Capturing Revenue through Appeals and Collections

Judy B Breuker, CPC, CPMA, CCS-P, CHCA, PCS, CEMC, CHC, CHAP

judy@judybreuker.com

Disclaimers

- This course was current at the time it was written.
- Every reasonable effort has been made to assure the accuracy of the information.
- Proper coding may require analysis of statutes, regulations or carrier policies and as a result, the proper code result may vary from one payer to another.
- This program is not intended to be legal advice and your attendance should not be construed as a legal opinion of the presenter.
- Every attempt has been made to identify the source of the information contained in this presentation. Any omission is unintentional.
- No financial remuneration or incentives are received for any items or services mentioned in the presentation.

Agenda

- The claim has been submitted – now what?
  - Audience participation is encouraged.

Three parts of the revenue cycle

- Activities related to the time of service
  - Obtaining correct information from the patient
  - Verifying insurance coverage
  - Establishing a clear and concise financial policy
- Collection of the account
  - Copays, deductibles, clean claims
- Monitoring the accounts receivable
  - Follow up……..

Why?

- OIG Compliance Program for Individual and Small Group Physician Practices
  - Federal register Vol. 65, No. 194, October 5, 2000
  - *A well-designed compliance program can:*
    - *Speed and optimize proper payment of claims*
    - *Minimize billing mistakes;*
    - *Reduce the chance that an audit will be conducted by CMS or the OIG; and*
    - *Avoid conflicts with the self-referral and anti-kickback statues*

More from the OIG

- *When physicians discover that their billing errors, honest mistakes, or negligence result in erroneous claims, the physician practice should return the funds erroneously claimed, but without penalties. In other words, absent a violation of a civil, criminal or administrative law, erroneous claims result only in the return of funds claimed in error.*

OIG…..

- *It is reasonable for physicians (and other providers) to ask: what duty do they owe the Federal health care programs?*
- *The answer is that all health care providers have a duty to reasonably ensure that the claims submitted to Medicare and other Federal health care programs are true and accurate. The OIG continues to engage the provider community in an extensive, good faith effort to work cooperatively on voluntary compliance to minimize errors and to prevent potential penalties for improper billings before they occur.*

OIG…….recommends self-audits

- *The practice's self-audits can be used to determine whether:*
  - *Bills are accurately coded and accurately reflect the services provided (as documented in the medical records);*
  - *Documentation is being completed correctly;*
  - *Services or items provided are reasonable and necessary; and*
  - *Any incentives for unnecessary services exist.*
- *A baseline audit examines the claim development and submission process, from patient intake through claim submission and payment, and identifies elements within this process that may contribute to non-compliance or that may need to be the focus for improving execution*

Example from OIG

- In 2010, the Centers for Medicare & Medicaid Services (CMS) reported Medicare improper payments totaling $47.9 billion. Of that total, $34.3 billion is attributable to Medicare Fee-for-Service (10.5-percent error rate) and $13.6 billion is attributable to Medicare Part C (14-percent error rate).
- Some but not all improper payments are the result of fraud. Improper payments can also result from medically unnecessary claims, miscoded claims, eligibility errors, or insufficient documentation. Examples of improper payments include payments made to an ineligible recipient, duplicate payments, or payment for services not received. For example, OIG recently identified $3.6 million in improper Medicare Part D payments on behalf of deceased beneficiaries.

How?

Be a consultant to your own practice.

GET YOUR TOOLS

A favorite tool

- AAPC Health Plan Search: Provider Manuals and Policies
  - Complied data from over 500 local and national health plan's websites, provider manuals, provider policies, physician credentialing and Medicare/Medicaid eligibility.
  - http://www.aapc.com/provider-manual/

Sign up for secure payer Web sites or portals

- Eligibility
- Claim Status
- Claim corrections
- Appeals

Electronic Transactions

- Claims
- Eligibility verification
- Electronic Remittance Advice
- Electronic Funds Transfer
- Pre-certification/prior authorization
- ePrescribing

Electronic Tools

- Maximize the use of electronic resources
- What other electronic resources do you use 

Print resources

- AMABookstore.com
  - Reimbursement Management and Maximizing Billing and Collections package
- Shopingenix.com
  - Auditing and Denial Management Toolkit
- What other print resources do you recommend 

Reports…reports…reports

You cannot monitor what you do not measure.

