

Billing Efficiency

DPH PHNPDU LTAT CONSULTANTS

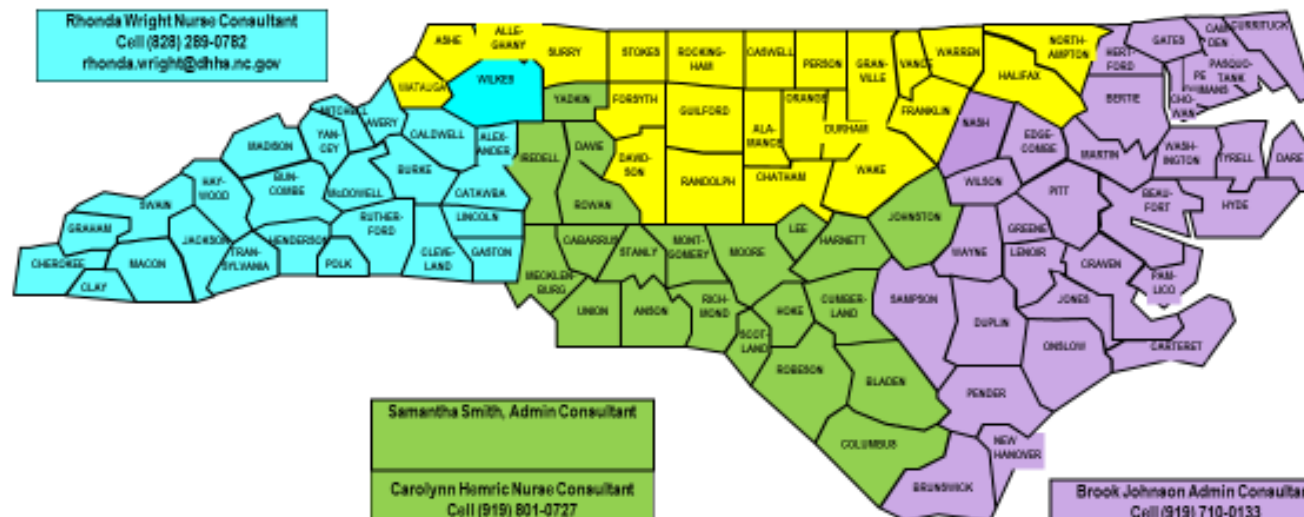
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What is one tool I can use to improve Billing Efficiency?

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 CREDENTIALIAED.....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](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 submittedaccepted/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



