Biggest Hurdles for Oncology Payment/Obstacles and Best Practice

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28 JANUARY 2018

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Disclaimer

This presentation was prepared as a tool to assist attendees in learning about documentation, charge capture and billing processes. It is not intended to affect clinical treatment patterns. While reasonable efforts have been made to assure the accuracy of the information within these pages, the responsibility for correct documentation and correct submission of claims and response to remittance advice lies with the provider of the services. The material provided is for informational purposes only.

Efforts have been made to ensure the information within this document was accurate on the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance.

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The Revenue Cycle

- What does this mean?
- Where does it begin and end?
- Why should I be concerned with all these details?
- Where do I fit in?
  - Who and what does my work affect?
  - Who's work affects me?

Section 1

- Credentialing and Contracting
- Front Office Processes
- Financial Counseling

Credentialing vs. Contracting

Credentialing and network contracting are separate processes.

Credentialing:

- Process of verifying the qualifications of physician OR organization
- Must be credentialed to negotiate rates

Contracting:

- Once contracted, the provider is “In-Network”
- Determines the fees a provider is allowed to collect
- Determines responsibilities for both provider and plan for entire revenue cycle process

Contract Rate Negotiation

- Leverage varies based on market
- Reimbursement Rates
  - Goal - percentage of charges
  - 100% of Medicare allowable at least
  - 105-115% of Medicare allowable is good
  - Can be as high as 150% or more if have leverage
  - Fixed contract preferred
  - New yearly codes at % of charges
- Filing deadline goal – 12 months
- Appeals deadline goal – 3 months

Having a Contract with a Payer

Advantages of Contract

- Pre-determined reimbursement rate
- Reimbursed in 30 days or less
- Less administrative burden
- Lower cost per claim
- More volume from insurance company as a participating provider
- In network provider less out of pocket for patient

Advantages of NO Contract

- Spot agreement for more than normal contract amount
- Don't require pre-authorization procedures/process
- Could collect 100% of billed charges, high out of pocket

Place of Service (POS) CY 2017

11	• Physician or physician office • Free-standing facility
19	• Outpatient Hospital • Off campus (250 yards to 35 miles)
21	• Inpatient Hospital
22	• Outpatient Hospital • On Campus (within 250 yards)
24	• Ambulatory Surgery Center (ASC)

Complete list found here:

http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Charge Master & Fee Schedules

Provider Charge Master

- What provider charges
- More than allowable rate

Payer Fee Schedule

- Allowable rates for each service
- Allowable rates are the contracted amount the provider is allowed to collect in total from insurance and patient

Fee Schedules & Contracts

Provider Charge
- From provider charge master

Payer Allowable Rate
- From payer fee schedule in contract
- Rest must be contractually adjusted

Payer Responsibility
- Based on beneficiary agreement

Patient Responsibility
- Based on beneficiary agreement

Example

Charge $400.00

Allowable Rate $100.00

Contract Adjustment $300.00

Allowable

Insurance $80.00

Patient $20.00

Avoid “Netting the Charge”

- Charge = allowable amount
- payer pays “the lesser of the allowable or the charge”
- AR reports are compromised
- payers gain leverage in negotiations.

Examples

Charge $100.00

Allowable Rate $100.00

Contract Adjustment $0.00

Amount Paid $100.00

Charge $100.00

Allowable Rate $110.00

Contract Adjustment $0.00

Amount Paid $100.00

Front Office Processes

- Registration
- Financial Clearance
- Financial Counseling
- Front Desk Collections
- Charge Capture Review

Top Billing Errors

1. Duplicate claims
2. Claim lacks required information
3. Lack of authorization
4. Bundled
5. Eligibility expired
6. Service not covered by insurer
7. Claim Submission time limit expired

Being Pro-active

The likelihood of collecting what is owed is directly attributable to the quality of information obtained at the initiation of services

Pre-Registration

- Verify demographics and insurance information prior to the patient arriving for first visit
- Verifying all information speeds up the check in process and ensures the patient brings all necessary items
- Recommend discussing appointment time, copays, current balances due, to bring any financial documents needed for review of assistance
- Recommend ability to obtain all information via portal

Insurance Verification

- Verification is determining if patient has active coverage
- Determine patient eligibility –
  - Effective dates of coverage, in/out of network
- Determine patient benefits
  - Out of pocket max, deductible, copay, coinsurance
- Does service require pre-authorization
  - What information is needed? What policies are being followed?
- How do I verify insurance?
  - Found on insurance websites, vendor verification website, call the payer
- Document all calls in practice management system

