The following information was used as visual aid during a presentation/training session led by a BKD, LLP advisor. This content was not designed to be utilized without the verbal portion of the presentation. Accordingly, information included on these slides, in some cases, are only partial lists of requirements, recommendations, etc. and should not be considered comprehensive. These materials are being issued with the understanding they must not be considered legal advice.
CONTAINING COSTS

In the past.  Today.

THE REVENUE CYCLE
# Program Requirements

Health centers are non-profit private or public entities that serve designated medically underserved populations/areas or special medically underserved populations comprised of migrant and seasonal farmworkers, the homeless or residents of public housing. A summary of the key health center program requirements is provided below. For additional information on these requirements, please review:

- Health Center Program Statute: Section 330 of the Public Health Service Act (42 U.S.C. 2004a)
- Program Regulations: 42 CFR Part 35a and 42 CFR Parts 56, 90, 5031
- Grants Regulations: 45 CFR Part 74

## Program Requirements

- NEED
- SERVICES
- MANAGEMENT AND FINANCE

## Program Requirement 13: BILLING AND COLLECTIONS

**Authority:** Section 330(a)(3)(F) and (G) of the PHS Act

**Documents to Review Onsite or in Advance:** 1) Policies and procedures for credit, collection, and billing 2) Encounter form(s) 3) Most recent Income Analysis (Form 3) 4) Managed care or any other third party payor contracts 5) Most recent Health Center Program financial performance measures/UCRS Report.


<table>
<thead>
<tr>
<th>Requirements</th>
<th>Questions</th>
<th>Response</th>
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| 1. Health center has systems in place to maximize collections and reimbursement for its costs in providing health services. | Does the health center participate in or make every reasonable effort to participate in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), MarketPlace qualified health plans, and any other public assistance programs that are available to its patients?  
Does the health center have Medicare and Medicaid provider numbers, where applicable (e.g., do all Permanent and Seasonal Sites on Form 5B have Medicare CMS Certification Numbers)?  
Does the health center make every reasonable effort to collect reimbursement for services provided to persons covered by private health insurance?  
Does the health center make reasonable efforts to secure payment from patients for amounts owed for services based on their established sliding fee discount schedule in a manner that assures that no patient will be denied services based on an inability to pay? |                                                                                                                                                                                                                                                                                        |
| 2. These systems include written policies and procedures addressing: Billing  
Credit  
Collections | Does the health center have written board-approved policies and procedures for:  
Billing  
Credit?  
Collections? |                                                                                                                                                                                                                                                                                        |
BILLING & COLLECTIONS

➢ Health Center programs must:
  • Maintain adequate cash flow to support operations
  • Maximize revenue from non-Federal sources
  • Have systems in place to maximize collections & reimbursement for its costs in providing health services, including written billing, credit & collection policies & procedures. (Section 330(k)(3)(F) & (G) of the PHS Act)

BILLING & COLLECTIONS, CONT.

➢ Revenue maximization requires
  • An adequate & competitive fee schedule
  • A corresponding schedule of discounts
  • Prompt & accurate billing of third-party payers
  • Billing of patients in accordance with the schedule of discounts
  • Timely follow-up on all uncollected amounts
BILLING & COLLECTIONS, CONT.

➢ Process necessary to ensure that federal grant resources address true financial access barriers to the maximum degree possible

➢ Health Centers are expected to utilize information to monitor performance compared to internal & external benchmarks, as well as for tracking trends

THE REVENUE CYCLE

➢ Charge structure
➢ Patient scheduling
➢ Patient registration
➢ Pre-appointment activities
➢ Patient flow
➢ Charge capture & entry
➢ Third-party billing
➢ Denial management
➢ Patient collections
DO ALL OF THE PIECES FIT?

KEY AREAS FOR FRONT DESK SUCCESS

1. Recruitment & retention
2. Training
3. Customer service
4. Telephone
5. Patient scheduling
KEY AREAS FOR FRONT DESK SUCCESS, CONT.

