Evaluating Your Billing Office:
What to Look for

Linda Georgian, COE
Consultant, Corcoran Consulting Group

Donna McCune, CCS-P, COE, CPMA
Vice President, Corcoran Consulting Group

Financial Disclosure

Linda Georgian is a consultant with Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Donna McCune acknowledges a financial interest in the subject matter of this presentation as an employee of Corcoran Consulting Group.

Course Objective

- Recognize the most common errors made in the billing office
- Utilize industry benchmarks for comparison purposes
- Develop a strategy to minimize errors

Billing Evaluation

- Most common reasons to have one
  - New Biller who doesn’t have much experience
  - The doctor volume hasn’t changed but the cash flow has diminished
  - We haven’t looked at it in a long time and want to make sure we are doing it right
  - New Administrator with no billing background

Challenges

- Eligibility and Data Entry
- Aging – Analyzing it and Working it
- Patient Collections
- Reports

What is the Clinic Philosophy?

- Collect every dime?
- Never turn a patient over to collections?
- Allow some claims to deny as untimely?
- All claims will be pursued no matter what?

- Whatever it is, make sure it’s in line with the owners and passed on to new employees
Front End

- At check-in always ask for the card
- Pre-certification and pre-authorization
- Eligibility – outside vendor or your PM
  - Patient active?
  - Prior authorization/referral
  - Deductible
  - Co-pay

Front End

- First point of contact drives payment
  - Important to advise patient of their obligations
  - Notify them of the paperwork you require from them
  - Make sure you get the correct insurance information
    - Are you in network
    - Do they need a referral
    - Do we have a claims address on the card

Doctor / Tech Responsible

- Chart and code correctly, make sure your chart supports the codes you select
- Make sure the services you are providing are authorized and covered
- Make sure the charge ticket is complete, link diagnosis codes to CPT codes, mark all services performed, indicate next step

Check Out and Data Entry

- Collect patient responsible balances that were unknown at check-in (i.e., refraction)
- Proof the encounter form
- Locate missing tickets
- Confirm demographic data and insurance is correct
- Scrub the information

Data Entry

- Who is entering the data and how are they doing?
- How much should you check? (Check each fee slip until accuracy is 99%, then check a sample every month)
- Does your PM have edits that you can create?
- Does your clearinghouse? For all others, it’s your data entry staff
- Modifiers, post op time, diagnosis go with CPT?

Data Entry

- Payment entry
  - Post the denials
  - Verify contractual adjustments and accurate payments
  - Automate when possible
- Track all deposits and EOBs
### Billing Function
- Post charges and payments daily
- Scrub your claims before you transmit
- Transmit and print claims daily
- Fix transmission errors daily
- Work denials as soon as they arrive
- Payment posting – utilize electronic posting
- Work the Aging report

### Challenges
- Eligibility and Data Entry
- Aging – Analyzing it and Working it
- Patient Collections
- Reports

### Aging Report
- Track monthly watching healthy benchmarks
- Futile to run when you don’t adjust off bad debt, you are basically disabling your most powerful tool
- Sum by payor and extract patient balances

### Aging Report – Supervisor’s Job
- Review summary by payer, identify problems
- Run detail for that payer
- Isolate the aging bucket and look for a trend
- If it’s all the claims for one payer, then you may have a transmission error or the payer is having a problem
- Transmission error- check dates and other payers to retransmit

### Aging Report – Supervisor’s Job
- Think outside the box – don’t fight small balances unless you can do it all together.
- Can you educate the staff to stop making certain errors?
- Can you run a report to catch other problems without waiting for the denial or until you catch the next one on your aging?

### Working the Aging- Sorting
- Right way - high balance, sort and highlight then re-sort on payer and patient to catch all claims pending for the same patient
- Mistake - sort by payer and high balance and leave it that way, you end up looking at the same patient 2-3 times.
- Biller should make notes in PM regarding status
Working the Aging - Prior to Running

• Before you start . . .
  • Make sure all payment posting is current
  • Don’t run too frequently
  • Make sure the entire report is worked in 30 days
  • Timely filing - important to know when to write off and when to panic (initial claim and appeals)

Working the Aging - Prior to Running

• Consider each payer and the timing of payment for each, for example:
  • In CA, HMO has 45 working days (60 calendar)
  • Medicare 14 days
  • Humana, United Healthcare, 30 days
  • Timing of payments - helps you determine how to work your aging report

Working the Aging Report

• If your Practice Management System won’t report claims, only individual transactions
• Determine the average line items per claim by reviewing EOBs
• For example, on a Medicare EOB that contains 15-20 claims
  • Add all the line items (CPT codes excluding PQRS)
  • Divide by the number of claims to get an average