Denials Prevented by Verification

Coverage terminated or member not eligible on this date of service

- Insurance information can change at anytime

Services performed are non-covered

- Just because someone has insurance doesn't mean the insurance covers oncology

Lack of authorization

- Ensure all services authorized for the correct codes and quanitities

Coordination of Benefits

- Which insurance has primary payment responsibility?
- Medicare Secondary Payment - MSP

Table 1. Analysis of Common MSP Coverage Situations

Individual	Condition	Pays First	Pays Second
Is age 65 or older, and covered by a Group Health Plan (GHP) through current employment or spouse's current employment	The employer has less than 20 employees	Medicare	GHP
Is age 65 or older, and covered by a GHP through current employment or spouse's current employment	The employer has 20 or more employees, or the employer is part of a multi-employer group with at least one employer employing 20 or more individuals	GHP	Medicare

CMS has provided an example questionnaire
https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/providerservices/downloads/cms-questionnaire.pdf

Pre-Authorization

- Pre-Authorization is obtaining permission to perform a procedure
- Commercial, Medicare replacements and Medicaids
- 2-3 day timeframe to acquire approval for most payers
  - Some happen in real time
  - May require physician review - up to 3 days
  - Most authorization delays are due to provider not supplying complete information
- Document call, get all information in writing when possible
- Attach award letter to patient chart so AR has something to work with in appeals

Note: Insurance calls are recorded

What Requires Authorization?

Different for every payer and specialty

- Specific modalities or drugs
  - IMRT, Proton, SBRT, Neulasta, PET, etc
- Specific codes
  - High dollar items or those specific to a high spend area
- All codes

Recommendation

- Authorization per specialty
- Create a payer profile for staff to follow
  - Referral needed?
  - Pre-certification/Pre-authorization rules
  - Website or phone number for verification
- Easily referenced by front desk
- Updated frequently

Management Companies:
Radiation Oncology Benefits Management (ROBM)

- 3rd Party companies contracted to handle pre-authorization
- Have their own policies/ guidelines adopted by the health plan
- May handle pre-authorization or claims payment or both
- Examples : Carecore & Med-Solutions (eviCore), NIA, HealthHelp, AIM

Defining a Financial Counselor

Patient advocate

- Financial educator
- Provider of the patient's financial health

Billing office advocate

- Ensures services are covered
- Collects patient responsibility

Financial Clearance!

What Does Financial Clearance Mean?

- The institution or physician knows how they are going to be paid before they deliver the service
- The designated financial clearance staff reviews and ‘clears’ all patients before services
- Lack of payment is 1 of 2 things:
  - Insurance denials
  - Lack of patient payment

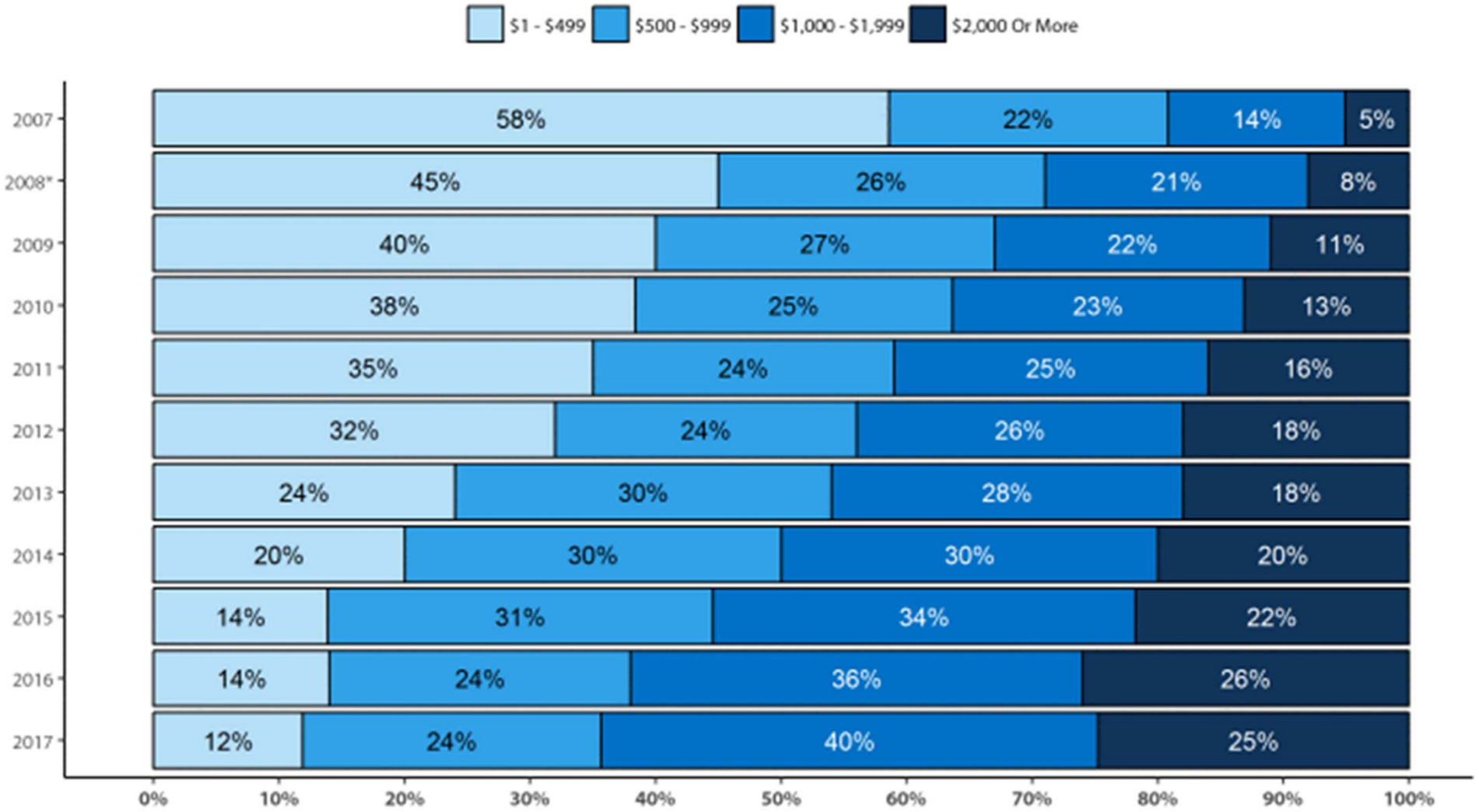
Financial Counseling, is it Important?