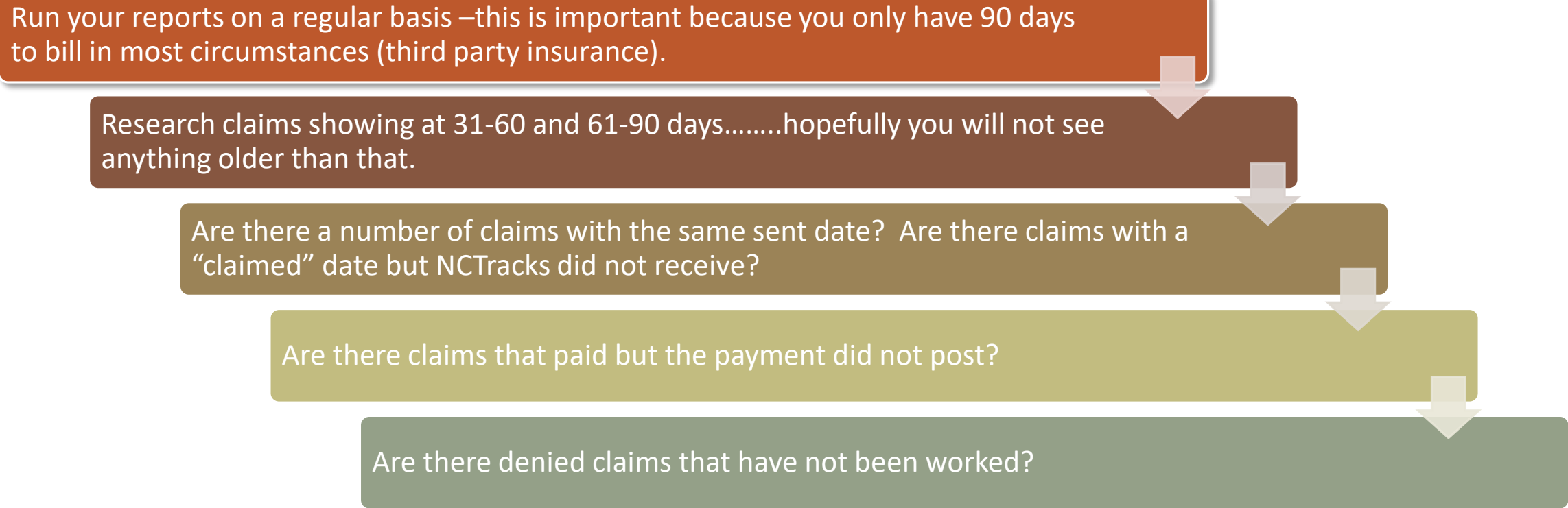
Payments were received.....but

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

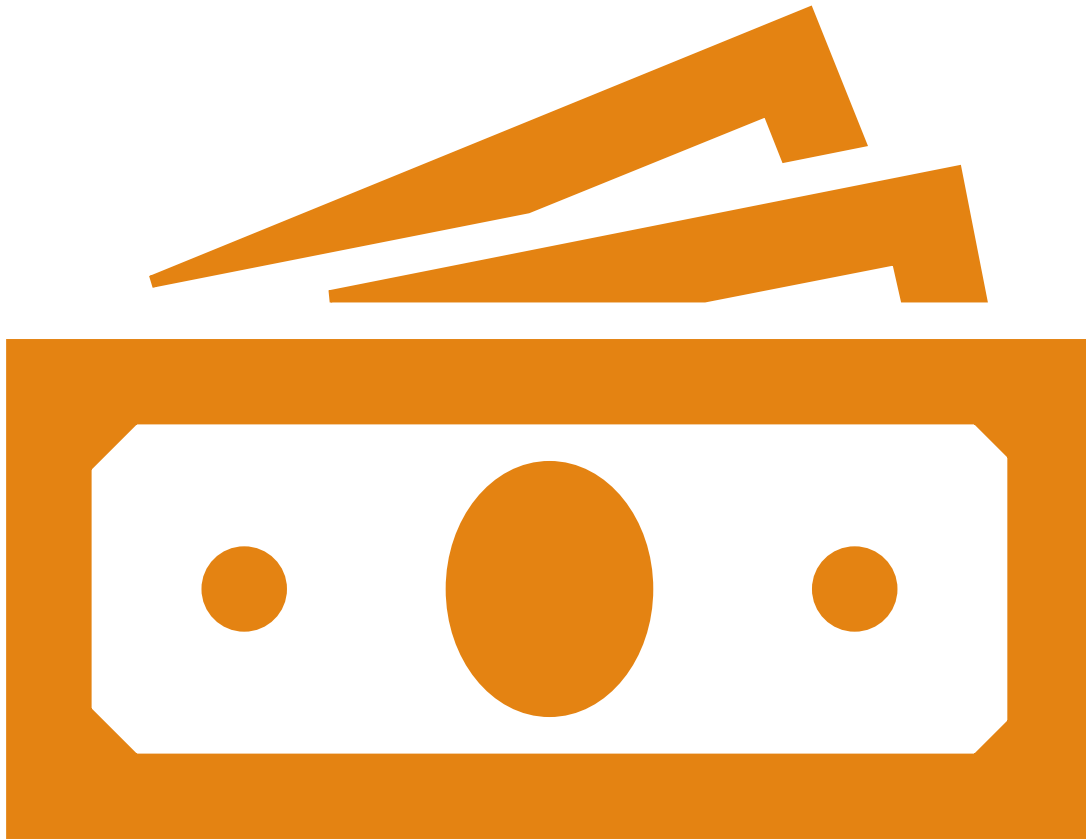
NC General Statutes

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 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.