Working the Aging Report

• For example, for 15 claims there are 27 CPT codes
• This equals 1.8 lines per claim
• If your total outstanding AR is 1800 lines of CPT codes, that represents about 1000 claims
• Use the formulas discussed previously to distribute the work
• Consider allocating work by doctor

Challenges

• Eligibility and Data Entry
• Aging – Analyzing it and Working it
• Patient Collections
• Reports

Patient Collections

• Credit balances and small balances
• Payment plans and acceptable amount
• How to track it and how do you divvy up the work?
• Obamacare and high deductibles.
Optimize Collections

- Maximize the practice’s ability to collect
  - Gather and confirm patient’s insurance
  - Notify patients of your collection policy
  - Collect patient responsible balance at time of service
  - Follow procedure when patient’s don’t pay

Rate of Collectability

$1000 due from the Patient

- 30 days – $899.00 - 89.9%
- 60 days – $813.00 - 81.3%
- 90 days – $696.00 - 69.6%
- 6 months – $521.00 - 52.1%
- 1 year – $228.00 - 22.8%

Source: Commercial Collection Agency Association

Sample Collection Policy

Day 1  First Statement
Day 30  Second statement with note that informs patient that insurance has paid its portion
Day 60  Collection letter with demand for payment in 15 days
Day 75  Phone call
Day 90  Send to collection agency

Successful Case Study

- Practice sent multiple statements and dunning letters
- No phone call to patient
- Implemented tighter follow-up and one phone call
- Saw results within 3 months

Successful Case Study

<table>
<thead>
<tr>
<th>Date</th>
<th>0-30 Days</th>
<th>31-60 Days</th>
<th>61-90 Days</th>
<th>Over 120+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/12/1x</td>
<td>$40,160</td>
<td>$21,231</td>
<td>$13,519</td>
<td>$70,785</td>
<td>$155,688</td>
</tr>
<tr>
<td>9/4/201x</td>
<td>$24,889</td>
<td>$10,036</td>
<td>$9,402</td>
<td>$48,396</td>
<td>$92,722</td>
</tr>
</tbody>
</table>

Case Study – No Execution

- Practice sent multiple statements and dunning letters
- No phone call to patient
- Turned into Office Manager at 6 months
- Office Manager did nothing
- Up to 900 statements a month $.68 a claim = $612
- Audit showed some accounts received over 20 statements for $5
**Sample Small Balance Policy**

- Small patient balances less $25.00 but greater than $5.00 will be billed twice.
- Small insurance balances $5.00 dollars or less will be written off at the end of the month.
- Credit balances on government program accounts (Medicare) will be refunded, regardless of the amount.
- Small credit balances for all others may be written off the system if the account balance is $5.00 dollars or less.

**Challenges**

- Eligibility and Data Entry
- Aging – Analyzing it and Working it
- Patient Collections
- Reports

**Reports**

- Keep End of Month numbers in a spreadsheet to track monthly changes
- Calculate average collections to measure and project
- Benchmarks
  - Days in AR
  - Aging bucket
  - Net collection ratio

**Your Numbers**

- Is your practice’s net collection rate is less than 97 percent? The benchmark is 95-99%.
  - Formula: payments / (charges - adjustments)
  - Run an average for the year, one month at a time is not going to give you accurate data
- Is your denial rate less than 7%?
- Are you verifying insurance benefits and eligibility on every visit?

**End of Month Reports**

<table>
<thead>
<tr>
<th>Date</th>
<th>Charges</th>
<th>Payments</th>
<th>Adjustments</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>January-16</td>
<td>$389,751.94</td>
<td>$171,291.46</td>
<td>$177,852.27</td>
<td>44%</td>
</tr>
<tr>
<td>February-16</td>
<td>$322,964.14</td>
<td>$147,940.24</td>
<td>$167,559.74</td>
<td>46%</td>
</tr>
<tr>
<td>March-16</td>
<td>$398,691.00</td>
<td>$208,794.12</td>
<td>$227,397.57</td>
<td>52%</td>
</tr>
</tbody>
</table>

- Payments divided by charges equals the gross collection ratio

**Tools for Monitoring- Aging Buckets**

<table>
<thead>
<tr>
<th>Percent of Total A/R</th>
<th>Healthy Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 30 Days</td>
<td>55% - 75%</td>
</tr>
<tr>
<td>31 - 60 Days</td>
<td>8% - 18%</td>
</tr>
<tr>
<td>61 - 90 Days</td>
<td>3% - 9%</td>
</tr>
<tr>
<td>91 - 120 Days</td>
<td>2% - 6%</td>
</tr>
<tr>
<td>Over 120 Days</td>
<td>4% - 17%</td>
</tr>
</tbody>
</table>
Tools for Monitoring – Days in AR

• Divide the entire month’s receipts by 31 days = X
• Multiply your AR balance by your collection average = Y
• Divide Y by X = Days in AR
• Healthy Range is 35 to 50 Days
• Perform monthly
• Show IIEI EOM

Coding and Billing Flaws

• Incorrect modifiers
• Diagnosis code errors
• POS inaccuracies
• Misuse of waiver forms

Case Study

“Don’t worry, I know how to get the claim paid, add a modifier!”