- Auth/Appropriate Use Criteria/Clinical Decision Support
  - All basically same idea – Pathways for medical necessity
- Cost sharing is on the rise
  - Estimated - $1 out of every $4 come from patients
- Kaiser Family Foundation

  http://www.kff.org/report-section/ehbs-2017-section-7-employee-cost-sharing/

Figure 7.18

Among Covered Workers With a General Annual Health Plan Deductible for Single Coverage, Distribution of Deductibles, 2007-2017



* Distribution is statistically different from distribution for the previous year shown ($p < .05$).

NOTE: Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Financial Counseling Points of Contact

Initial meeting at consultation

Introduction
Education
Request Info

Prior to first treatment

- Cost Estimate
- Payment plan
- Charity/Assistance

Periodically & Prior to Completion

- Monthly Verification
- Discuss balances
- Payment Plan

Treatment Estimate Worksheet

HCPCS	Description	Qty	Charge	Medicare	Commercial
77263	Clinical Tx Plan	1	$600	$157.22	$175.00
77290	Complex Simulation	1	$2,000	$463.57	$500.00
77334	Complex Tx Device	1	$500	$140.50	$150.00
		Totals	$3,100	$761.29	$825.00

Commercial Insurance		$825.00
Deductible to pay		$300.00
	Balance	$525.00
Coinsurance	20%	$105.00
Estimated Patient Responsibility		$405.00

Delivering the Message

- Use a worksheet
- Discusses every factor in decision
- Gives the FC a template for the discussion
- Stress this is an estimate!
- Explain how underpayments or overpayments are handled
- Script initial discussion:
  - *"You are estimated to owe $XXX, how would you like to handle that today? We take cash, credit or check."*
  - *"What can you pay today?"*
- You'll be surprised at what they can pay!

- Patient name
- Insurance
- Benefits
- Treatment Plan
- Estimated Responsibility
- Payment Agreement
- Signatures
- Estimation Statement

Benefits and Estimated Patient Responsibility					
Patient Information	Date:				
	Patient Name:				
	Patient DOB:				
	Oncology Physician:				
Insurance Information	Insurance Co Name:				
	Secondary Ins or Supplement				
	Preauth Needed Drugs:	Yes	No		
	Preauth Needed Imaging:	Yes	No		
	Preauth Needed Rad Onc:	Yes	No		
	Referral Required:	Yes	No		
Benefits	Policy #				
	Group #				
	Effective dates	To	From		
	In Network?	Yes	No		
	Yearly / Lifetime Max	Total	Met?	Left	
	Annual Deductible	Total	Met?	Left	
	Annual Max Out of Pocket	Total	Met?	Left	
	Coinsurance				
	Copay				
	Notes				
Treatment Plan	Written Account of Plan. Drugs, Services, Frequency, CPT® codes, etc				
Estimated Responsibility	Estimated Charges				
	Estimated Patient Responsibility				
	Payment Agreement				
	Date:				
	Signature				

