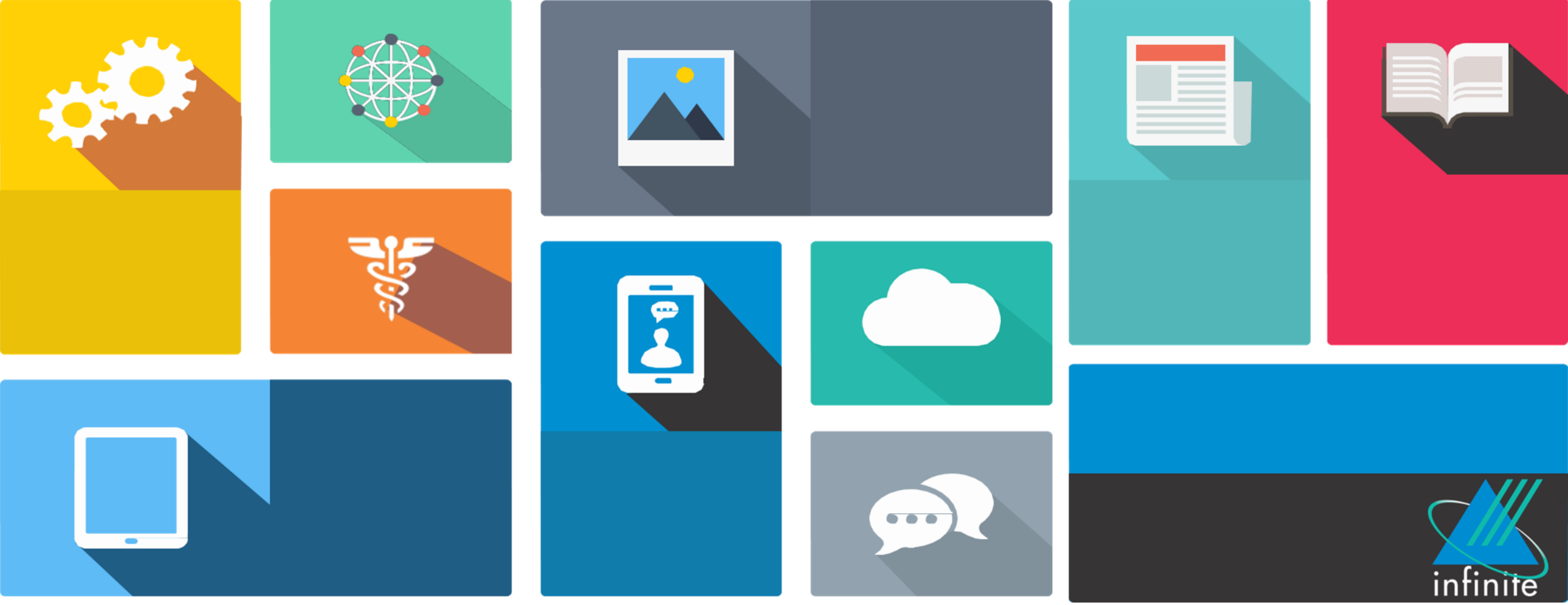
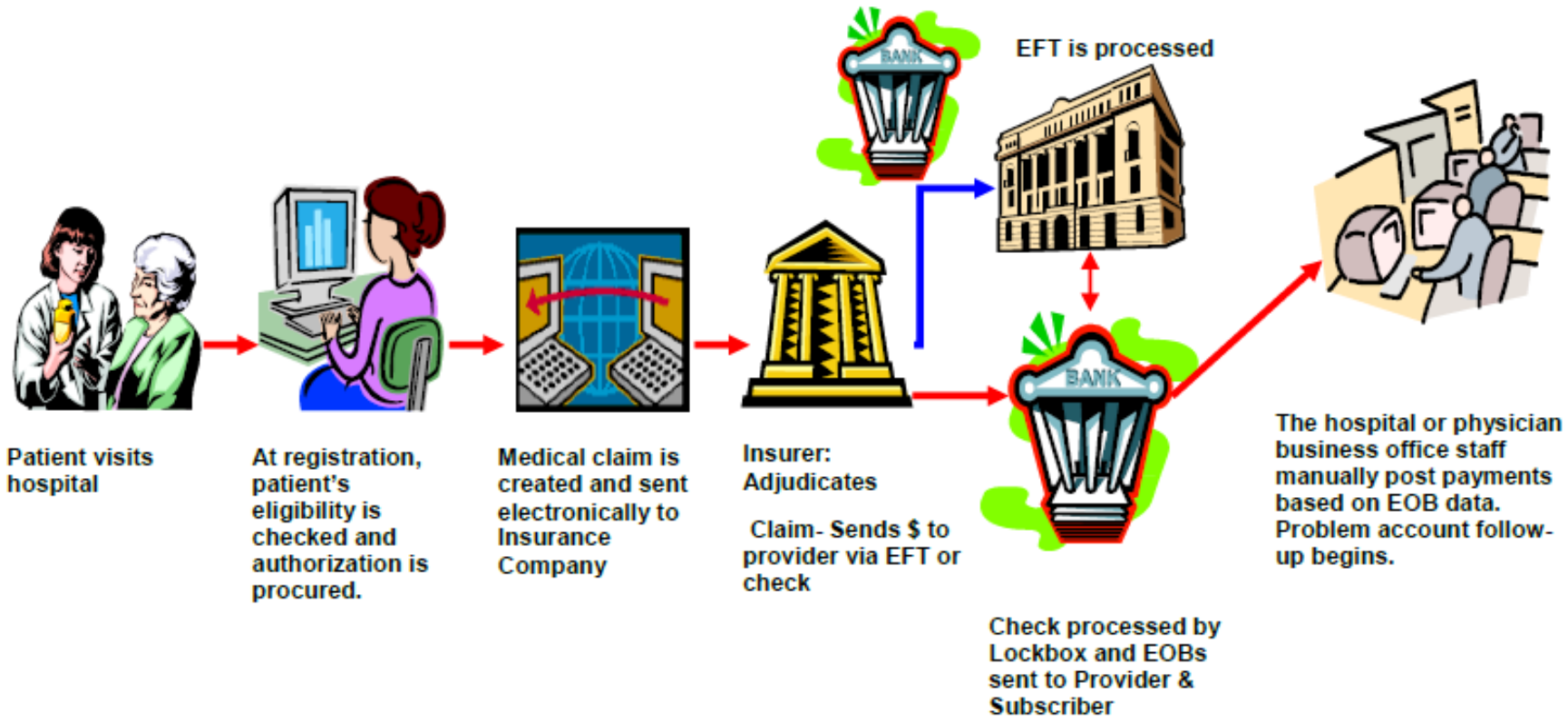