Modifiers

• Indicates both a professional and technical component
• More than one physician and/or location involved
• Increased or reduced service provided
• Only part of service performed
• An adjunctive service performed
• Bilateral
• Repeated
• Unusual events occurred

Source: AMA, CPT

Medicare Expected Frequency

• Modifier -24 1%
• Modifier -25 9%
• Modifier -57 1%
• Modifier -59 (inc. X) 3%

• Based on Medicare paid claims for office visits (920xx, 992xx)
• Considers all ophthalmologists
• Subspecialists’ utilization likely varies
• Requires supportive documentation

Source: CMS data (2015), 18 – Ophthalmology

Medically Unlikely Edits (MUEs)

• Table on CMS website
• Updated quarterly
• Example – 67820 Correction of trichiasis; epilation, by forceps only

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Practitioner Services MUE Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>67820</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: http://www.cms.gov/Medicare/Coding/NationalCorrectCodIniEdMUE.html
**Claim Example**

- Epilation on both left and right lower eyelids
- Claim is paid; does not "violate" the MUE limit of “1”

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>67820-50</td>
<td>Epilation</td>
<td>$$$</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>67820</td>
<td>Epilation</td>
<td>$$$</td>
<td>1</td>
</tr>
</tbody>
</table>

**Claim Example**

- Epilation on both left and right lower eyelids
- Claim is denied; "violates" the DOS MUE limit of “1”

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>mm/dd/yyyy</td>
<td>67820-RT</td>
<td>Epilation</td>
<td>$$$</td>
<td>1</td>
</tr>
<tr>
<td>mm/dd/yyyy</td>
<td>67820-LT</td>
<td>Epilation</td>
<td>$$$</td>
<td>1</td>
</tr>
</tbody>
</table>

**Avoiding Incorrect Errors**

- Physician and staff training on proper modifier use
- Establish policy regarding who appends modifiers
- Conduct reviews specifically for appropriate modifier use
- Monitor utilization of modifiers

**Coding and Billing Flaws**

- Incorrect modifiers
- Diagnosis code errors
- POS inaccuracies
- Misuse of waiver forms

**Case Study**

- Billing office receives call from technician / MD
- Provides “list” of covered diagnosis codes for a particular test
- Technician / MD append one of the “covered” diagnoses to ensure payment
- Billing office works only from list of approved codes and never checks the chart to confirm condition exists

**General Guidelines**

- Diagnosis codes are to be used and reported to the highest number of characters available.  
- Signs and symptoms are acceptable when a definitive diagnosis has not been established by the provider.  
- Do not code diagnoses documented as “probable”, “suspected”, “questionable”, “rule out”, or “working diagnosis” or other similar terms indicating uncertainty.  

Sources:  
1. ICD-10 Official Guidelines, Sect 1 B. General coding guidelines  
2. ICD-10 Official Guidelines; Sect 4 H. Uncertain diagnosis
General Guidelines

- Multiple codes may be required for a single condition that affects multiple body systems.¹
- Principal diagnosis should be based on the condition that prompted the visit and was the primary focus of treatment.²
- Code all documented conditions that coexist at the time of the visit, and require or affect patient care treatment or management.³
- Do not code conditions that were previously treated and no longer exist.³

Sources: ¹ ICD-10 Official Guidelines, Sect 1 B. General coding guidelines ² Terminology ³ ICD-10 Official Guidelines; Sect 4

Avoiding Diagnosis Code Errors

- Physician and staff training on assigning correct diagnosis codes
- Physicians should “link” diagnosis codes
- Patient inquiries require chart review of chief complaint and finding
- Establish policies regarding changing diagnosis codes

Coding and Billing Flaws

- Incorrect modifiers
- Diagnosis code errors
- POS inaccuracies
- Misuse of waiver forms

POS 11 vs POS 24

Case Study: POS 11 vs POS 24

- Practice hired an outside firm to do the 3 year review. The findings were:
  - POS was defaulted with last PM conversion. Never customized for claim / provider.
  - Laser procedures were routinely billed as being done in clinic POS 11 when performed in ASC (POS 24)
  - 3 year look back resulted in ≈ 750 claims that were billed with wrong place of service
  - Services included: 65855, 66761, 66821, 67228, 67210, 67145
  - Refund of ≈ $30K