Form an in-house Audit Committee

- 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 DIAGNOSE 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 THE 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?

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

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

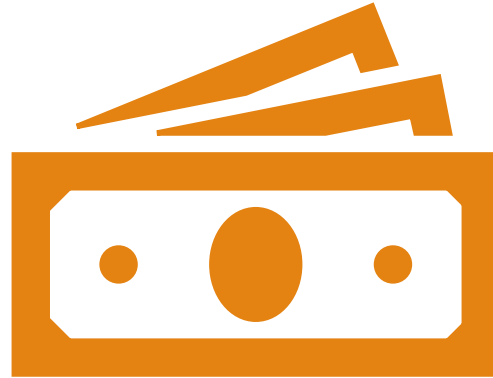
The
supervisors in
each clinic

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. Audit 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 in-quire 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 patient 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

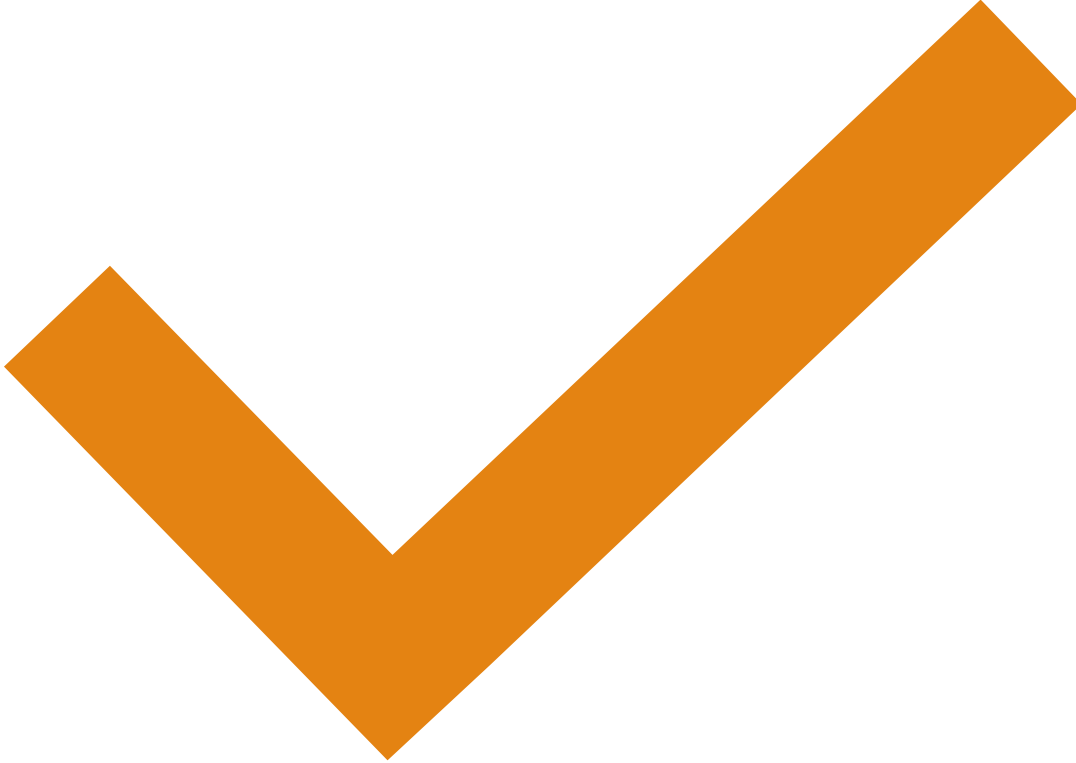
You can bill client for Non-Medicaid covered services, but you must inform the client that they will be responsible **PRIOR** to the service being performed.

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: What's What?

Correct CPT and ICD Must Be Used

CPT codes = what you did

ICD codes = why you did it

ICD 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

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.

