Provider-Payer Communication

Angela “Annie” Boynton
RHIT, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-I
Director 5010/ICD-10 Communication, Adoption & Training
annie_boynton@uhc.com

Speaker Background

- Started in small medical practices in MetroWest, Massachusetts.
- Vast experience in the Payer community – reviewing facility claims for coding and billing accuracy, auditing, policy development and within claims operations.
- Learned the ropes from the ground up.
- Teach at local community college.
- Speaker/Author on ICD-10, Provider-payer relations, and ethics.
- Coding/Reimbursement Consultant.
- Ethics, and bioethics are areas of particular interest.
Provider-Payer Strategic Conflict...

- Providers and Payers DO NOT have the same strategic goals.
  - Providers - seek to keep patients happy.
  - Payers – seek to keep stockholders happy.

Well, thank you!
Provider-Payer Strategic Conflict...

- Furthering the conflict are:
  - Lack of transparent claims adjudication information
  - Rapidly changing rules in payer adjudication related to codes and plans and benefits.
  - Changing national and state regulations around payment for procedures.
  - Other competing priorities

Communication = Reimbursement

- Better communication starts with better understanding of payer systems, processes and policies.
- Communication is paramount to expediting claims.
- Seems as if payers have a language all their own.
  - Foster communication.
  - Engage payers whenever possible.
  - Become memorable for your positivity!
- Constant attention is required for ultimate success.
- The system is seemingly designed in a way that eliminates human contact.
- The system is designed to put payers and providers in a constant state of conflict.
Hmmm....

Is it any wonder the we often feel like we are riding aboard the H.M.S. Titanic....

Dead Ahead...

...Heading for an iceberg?

So what can we do about it?
Contrary to Popular Belief...

- ...Payers and Providers can find common ground:
  - Both aggressively seek out and pursue operational efficiencies.
  - Reduce costs and improve to improve their bottom line.
  - Simplify administrative processes wherever possible.
    - Eliminate re-work.
    - Reduce the numbers of medical record requests.
    - Reduce the number of denials.

- Costs savings and successful reimbursement are not mutually exclusive...

10 Tips for Successful Reimbursement

1.) File claims electronically whenever possible.
2.) Documentation!
3.) Expectations regarding customer service.
4.) Know your contracts.
5.) Learn how your payer works.
6.) Read payer policy, and carrier specific manuals.
7.) Do not make assumptions about payer policy.
8.) Be willing to embrace change.
9.) Do not let claims pile up.
10.) Proof read claims.
1.) File claims electronically whenever possible

- **Benefits:**
- Ease of tracking
- Decreased chances of “lost claims”
- Fewer errors
- Faster processing times
- Increased revenue - reduce turn around times
  - Most electronic submissions average a 2 week turn around.
- *Paper will soon be the ENEMY....*

2.) Document, Document, Document!

- Document every payer contact
  - Names
  - Dates
  - Times
  - Brief synopsis of the conversation
- Beneficial during the appeals process
- Provide substantiation for physicians who not understand the claims process.
3.) Expectations regarding customer service

- Customer service representatives (CSR) are not the folks processing your claims.
- Often sequestered from claims processors.
- Larger payers customer service departments may not even be in the same building.
- CSRs generally are not coders, or billers.
- Disconnect between what customer service says and what is actually happening with your claims.
- Recognize that the amount of information customer service can provide is typically limited to questions regarding
  - Claims receipt
  - Adjudication

4.) Know your payer contracts

- The payer contract holds the answers to too many questions.
- Filing deadlines, appeals processes, fee schedules, co-payments/co-insurance, deductibles.
- Contracts are chock full of useful information. It is crucial that you read and understand the key points.
- This will become especially important as we move to ICD-10-CM/PCS.
5.) Learn how your payer works

- Pull back the veil and open the lines of communication with your payers by any means possible.
- Reputable payers will welcome your communication and try to assist you at any level.
- Few questions you should be able to answer about each of your payers:
  - What happens to claims upon submission?
  - Who are the medical reviewers?
  - How can you contact reviewers?
- By taking a few moments to understand how your claims are truly processed, you can better navigate the payer’s system which will help during the appeals process.

6.) Read payer policy, and carrier specific manuals

As in football, the best defense is a good offense:

- Know where to find your payer’s policies on the web
- Many payers will:
  - Distribute paper copies of their policies annually
  - Announce policy changes in newsletters
  - Other Provider Communications
- Policies are not static; rather dynamic and constantly changing.
- Gain the offensive by reading these policies!
7.) Do not make assumptions about payer policy

- Every payer has unique policies.
- Common assumptions include:
  - Modifier -50
  - Multiple units, services, DME, items, etc.
  - Multiple births

- Do not assume that because a new code is covered by one payer, that it will be covered by all.
- Don’t give payers any excuse to deny your claim.
- Follow due diligence and research each payer's individual policies.