POS Financial Impact

<table>
<thead>
<tr>
<th>CPT</th>
<th>201x POS 11</th>
<th>201x POS 24</th>
<th>Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>65855</td>
<td>$338</td>
<td>$298</td>
<td>$40</td>
</tr>
<tr>
<td>66761</td>
<td>$309</td>
<td>$255</td>
<td>$54</td>
</tr>
<tr>
<td>66821</td>
<td>$326</td>
<td>$307</td>
<td>$19</td>
</tr>
<tr>
<td>67145</td>
<td>$519</td>
<td>$490</td>
<td>$29</td>
</tr>
<tr>
<td>67210</td>
<td>$524</td>
<td>$504</td>
<td>$20</td>
</tr>
<tr>
<td>67228</td>
<td>$1,042</td>
<td>$968</td>
<td>$74</td>
</tr>
</tbody>
</table>

Source: 201x MPFS national rates
**Case Study: POS 11 vs POS 24**

- Retina surgeon brought anti-VEGF drugs to the ASC to inject in the ASC
- Office filed claim with POS 11 for the injection and drug
- ASC filed facility claim for injection
- Most claims paid based on claim submission
- When a small number of the surgeon’s claims were denied, billing person changed surgeon’s claim to POS office and told payer that she changed it to facilitate payment.

**Overpayment ??**

- Surgeon overpaid for injection due to SOS differential
- ASC should purchase drug and file claim for it
- Drug may be bundled with facility reimbursement

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**Compounded Drugs in the ASC**

*If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed.*


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**Avoiding POS Inaccuracies**

- Check your PM system for defaults
- Educate staff on site of service differential
- Spot check EOBs for accurate payments
- Know what your staff is saying and doing!

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**Coding and Billing Flaws**

- Incorrect modifiers
- Diagnosis code errors
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- Misuse of waiver forms

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**Assignment**

- To whom is payment made?
  - Beneficiary (non-assigned)
  - Provider of services (assigned)
- Beneficiary may “assign” payment
  - To physician
  - To supplier (e.g., optical dispensary)
- Signature on File, Assignment of Benefits, Financial Agreement (good for lifetime)
- Institutions receive payment directly (ASC, HOPD)
**Assignment Form**

**MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to ____(PRACTICE)__ for services furnished me by ____(PRACTICE)__. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. . . .

**Case Study – ABN**

- Medicare patients presented with blank ABN upon arrival
- Every encounter has an ABN in the chart
- Some areas are blank, others are filled in with a CPT code
- Options are not checked off
- Signatures missing
- Patient does not receive a copy

**Advance Beneficiary Notice of Noncoverage (ABN)**

- New form effective 6/21/2017
- Added language telling patients CMS does not discriminate and how to request ABN in alternate format
- Notice that Medicare will probably deny reimbursement
- Mandated by HIPAA
- Document reason why item is not covered
- Give signed copy of ABN to patient
- *(recommended)* Collect full fee from patient

*Source: CMS-R-131 (Exp. 03/2020)*

**When is an ABN required?**

- Get an Advance Beneficiary Notice (ABN) when
  - Beneficiary is financially responsible
  - Not covered…
    - No eligible diagnosis
    - Normal findings
    - Screening
    - Standing orders for a test
    - DME noncovered items

**When is an ABN NOT required?**

- No Advance Beneficiary Notice (ABN) required when
  - Item or service is statutorily (by law) non-covered
  - Not covered by statute…
    - Refrangtions
    - Routine eye exams
    - Most refractive surgery
    - Cosmetic surgery
    - Non-covered portion of deluxe IOLs
    - Eyeglasses or CLs outside of benefit

**Avoiding Misuse of Waiver Forms**

- Ensure proper version of ABN is in use
- Follow detailed instruction set for completion of ABN
- Utilize appropriate modifiers when waivers are used and claims are filed
- Educate on when ABNs are utilized
### Adjust and Prevent

- All practice employees have the ability to positively or negatively impact collections
- Post charges and payments daily
- Submit clean claims
- Verify insurance eligibility
- Collect patient responsible balances at time of service
- Fix transmission errors daily
- Payment posting – utilize electronic posting

### Adjust and Prevent

- Work denials as soon as they arrive
- Use event driven billing for your patient statements
- Use of ABNs when appropriate
- Internal auditing and modify your process when its not working
- Training and continual monitoring
- Use the resources
- Develop policies and procedures specifically addressing billing office activity

### Questions

Linda Georgian – (951) 265-7714
or
Donna McCune – (800) 399-6565
www.CorcoranCCG.com