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.

Health Choice Specific Modifier

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.

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 _____ City _____ State _____ Zip _____ County _____ Phone _____ E-Mail _____
Street Address

Household Members:

Line No.	HOUSEHOLD MEMBERS							TAX FILING STATUS					
	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)	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: \$
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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 _____

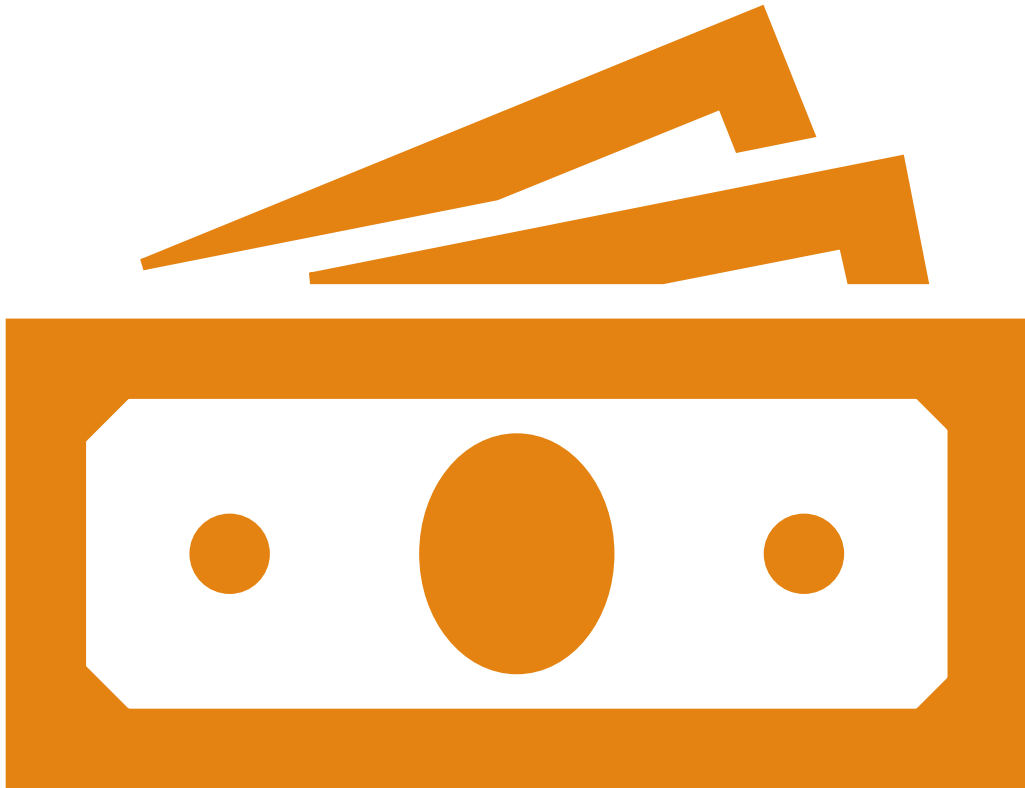
Signature/Date _____

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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.



Computing Income

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

Weekly = $\text{pay} \times 52$

Biweekly = $\text{pay} \times 26$

Twice a month = $\text{pay} \times 24$

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.