Estimated responsibility is based on a tool which averages the financial responsibility for Baptist patients who have the same or a similar insurance plan. Your particular financial responsibility may vary from this estimate based on your physician's plan of treatment for you. Any account credits created by overpayment of actual incurred responsibility will be applied to other Baptist accounts with outstanding balances. Account credits in which all balances have been paid to Baptist will be refunded. Any deficits between collected payments and incurred balances will be sent to the patient in statement form.

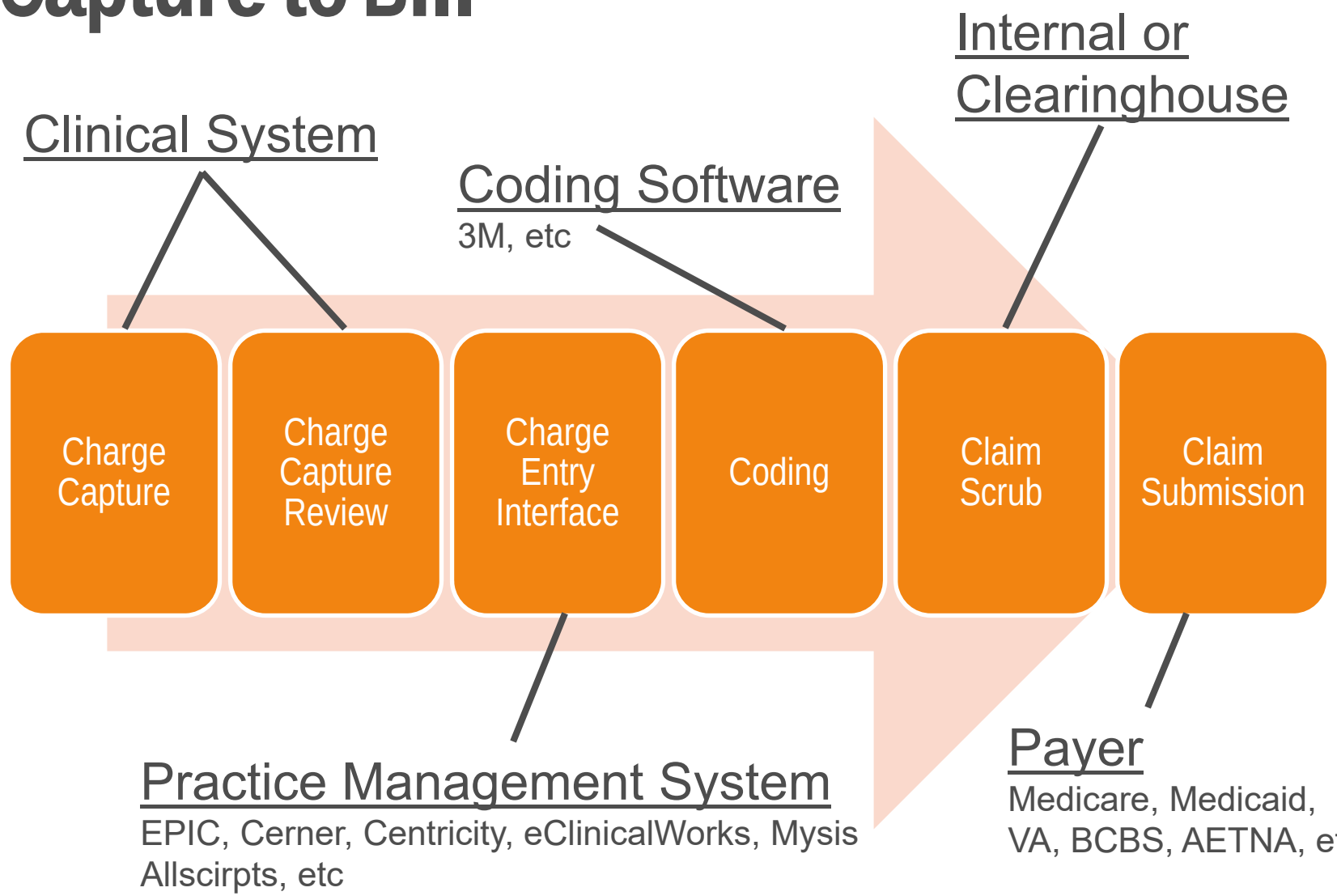
Financial Counseling Tips for Success

- Separation of physician and finance
- Create a policy manual and follow it
- Know your MAC's Local Coverage Determinations (LCD) and payer policies
- Weekly meetings with business office to discuss denial trends specific to front office
- Track patient collection amounts and set goals
- Discuss patient collections during weekly staff meetings
- Continuous education for financial counselors