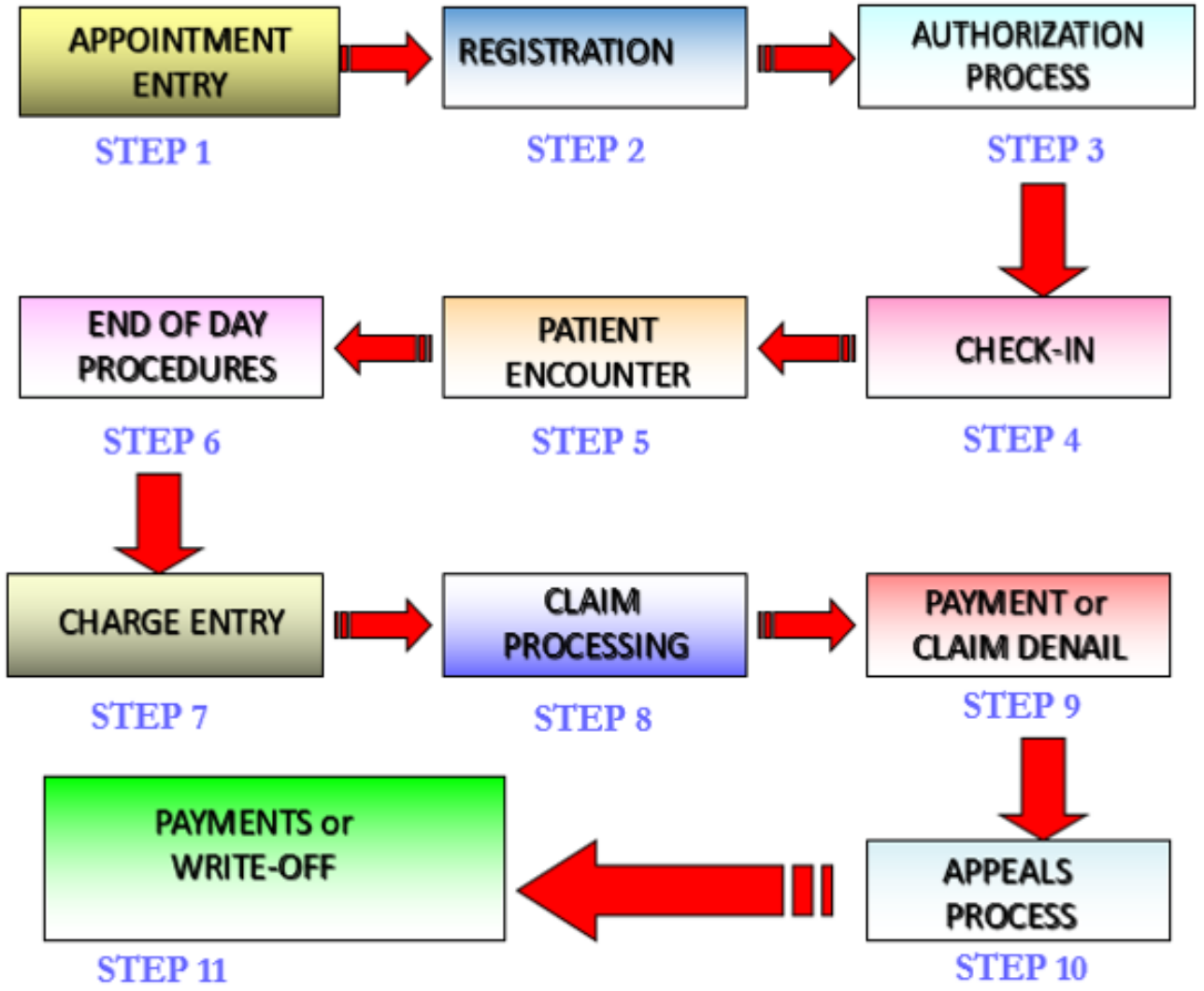
Medical Billing and Claims Financials

Medical Billing

- Medical billing is the process of submitting claims to insurance companies in order to receive payment for services rendered by a healthcare provider. The same process is used for most insurance companies, whether they are private companies or government-owned.



Medical Billing Process Work Flows



- STEP 1: Appointment Entry
- Medical record assignment through obtaining patient demographics.
- Confirmation with patient of existing insurance coverage.
- Appointment types and provider templates.

- STEP 2: Registration
- Creation or update patient's account with billing address and phone.
- Verification of insurance coverage with payer. (Direct phone contact, passport's online search and batch files, envoy real-time verification)
- Coordination of Benefits (COB) when multiple payers are billed sequentially.

- STEP 3: Authorization Process
- Patient referral for specialized consult and/or treatment.
- Payer requirements for referrals using authorization numbers for tracking.
- Storing and tracking of number of visits or services approved by payer.
- Required referral report identifies missing referrals for visits with coverage requiring referrals, either not obtained or promptly linked in system.

- STEP 4: Check In
- Verification of actual insurance card presented and patient's address and phone.
- Collection of co-payment based on system-prompt or amount indicated on card.
- Alert physician when patient presents and referral/authorization process not completed to determine necessity for visit.
- Selection of appropriate account type for services to be provided.

- STEP 5: Patient Encounter
- Physician codes procedures and diagnoses.
- Physician / clinical staff determine medical necessity for procedure for Medicare patients; alerts for advanced beneficiary notice (ABN) to be completed for patient signature acknowledging patient liability for non-covered service.