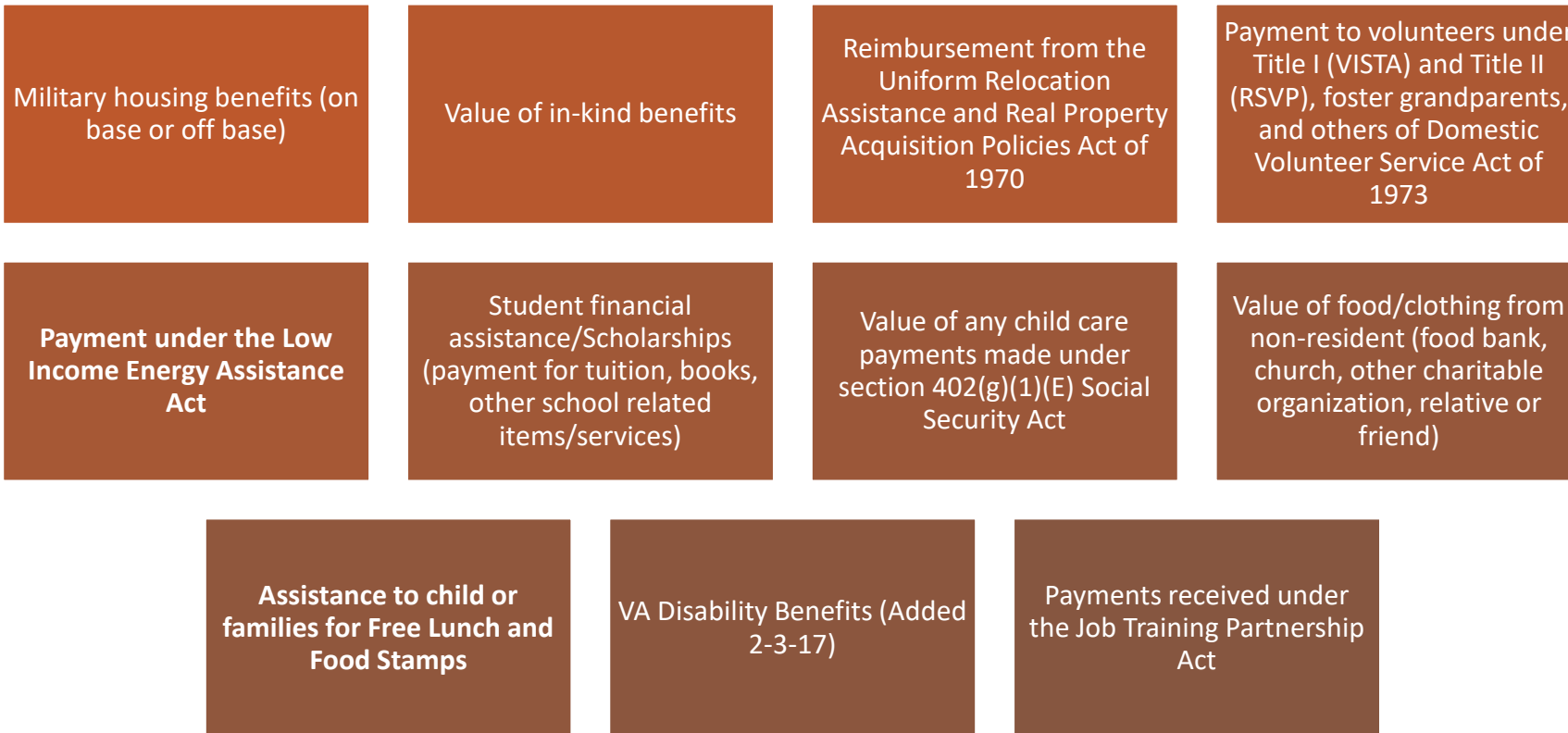
Regular monetary contributions from individuals not living in the household.

Prize winnings, Christmas bonuses.

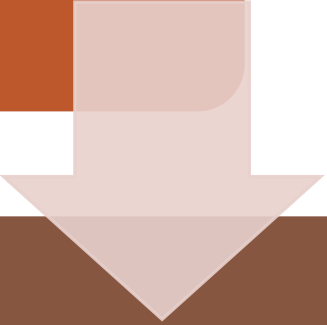
Income Verification Letter

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.



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 won't receive unemployment. If no unemployment compensation – ask how the client is going to support themselves

Computing Income

Computing Income

Employed today but unemployed last 6 months – Did the client receive unemployment the last 6 months? If 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.