6. Patient registration
7. Time of Service (TOS) collections
8. Patient checkout
9. Management
10. Communication

PATIENT COLLECTIONS IN A COMMUNITY HEALTH CENTER
TIME OF SERVICE (TOS) COLLECTIONS

➢ Best opportunity to collect

➢ Educate patients regarding payment for services
  • Financial policy
    ▪ Co-pay
    ▪ Self-pay
    ▪ Past due accounts

PATIENT COLLECTIONS

➢ Set the tone
  • Expectations consistently communicated by all health center personnel
    ▪ Initial telephone contact & front desk staff
    ▪ Providers & clinical staff
    ▪ Administration
  • Accountability: Measure & report cash collections
PATIENT COLLECTIONS, CONT.

➢ Patient Consequences

- Make money owed an issue – past balances are not ignored
  - Payment plans
  - Collection agency
  - Attorney

I can't create your bride until you make your co-pay...

PATIENT COLLECTIONS, CONT.

➢ Staff Consequences

- Require reason for nonpayment & actions taken to be written on the superbill
- Periodic measuring & reporting of collections at the time of service
- Include in performance reviews for applicable personnel
PATIENT COLLECTIONS, CONT.

➢ Where is the cash kept?
   • Lockbox
   • Cash register
   • Pockets

➢ Segregation of duties

INTERNAL CONTROLS

➢ Does cash received & cash posted balance daily?

➢ What happens to overpayments?

➢ Is every patient payment posted immediately?
   • End of day reconciling forms
   • System generated receipt
   • Ability to post adjustments
   • Statements generated
PATIENT COLLECTIONS, CONT.

After the visit
- Accuracy
- Understandable statements
- Speed
- Follow-up

 PATIENT COLLECTIONS, CONT.

In-house collection efforts
- Daily productivity target per FTE
- 45 to 70 accounts worked
- Can use 70 contacts per FTE per day as a reasonable expectation
- On average it takes 2.5 contacts to achieve account resolution
IMPACT OF CLINICAL PROCESSES ON REVENUE

- **Scheduling**
  - Highly restricted patient types & times
  - Acute patient/same day scheduling process
  - Volume

- **Charge tickets/Electronic Health Record (EHR)**
  - Accuracy & completeness
  - Timeliness of completion
  - Legibility (if by paper)
IMPACT OF CLINICAL PROCESSES ON REVENUE, CONT.

➢ Coding
  • Fear of over-coding
  • Under-coding to “help” the patient

➢ Patient flow
  • Taking patients back before front office processes are completed
  • Directing patients to check-out process

IMPACT OF CLINICAL PROCESSES ON REVENUE, CONT.

➢ Additional issues
  • ABNs
  • Staff & provider buy-in to collections process
BENCHMARKING FOR IMPROVED PERFORMANCE

KEY ATTRIBUTES OF SUCCESSFUL BILLING DEPARTMENTS

- Understand each piece of the revenue cycle
- Defined responsibilities
- Effective communication
- Leverage technology
- Written policies & procedures
- Comprehensive training
KEY ATTRIBUTES OF SUCCESSFUL BILLING DEPARTMENTS

- Individual accountability
- Appropriate staffing
- Competent management
- Monitoring tools
- Feedback & recognition
- Adaptability

KEY PERFORMANCE INDICATORS (KPIs)

- What is the revenue cycle?
  - Begins with appointment scheduling & ends with payment resulting in zero balance due

- How do I know if we are doing a good job?
PRACTICE MANAGEMENT SYSTEMS

➢ “Most practices only use 50% of their system’s capabilities?”

➢ Utilizing staff hours instead of automation

STAFFING

➢ Staffing levels
  • Better performing practices actually have higher billing staffing than others
    - Total business operations support staff FTE per physician
      o Better performers: 1.21*
      o Others: 0.97*
    - Total support staff cost per FTE physician
      o Better performers: $278,121*
      o Others: $203,334*

STAFFING, CONT.