8.) Be willing to embrace change

- Payers change their policies more than most of us change our socks!
- Prepare yourself for policy changes by reviewing policies annually.
- Be prepared to change your own processes in order to keep up.
9.) Do not let claims pile up

- File claims everyday
- Prompt filing often equates to prompt payment
- Create a system that encourages you to file claims on a daily basis:
  - Tickler files
  - Designate staff for claims/billing

10.) Proof read claims

- Everyday claims are denied for:
  - Misspellings
  - Transpositions
  - Invalid policy numbers
- Electronic submission doesn’t mean error free submission.
- Many errors can be prevented by taking a few moments to proof read your claims regardless of the method of submission.
Navigating the Appeals Process

- Appeals are time consuming!
- Understanding the way individual payers handle appeals can mean the difference between approvals and denials.

Reasons for denials

- Duplicate submissions
- Eligibility/coverage/benefit issues
- Billing specialty test services inappropriately
- Forgetting the global period
- Service lacks prior authorization/referral
- Medicare secondary payer rules
- Timely filing issues
- Errors on claim forms – missing/ illegible info
- Service lacks supporting documentation/medical necessity
How to avoid denials

- Know your payer contracts!
- Read all carrier/payer specific manuals and policies.
- Make sure your physicians know what is and isn’t covered in their contracts.
- If a service requires pre-authorization or prior-approval – don’t submit the claim without it!
- PROOF READ ALL CLAIMS!

Claim filing process

- Claims should be filed ASAP after service has been rendered.
- If supporting documentation is required, send it with the initial submission!
- Become a “details” person
- Develop and maintain an excellent tracking/tickler file system
- When in doubt send certified mail.
- Keep in mind that most payers allow 180 days to file an appeal.
What to do with denials

• Don’t assume the first denial is final – EVER!
• Carefully read EOBs/EOPs and documentation accompanying the denial –
  • Often it may be simple, quickly fixed errors/omissions that result in claim denials.
• Include supporting documentation if needed.
• Ask for extensions or learn to work within the payer’s system to gain timely filing advantages.
• Find out how/who reviews claims – know the specific people. It will help if you decide to appeal.
• Know your payer’s policies!

Filing Appeals –
The Best Defense...

...Is a Good Offense!

• Take the time to carefully analyze the denial and form an educated appeal.
• Determine what the problem is.
• Gather all documentation
  • Operative notes
  • Pathology notes
  • Radiology notes
  • Coding documentation
  • Policy documentation
• Draft a letter of appeal
Filing Appeals (cont’d)

• It is important to find the correct person to send your appeal letter.
  • Insurance companies by nature are big, paper can get easily lost if not sent to the right place.

• Send all appeals certified mail return receipt.

• KEEP COPIES OF EVERYTHING!
  • Insurance companies by nature are big organizations and paper can get easily lost.

Certified Mail Form

This is the first step to sending Certified Mail
Drafting the Letter of Appeal

- Straightforward issues do not require a physician to draft a letter. Issues like:
  - Transposed numbers or missing claim information
  - Basic coding errors
  - Missing pre-authorization/referral information
- Complex clinical cases should have a letter of appeal from a physician included in the appeal packet. Cases where denial is based on:
  - Medical necessity
  - Clinically intense cases
The Final Product

- The Appeal “Packet” should include:
  - Freshly printed claim form CMS-1500/UB-04
  - Payer’s appeal form
  - Supporting documentation, including:
    - Medical record documentation
    - Documentation from:
      - Peer-reviewed journals
      - Pub 100 references
      - AHA Coding Clinic/CPT Assistant
      - Payer’s policy
  - Letter of appeal
  - Letter of physician appeal

Wrap-up

- Seek to find areas of common ground with payers.
- File claims electronically whenever possible.
- Documentation!
- Expectations regarding customer service.
- Know your contracts.
- Learn how your payer works.
- Read payer policy, and carrier specific manuals.
- Do not make assumptions about payer policy.
- Be willing to embrace change.
- Do not let claims pile up.
- Proof read claims.
- Compile detailed appeals packets – leave no room for payer interpretation.
Questions?

Speaker Contact:

Angela “Annie” Boynton
RHIT, CPC, CCS-P, CPC-H, CCS, CPC-P, CPC-I
Director 5010/ICD-10 Communication, Adoption & Training
annie_boynton@uhc.com