- Determination whether additional procedures during this visit will require authorization with a process to contact payer for approval or reschedule patient.

- STEP 6: End of Day Procedure
- Reconciliation of combined department report to actual encounter forms.
- Reconciliation of user batch report to cash drawer and prepare deposit.
- Batching of professional and technical encounter forms;
- Quality control review to ensure data elements complete with appropriate coding specific to specialty.
- Final review to determine next-day appointments missing referral/authorization.

- STEP 7: Charge Entry
- Reconciliation of transaction count to user batch report to verify charges entered.
- Minimize charge lag between date of service to post Date
- Ensure co-payment is patient liability to reduce undistributed payments.
- Review charge entry warning messages before posting charges.
- Missing encounter form report (encounters without charges 2–12 weeks after visit)

- STEP 8: Claim Processing
- Submission through electronic format or paper claims based on payer.
- Claim edits for missing registration information, payer-assigned provider numbers, and missing inpatient/day surgery authorization numbers.
- Release hold between 5 to 15 days beyond date of service based on payer.
- Electronic clearinghouse and payer's electronic rejections understate denials.

- STEP 9: Payment or Claim Denial
- Remittance advice or explanation of benefits (EOB) indicating allowable, contractual, payment, patient responsibility, or denial reason.
- Correspondence with denial reason.

- STEP 10: Appeals Process
- Contact the payer; correct the system; and/or provide additional documentation.
- Outpatient denials for not authorized and medical necessity distributed to practices for resolution.
- Denial management through review of denials by reason, payer, provider, and procedure with feedback for process improvement or system updates.