- Feedback & recognition
  - Staff, department & organization receive feedback regularly
  - Improvements are celebrated

- Adaptability
  - Continuous research & education
  - Open to changing processes

TRAINING PROGRAM

- Comprehensive training
  - Practice management system is just a component
  - On-the-Job (OTJ) training should be a part, not the entirety
  - Effective trainer
  - Written training materials
  - Dedicated time
  - Competency assessments
TRAINING PROGRAM, CONT.

- Written, compliance driven policies & procedures
  - Undocumented = leaves room for interpretation
  - Detailed guidance in procedure format
    - Billing third-party payers
    - Credit balances
    - Insurance follow-up
    - Small balance adjustments
    - Budget plans
    - Bad address
    - Patient correspondence

BILLING PRACTICES

- Receiving Medicare payments from Part A & B?
- Recently reviewed services based on coverage or payment changes?
  - Initial Preventive Physical Exam (IPPE)
  - Diabetes Self-Management Training (DSMT)
  - Telehealth
  - Medicare Advantage
BILLING PRACTICES, CONT.

- Billing Requirements for FQHC Services
  - Revenue codes

- Define FQHC Services
  - Encounter understanding

- Non Billable Services
  - Nurse visits

- Non FQHC Services
  - Laboratory services
  - Technical component

MISSING REVENUE

- Missing Charge Rate: < 1%
  - < 1% of charges missed on audit (quarterly) of encounter form to charges entered
  - Processes in place to ensure all encounter forms are entered into the practice management system
  - Processes in place to ensure no missed offsite visits
ACCOUNTS RECEIVABLE MANAGEMENT

➢ Who is managing your accounts receivable?

➢ What information do they provide?

➢ What changes have they implemented within the last 60 days?

ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

➢ Monitoring tools

  • Key performance indicators (KPIs)
    ▪ Monitored & reported to executive management monthly
    ▪ Feedback provided to staff
    ▪ Visualization is often beneficial
ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

➡️ Performance indicators

• Average days in accounts receivable (A/R)
  ▪ Annual revenue divided by 365 days = average daily revenue
  ▪ Current accounts receivables divided by average daily revenue = average days in A/R
  ▪ Better performers: 27.49*
  ▪ Others: 44.15*


ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

• Percent of total A/R over 90 days old
  ▪ Better performers: 14.17%*
  ▪ Others: 32.04%*

• Adjusted fee-for-service (FFS) collections
  ▪ Better performers: 99.16%*
  ▪ Others: 96.02%*

• Gross FFS collections
  ▪ Better performers: 57.42%*
  ▪ Others: 46.77%*

ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

- **Percent of claims billed electronically**
  - Best practice & average: **95%**

- **Days to charge entry**
  - Best practice & average: **Same day or 24 hours**

- **Days to claim submission**
  - Best practice & average: **2 days**

- **Bad debt due to FFS activity per FTE physician**
  - Better performers: **$9,685**
  - Others: **$24,998**


ACCOUNTS RECEIVABLE MANAGEMENT, CONT.

- Measure performance to determine success
- Set goals for financial performance related to the revenue cycle
- Various performance indicators
ACCOUNTS RECEIVABLE FOLLOW-UP

- Is your denial rate close to benchmark?
- What happens when a claim is not paid?
- How many outstanding claims do you have?
- What guidance is provided to staff on prioritization of claims?

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

- Claim Denial Rate
  - Target = < 5% of total claims
    - Better performers: 3.15%*
  - Reduce re-work & get paid faster
  - Improve cash flow

* Source: MGMA Performance & Practices of Successful Medical Groups, 2013 Report based on 2012 data
ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ Prevention is key

• Monitoring denials is an ongoing basis
• Provide feedback to staff, providers & management
• Implement changes as appropriate
• Re-educate staff & providers collectively & individually

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ Sample follow-up policies – do you have something similar?