Reports

- Standard report
  - Total charges, dollar amount submitted payment, amounts paid/adjusted/written off
    - Breakdown by physician, location, CPT/RVUs, payer
- Aging
  - Check the parameters
    - Aging by date of service
    - Aging by the date the last resubmission
      - Can give false information if rebilling

Reports

- Charge lag time
  - Average number of days from date of service to posting date
  - Benchmark < 7 days
- Denial reports
  - Run by Remittance Advice Remark Codes
  - http://www.wpc-edi.com/content/view/739/1

Example next slide

Another source

- 184 page file on the Medicare Learning Network page.
- Remittance Advice Guide 3rd Edition

Accounts Receivable Formulas

- Gross Collections
  - Payments ÷ Charges
    - Dependent on how high your charges are.
- **Net Collection Ratio**
  - Total net collections less patient refunds ÷ gross charges less contractual adjustments
  - Net collection ratio shows the % of total collections after factoring in contractual adjustments and refunds.
  - MGMA net collection ration is 98%

Formulas

- Days in Accounts Receivable
  - How long it takes to collect your money
  - Total Accounts Receivable ÷ Average daily charges for the past 90 days (the previous 3 months in charges divided by the total number of working days during that period)
    - Some divide it by 30 days, just be consistent

Claim Processing

- File claims daily if possible
- Research errors and correct
- Post payments
- Update accounts
- Now the work begins…..Appeals

Setting up your appeal policy

- What $ amount is your minimum?
- Who is responsible for the appeals?
- How do you determine which claims to appeal?
- Do you have a policy or a procedure to enlist the assistance of the patient?
- How do you track your pending appeals?

Appealing claims

- Check out the free sample letters at www.appeallettersonline.com
- AMA Practice Management Center
  - 65 page .pdf file titled "Appeal that Claim"

Beginning the appeal process

- Carefully read the EOB/RA
  - The EOB/RA will show the rationale for the partial payment, delay or denial.
  - Do NOT automatically modify the claim and re-submit for payment.
    - Example: If the denial states a modifier is needed, do not just add the modifier and re-submit. Review the documentation to see if a modifier is warranted.

Preparing your appeal letter

- Review your contract with the payer.
- Include all of the patient's information.
- Clearly state why you are appealing the claim. Do not just send the documentation.
- Support your case with authoritative references.
- Include your contact information.

Appeal Examples

- Coding issues
  - Verify the correct codes were used.
    - ICD-9-CM issues
      - Follow the Official Coding Guidelines
    - CPT issues
      - Carefully read the CPT manual, especially the guidelines and the notes.
      - Use CPT Assistant to clarify the intention of the code
      - Use the RBRVS Data Manager.

        - Examples on the next few slides using code 69210

Appeal 69210 using CPT Assistant with CodeManager

Appeal 69210 with RBRVS Data Manager

Appeal 69210 using the specialty society

Appealing claims with Prompt Payment Laws

Prompt Payment Laws by State & Sample Appeal Letter

State	Payment Timeframe	Penalty(ies)	Contact
Alabama	30 working days for electronic claims; 45 paper	DOI fine	Alabama Department of Insurance, Life and Health Division 334-269-3550 http://www.aldoi.gov/
Alaska	Paper: 20 working days Electronic: 10 working days	< $250: 5 % payment or $5, whichever is less > $250: 2 % of the payment	Alaska Division of Insurance (907) 465-2515 http://www.dced.state.ak.us/insurance/
Arizona	All claims types: 30 days after claim approved	Legal interest rate	Arizona Department Of Insurance (602) 912-8456 http://www.id.state.az.us/index.html
Arkansas	Paper: 45 calendar days Electronic: 30 calendar days	12% annually	Arkansas Insurance Department (501)371-2600 or 1-800-282-9134 http://www.state.ar.us/insurance/
California	Non-HMOs: 30 working days HMO's: 45 working days	15% annually; $10 additional non-inclusion of interest with payment	California Department of Insurance (800) 927-HELP (4357) (213) 897-8921 http://www.insurance.ca.gov/

Woodcock & Associates www.elizabethwoodcock.com

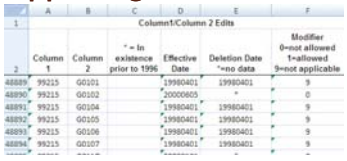
Appealing underpayments

- Downcoding?
  - Not limited to E/M services
    - Lack of recognition of modifier -50
    - Procedures can be downcoded from the code which contains the word "complex" to the code that contains the word "simple".
    - Add-on code not recognized.
    - Units not recognized.
  - It can be easily missed if your payments are being automatically posted or even manual posting.

Appealing claims by payer

- Do you have access to the policies and procedures page?
- Do you have access to medical policy
- Is there an electronic process for appeals using the payer's website
- Don't forget the payers provider relations department
- Are you sure your practice has a participating agreement with the payer?

Appealing bundled claims



	A	B	C	D	E	F
1	Column1/Column 2 Edits					
2	Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
48889	99215	G0101		19980401	19980401	9
48890	99215	G0102		20000605	*	0
48891	99215	G0104		19980401	19980401	9
48892	99215	G0105		19980401	19980401	9
48893	99215	G0106		19980401	19980401	9
48894	99215	G0107		19980401	19980401	9

CMS Website – 18 page .pdf file

Appeals involving modifiers

- First – Verify the documentation supports the use of modifiers.
- Check if the payer has information on the use of modifiers on their website.
- Verify the payer received the claim with the modifier attached.

