplete registration information
    - Patient not eligible on date of service
    - No referral/preauthorization
    - Not a covered service/benefit

# What Causes Low Collections?

- ▶ Are you editing your CPT, ICD, Modifiers
- ▶ Are you verifying/validating insurance coverage and eligibility
- ▶ Are you collecting patient copays and/or past due balances
- ▶ Can you accept Debit/Credit Cards
- ▶ When are payments posted on the account?



# What Causes Low Collections?

- ▶ What is your office policy for AR review?
- ▶ What is your office policy for claim appeals?
- ▶ What is your office policy regarding patient follow up, statements, calls, payment plans?
- ▶ What is your office policy regarding collections/agencies?



**WORK IT, WORK IT,  
WORK IT**



# Questions and Answers



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