1. Claim submitted to commercial insurance
2. After 45 days, check claim status online or call. Resubmit, if necessary.
3. After 65 days, telephone call to payer with notes documented on account, move to patient due, if applicable.
ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ “Unresolved claim” policy
  • In theory, either a third-party or the patient should pay every claim
  • Practically, it is not cost efficient to resolve every unpaid claim

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ Staff productivity indicators
  • Outstanding claim follow-up
    ▪ Approximately 800 – 1,000 claims per month
ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ In-house collection efforts

  • Daily productivity target per FTE
  • 45 to 70 accounts worked
  • Can use 70 contacts per FTE per day as a reasonable expectation
  • On average it takes 2.5 contacts to achieve account resolution

ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

➢ In-house collection efforts, cont.

  • Low dollar high volume accounts
  • Two methods of sizing the collection effort
    ▪ Dollar amounts to be collected (e.g., over $75, $100, $200, etc.)
    ▪ Available staff
ACCOUNTS RECEIVABLE FOLLOW-UP, CONT.

- Quick follow-up on non-payment
  - Tighten statement cycles

<table>
<thead>
<tr>
<th>Days from Initial Statement</th>
<th>Billing Cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>—</td>
<td>Initial statement</td>
</tr>
<tr>
<td>30 days</td>
<td>2nd statement</td>
</tr>
<tr>
<td>45 days</td>
<td>1st pre-collect</td>
</tr>
<tr>
<td>60 days</td>
<td>2nd pre-collect</td>
</tr>
<tr>
<td>75 days</td>
<td>Refer to agency</td>
</tr>
</tbody>
</table>

COMMON BILLING ISSUES TO AVOID
COMMON BILLING ISSUES

- Failure to verify insurance
- Incorrect patient information
- Upcoding (downcoding)
- Unbundling (bundling)
- Documentation not supporting code(s)
  - Lack of documentation
  - Lack of medical necessity
  - Incorrect modifier usage
  - Wrong diagnosis or procedure code
- Duplicate claims

BILLING & CODING COMMON SENSE

- If it wasn’t documented, it wasn’t done.
- If it wasn’t done, it can’t be billed.
- If the service isn’t necessary, it won’t be provided.
- If you weren’t there, your name won’t appear in the medical record or on the claim.
- If your physician is offered money or gifts to prescribe drugs, refer patients, or order procedures/tests, decline.
MEDICARE REGULATIONS: LIVING IN THE PRESENT & PLANNING FOR THE FUTURE

EXAMPLE COMPLIANCE AGENCIES

- Comprehensive Error Rate Testing Program (CERT)
- Medicaid Integrity Contractors (MICs)
  - Education MICs
  - Review MICs
  - Audit MICs
- Recovery Audit Contractor (RAC)
  - Includes State Medicaid RAC audits & Medicaid Fraud Control Units
- Zoned Program Integrity Contractors (ZPICs)
  - Formerly known as Program Safeguard Contractors (PSCs)
- Health Care Fraud Prevention & Enforcement Action Team (HEAT)
- Office of Inspector General (OIG)
THE MANY LAYERS OF AUDITING AGENCIES

- OIG
- HEAT
- ZPICs
- Medicare & Medicaid RACs
- CERT
- MICs
- SMRCs

Bob, do you have time for an audit?
COMPLIANCE CONSIDERATIONS

➢ Evolution of technology in the healthcare industry
  • Electronic Health Record (EHR)
    ▪ Patient Portal
  • E-consults
  • Telemedicine
  • Practice Management System (PMS)

COMPLIANCE CONSIDERATIONS, CONT.

➢ Changes in regulations
  • ICD-10 implementation
  • FQHC PPS Rule

➢ Is your organization prepared?
DISCLOSURE

Information contained in this presentation is informational only & is not intended to instruct hospitals & physicians on how to use, or bill for health care procedures. Providers should consult with their respective insurers, including Medicare fiscal intermediaries & carriers, for specific information on proper coding & billing for health care procedures. Additional information may be available from physician specialty societies & hospital associations. Information contained in this presentation is not intended to cover all situations or all payers' rules & policies. Reimbursement laws, regulations, rules & policies are subject to change.