Section 2

- Coding & Billing
- Contract Management
- Denials Management

Capture to Bill



Charge Capture & Review

- Capture all services by person performing – Point of Service
- Capture services same day as performed
- All charges should be verified daily against the documentation within the medical record
- Goals:
  - Charge capture at time of service
  - Clinical charge review within 24 hrs
  - PFS coding review within 48 hrs
  - Applied to account/ claim filed

Services Not Supported

Documentation missing? Code captured incorrectly?

Place charge on hold

Alert staff who captured service

- Let them fix their own mistakes or document

Review change in next day's review

- Quantify corrections for yearly review

Charge Entry

- Entering captured charges into practice management system
- Manual key or interface. 3 things to consider
  - Accuracy – How many errors occur
  - Speed – Lag time from DOS to Date of Entry
  - Cost – Recurring vs one time
- Recommended standards
  - 0% error rate in scribing to billing system
  - Charge entry within 24 hours of review

<u>USE INTERFACES!!!!!!</u>

Rejections (Scrub)

- Each rejection comes with a reason code
- Work rejected charges and resubmit daily
- Working rejections is far less costly than appealing a denial
- Denials tie up money for 30-100 days at least
- Current Trend: Rejections going back to point of origin for correction via work queues

Claim Filing Deadlines

- Many commercial payers maintain 60-90 day filing deadlines from DOS
- Medicare deadlines are 12 months from date of service
- Payers vary on their deadlines. Read contract!
- Know your claim submission and appeals deadlines
- Some state legislation requires 6 month filing deadlines for all claims

Incorrect Payments

- Who's responsible for identifying and correcting underpayments?
- Who's responsible for identifying and correcting overpayments?

Accounts Receivable

- Legally enforceable claim for payment of services rendered
- Amount of money billed to responsible parties but not yet paid
- Measuring AR shows the efficiency of the billing office
- Important items for AR:
  - Claims aging – age of claims in system
  - AR days – avg amount of time to collect money
  - Insurance vs Patient responsibility
    - Next 5 years, 30-50% of hospital AR is patient responsibility due to high deductible plans

Claims Communication Log (CCL)

- Best way to fix a problem, stop it from happening
- Excellent tool for communicating claims issues
- For every denial, send it back to the owner
- Creates a method of education and gives responsibility of accurate claims back to the originator
- Require action and response from the originator
- Example: claim denied due to medical necessity; breast IMRT. Request supporting documentation from physician

Denial Management Committee

- Trending denials to determine root cause
- Request reports by service, site, physician, insurance
- Measure by quantity & dollar amount
- Identify major reasons for denials (CCL, denial reports)
- Create a tracking/reporting process to measure successes and failures
- Share with team leads and develop action plan
- Measure results

Original Medicare Appeals

Once an initial claim determination is made, beneficiaries, providers, and suppliers have the right to appeal Medicare coverage and payment decisions

Redetermination by a CMS Contractor (FI, carrier, MAC)	• Must file appeal w/in 120 days of the initial decision • MAC must issue its decision w/in 60 days
Reconsideration by Qualified Independent Contractor (QIC)	• Must file appeal w/in 180 days of the redetermination • QIC must issue its decision w/in 60 days
Administrative Law Judge (ALJ) Hearing	• Must file appeal w/in 60 days of the QIC's reconsideration • Must be more than $140 in dispute • The ALJ must issue a decision w/in 90 days
Review by Medicare Appeals Council	• Must file appeal w/in 60 days of the ALJ's decision • Medicare Appeals Council must issue a decision w/in 90 days
Judicial Review in U.S. District Court	• Have 60 days to file for judicial review • Must be more than $1,400 remaining in dispute

Denial Reporting/QTR Meetings – WITH ACTION!!! ☺

- For each department to identify where it originates
- Provide monthly to trend denial reasons

Reason Code	Amount
Authorization	$100,000
Medical Necessity	$50,000
Incorrect registration	$50,000

Payer	Amount
BCBS	$100,000
Cigna	$50,000
UHC	$50,000

Physician	Amount
Dr Green	$100,000
Dr White	$50,000
Dr Black	$50,000

Service	Amount
CPT® 77300	$100,000
CPT® 77427	$50,000
CPT® 77301	$50,000

Questions?