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

Computing Income

*If someone **outside** the home is providing food, clothing or **if pays utilities directly to utility company etc.**, make a note **but don't count as income**. (If the money is given to the client, to in turn pay their bills, you count as income. (refer back below)*

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

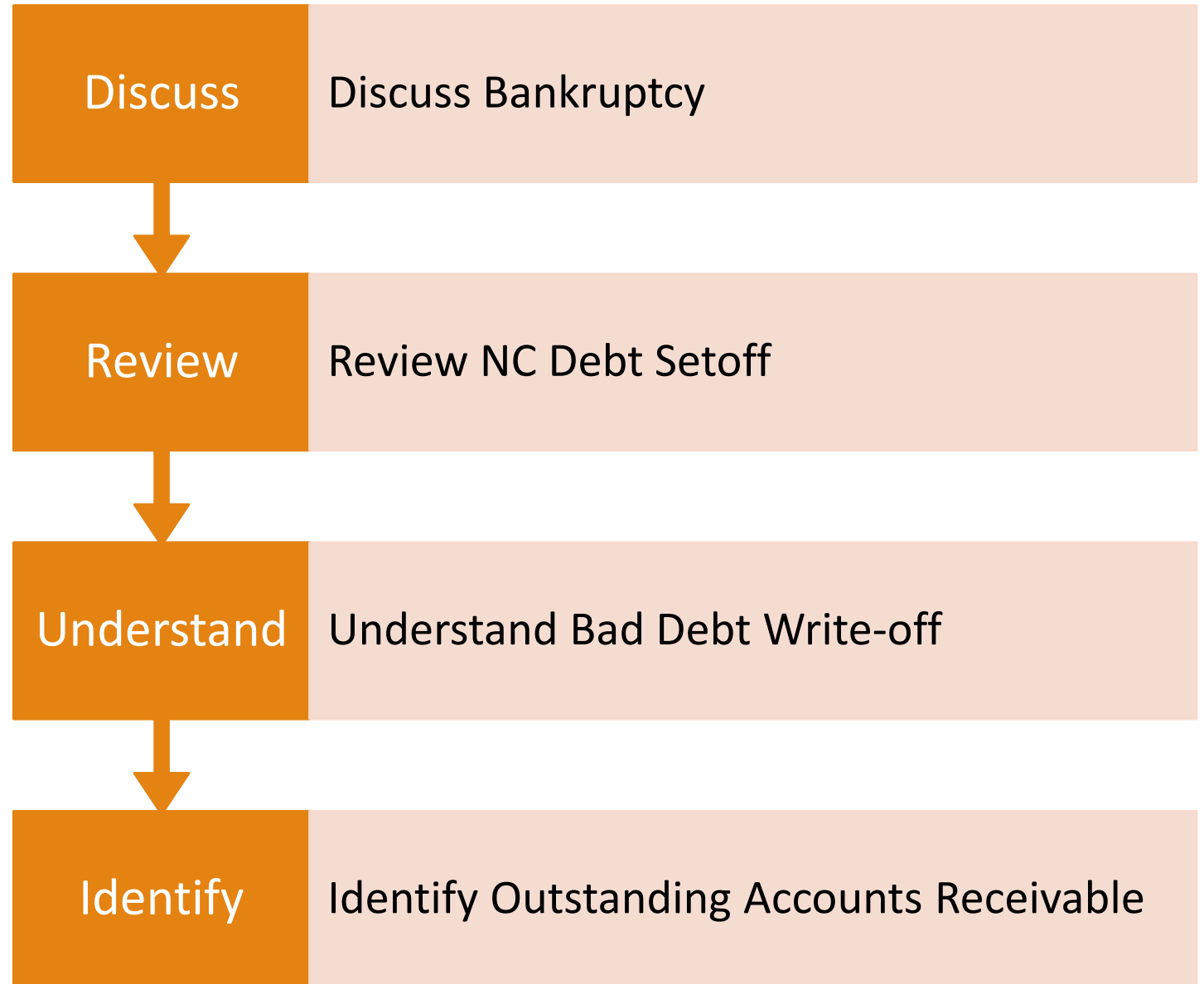
Regular monetary contributions from individuals not living in the household.

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