Appeals involving modifiers

Medical necessity appeals

- Find out which services are subject to medical necessity review.
- Enlist the help of your physician or your physician's specialty society.

The Medicare Appeals Process

- **First** Level of Appeal: Redetermination
  - 120 days from the date of receipt of the initial claim determination.
  - A minimum monetary threshold is not required to request a redetermination.
  - Go to the CMS website for the redetermination form.

The Medicare Appeals Process

- **Second** Level of Appeal: Reconsideration
  - If you are dissatisfied with the redetermination file a reconsideration request within 180 days of receipt of the redetermination.
  - A QIC (Qualified Independent Contractor) will conduct the reconsideration.
  - No minimum monetary threshold.
  - Use the form included with your Medicare Determination Notice.

The Medicare Appeals Process

- **Third** Level of Appeal: Administrative Law Judge Hearing
  - At least $130 in controversy following the QIC's decision.
    - The $ amount increases annually with the consumer price index
  - Request ALJ hearing within 60 days of receipt of the reconsideration.
  - Generally held by video-teleconference or by telephone

The Medicare Appeals Process

- **Fourth** Level of Appeal: Appeals Council Review
  - The request for Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision.
  - Usually the AC will issue a decision within 90 days of receipt of a request for review.

The Medicare Appeals Process

- **Fifth** Level of Appeal: Judicial Review in U.S. District Court
  - At least $1,300 in controversy.
  - File the request for review within 60 days of receipt of the Appeals Council's decision

Appeals

- Do you have examples of appeals that you performed and were successful 

Collection Policy

- Publish it!
- Verify you are in compliance with your state laws regarding collection of consumer debt.
- Find a reputable collection agency
  - Get references from other medical practices
  - Enter into a trial period with some of your accounts.

Cleaning up your account receivables

- Do not "clean up" your AR by adjustments.
  - Monitor adjustments
  - Routine waiver of copay and deductible
    - Misrepresenting the charge to the payer
    - Violates your payer agreements
    - See OIG Fraud Alert in 1994

Bad debts versus charity write-offs

- Bad debt write-offs
  - A reasonable collection effort has been made but the individual is able but unwilling to pay.
- Charity care
  - For individuals who are determined unable to pay
  - Follow state or federal guidelines for financial screening process

Fair Debt Collection Practices Act

- Federal Trade Commission
  - www.ftc.gov has an easy to read 28 page .pdf file explaining the FDCPA
  - Purpose is to protect consumers from unfair, deceptive, and abusive debt collection practices.
  - As of July 21, 2011 a new agency, the Consumer Financial Protection Bureau, will have the authority to issue rules under the FDCPA debt collection practices.

Credit balances

- Review credit balances monthly
  - Research the account thoroughly
  - How did the need for the refund happen?
  - Who gets the money? The patient or payer?
  - Unclaimed refunds
    - Follow your state's escheat guidelines

Voluntary Refunds

- OIG self-disclosure if there is a potential violation of the law.
  - Provider Self-Disclosure Protocol on OIG website
  - If you have a straightforward overpayment use your carrier's process.
- Overpayment / Voluntary Refund processes are listed on the individual carriers' websites

Giving Medicare $ back

- Physician's Services Refund Requirements to beneficiaries
  - Medicare Claims Processing Manual,
    - Chapter 30, Section 50.12.1
  - A required refund to a beneficiary must be made within 30 days after the date the physician/supplier received the remittance advice if the physician/supplier does not request a review

Medicare Overpayment Collection Process

- A 2 page fact sheet is available at the Medicare Learning Network page
  - Once a determination of an overpayment has been made, it becomes a debt owed by the debtor to the Federal government.
  - When Medicare discovers an overpayment of $10 or more, the overpayment recovery process will be initiated.
    - Interest accrues from the date of the letter if the overpayment is not received by the 31st calendar day from the date of the letter.

IF IT IS NOT YOURS, DON'T TAKE IT.

Embezzlement

It happens more than you think

The Hekman Group has a white paper titled "Employee Embezzlement: How to Tighten the Loopholes" www.hekmangroup.com

Your turn

- Questions 
- Discussion 

Thank you for your time and attention!
~ Judy

judy@judybreuker.com

Sources and Resources

- AAPC *BillingInsider* (e-Newsletter)
- American Medical Association practice management center
- BC Advantage Magazine http://www.billing-coding.com/
- Centers for Medicare and Medicaid Services
- *The Medicare Appeals Process*, Medicare Learning Network, ICN: 006562 January 2011