- STEP 11: Payments or Write-Off's
- Successful appeal yields payment.
- Review of subsequent denial following appeal; write-off occurs if no additional support for appeal can be identified; supervisory approval for write-offs.

Billing Procedure

Uniform Claim Forms

- UB04
- CMS-1500
- NCPDP
- American Dental Association

Uniform Claim Codes

- CDT codes
- CPT codes
- HCPCS codes
- ICD9, ICD10 -CM codes
- NDC codes
- Revenue codes

Filing a Claim

- Prepare Claim / Check Compliance
  - Once the patient checks out, the medical report from that patient's visit is sent to the medical coder, who abstracts and translates the information in the report into accurate, useable medical code. This report, which also includes demographic information on the patient and information about the patient's medical history, is called the "superbill."
  - The medical biller takes the superbill from the medical coder and puts it either into a paper claim form, or into the proper practice management or billing software
  - Biller's will also include the cost of the procedures in the claim.
  - Each claim contains the patient information (their demographic info and medical history) and the procedures performed (in CPT or HCPCS codes). Each of these procedures is paired with a diagnosis code (an ICD code) that demonstrates the medical necessity.
  - Claims also have information about the provider, listed via a National Provider Index (NPI) number

- Transmit Claims
  - Since the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all health entities covered by HIPAA have been required to submit their claims electronically, except in certain circumstances. Most providers, clearinghouses, and payers are covered by HIPAA.

Claims Financials

- **Financial Entity —**

A financing entity is the party in a financing arrangement that provides money, property, or another asset to an intermediate entity or financed entity. A financing entity receives a fee for providing financing and is linked to the financed entity through a chain of financing transactions across all intermediaries.

Example : provider, carrier, member, county, etc.

Account Receivables

- Accounts Receivable represents an outstanding balance of monies that are owed by the financial entity to the Payer. The financial entity is expected to pay down the balance until it reaches zero

Account Receivables

Financial Claims Accounts Receivable Update:

The process for viewing Claims Receivables and updating the recoupment, if needed. Claims Receivables are created by the claims payment process and are automatically recouped at 100 percent for every payment cycle.

The user can change the recoupment rules (setting up a payment schedule or reverse, adjust, write-off)

Account Receivables

Financial Accounts Receivable Transfer:

Transferring the account receivable balance to other financial entity. The accounts receivable balance must be greater than zero. Once the transfer request is submitted and saved, the outstanding balance of the receivable is transferred to the new financial entity.
Example : Transferring pending payments from provider to an hospital.

Financial Accounts Receivable Reversal:

Financial Receipt Reversal can only be performed on existing accounts receivable, which have no posted applied payment amounts.

Reversal functionality is primarily used for those accounts receivables entered in error.

Account Receivables

- **Financial Accounts Receivable Adjustment:**

Adjusting an Accounts Receivable is used to adjust existing AR balance, interest, penalty, or fees.

- **Financial Accounts Receivables Write-off:**

Writing-Off an Accounts Receivable is used for the AR's that are deemed uncollectible. Once the Write-off request is saved, the system sets the balance to zero.

- **Financial Accounts Receivable Write-off Re-Establishment:**

Re-establishing a previously written-off Accounts Receivable. The user enters desired information to create a duplicate of the original receivable. Once the write-off re-establishment request is submitted and saved, As the new receivable is a clone/duplicate of the original A/R

Account Receivables

Financial Advance Payment (Manual/System) Add/Update

- Advanced Payment to be generated by the system or manually produced. This function will trigger the system to pay designated financial entities before their claims have been processed through claims payment. The system will provide funds to the payee for services where the associated claims have not yet processed. The payee then owes the amount of the Advance Payment back to the Payer for reimbursement in the amount and on the timeframe defined by the request.

Manage Receipts:

- **Financial Receipt Check Add/Update**

Checks from financial entities (e.g., Provider, Carrier, Members, etc.) are considered receipts. The management of receipts are handled as they come into the mailroom. The Authorized Internal User takes the appropriate action depending on the kind of receipt (Example: Refund)

- **Search financial receipt**

The internal user can search for a Financial Receipt on the payment status

Manage Receipts

Financial Receipt Reversal:

The process for reversing a Financial Receipt that is entered in error. Once a check has been dispositioned, fully or partially, it cannot be reversed

Financial Receipt Adjustment:

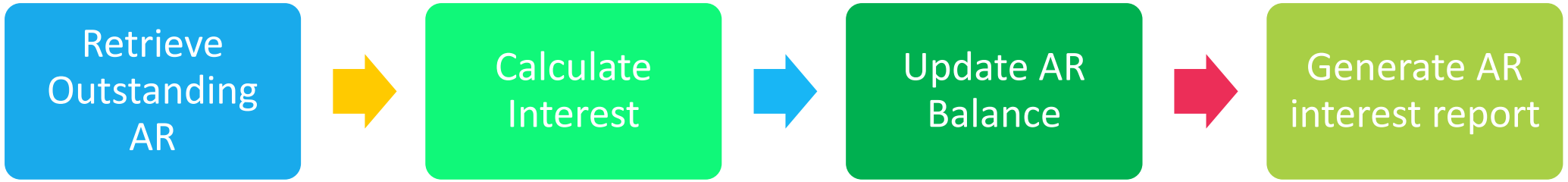
- The process for adjusting a Financial Receipt by an internal user.

Manage Receipts

Calculate Interest Penalty:

The interest, penalty, and fees are calculated and applied to Accounts Receivable (AR). Interest, penalty, and fees values are maintained in a system parameter and can be updated based on User permissions. Various monthly and quarterly reports are generated to identify the AR affected as well as the amounts being assessed.

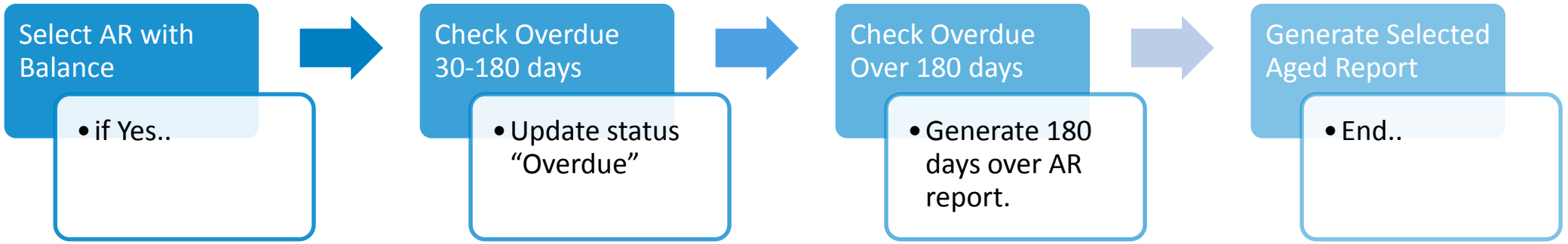
The calculate interest and penalty process is initiated as a scheduled event (e.g., weekly, monthly, etc.).



Manage Receipts

Produce A/R Letters:

The system generates letters to Financial Entities (e.g., Providers, Members, etc.) alerting them of their receivable status.



Financial Payouts

Financial Payout Add :

This is used to produce payments to Financial Entities (such as Member, Provider, Carrier, County, etc) whereby claims are not tied to specific payment.

Healthcare standards

DICOM -Digital Imaging and Communications in Medicine – provides for handling, storing, printing, and transmitting information in medical imaging.

HL7 -Health Level Seven – provides standards for exchanging clinical data.

LOINC - Logical Observation Identifiers Names and Codes – applies universal code names and identifiers to medical terminology related to the Electronic Health Record and assists in the electronic exchange and gathering of clinical results (such as laboratory tests, clinical observations, outcomes management and research).

ELINCS -EHR-Lab Interoperability and Connectivity Standards – an emerging standard for reporting lab test results.

SNOMED - Systematized Nomenclature of Medicine Clinical Terms – provides comprehensive computerized clinical terminology covering clinical data for diseases, clinical findings, and procedures.

NCPDP -National Council for Prescription Drug Programs – governs prescription transactions.

Accountable Care Organizations (ACOs)

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve

Benefits

- Improved population health. One fundamental goal of ACOs is that they will improve the health and wellness of a defined population for which the ACO is accountable.
- Improved patient quality of care. ...
- A focus on the patient. ...
- Physician leadership. ...
- Lower costs. ...
- Shared savings

EPSDT

- **Early and Periodic Screening, Diagnostic and Treatment** (EPSDT) is the child health component of Medicaid.
- Children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that States must cover a broad array of preventive and treatment services.
- EPSDT is designed to address problems early, ameliorate conditions, and intervene as early as possible
- For the 25 million children enrolled in Medicaid and entitled to EPSDT in 2012, the program is a vital source of coverage and a means to improve the health and well-being of beneficiaries.
- It includes: a comprehensive health and developmental history, comprehensive physical exam, appropriate immunizations, laboratory tests, and health education.

Thank You