salud
revenue partners

200 Elmwood Ave. Suite 2-C
Lafayette, IN 47904
765.637.2400
info@saludrevenue.com

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REVENUE CYCLE UPDATE

Revenue cycle expertise, data analytics, workflow optimization and problem solving: We make your performance improvement our responsibility.

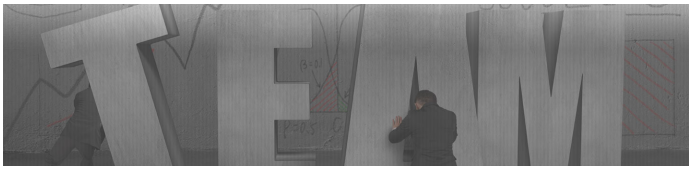
Cracking a tough nut in accounts receivable: Balance-due paid claims

By Jesse Ford, CEO

At a time when providers are under increasing pressure to find new sources of revenue and savings, most are downplaying an opportunity hiding in plain sight. It may not have such an easy or immediate payoff as unpaid accounts, but it can have a substantial impact on finances.

I am speaking about balances due on paid claims. How much this amounts to depends entirely on each organization and the payers they work with. Among our clients we see as much as 63% of accounts already have payments on them, and those with a balance due ranging from just a few dollars to several thousand dollars. The question is whether you have the savvy and the technology to work the accounts cost-effectively enough to make the effort worthwhile. At one large system paid claims are 58% of all claims, and account for 41% of total accounts receivable.

Read more inside...



Committed to our clients

In this issue of *Revenue Cycle Update*, we take a look at balance-due payments, a thorny problem for many providers, as it requires much focused strategizing about when and how to go after these accounts. Although many have just a few hundred dollars or less in balance due, the fact that more than half of all claims have some payment on them makes this a big opportunity. Many of these claims have unpaid balances or inaccurate reimbursements. And clearly some have significant balances, as we uncover paid claims where only one part of the total bill has been accounted for, such as ER vs. inpatient. At a time when everyone is looking for dollars to meet health system edicts for cost reduction, we believe balance due payments are an area ready for patient accounts staff to step up to the plate.

Meanwhile, in her column, Jennifer Swindle, our national coding expert, examines new coding changes for 2019 and how to adapt processes to meet them.

And we debut a new column called *Employee Spotlight*. Each issue we will highlight someone on our staff who has contributed to improving what Salud provides to our clients. Jason Smith is our payer collaboration leader, a new role that is proving extremely helpful as we look to better efficiencies in solving persistent claims issues.

Finally, we welcome our new clients, Great Plains Health, North Platte, Neb.; and Emory Healthcare, Atlanta, the latter through our new partnership with Windham Brannon, an Atlanta accounting firm that has engaged us around revenue cycle services for its health system clients. These new clients cap a year of extraordinary growth for Salud, which is 8 years old. We now have engagements in 17 states, from Illinois to Mississippi and Arizona to New York, and have more than doubled our staff to 80+ employees.

That staff is more engaged and empowered, as we have adopted a flat organizational chart comprised of focused teams that are committed to improving what we do for clients. They know that when we help a client be more successful, we are keeping jobs in a community, as well as freeing up resources to improve the lives and well-being of hospital staff and their patients.

Jesse Ford, CEO

EMPLOYEE SPOTLIGHT

PAYER COLLABORATION LEADER:

JASON SMITH

In late 2018 Salud Revenue Partners began to manage payer issues through a new position called the payer collaboration leader. I recently wrote on this topic for *Managed Care* magazine. This staffer works closely with leadership, staff and payers to develop employees' understanding of payer requirements and assisting client teams in resolving challenges associated with payers.

Our payer collaboration leader is Jason Smith, who has been with Salud for more than five years has more than a decade's experience in healthcare. He is an ideal fit for this role. Jason has served a Chicagoland client whose Medicaid HMO accounts receivable older than 90 days is well below 20%. He was instrumental in that client's results because he has billing expertise, a knack for overcoming challenges, and has effectively built relationships with payers.

Jason began his career within a behavioral health facility working in both inpatient and outpatient settings as a case manager. His role within Salud began as a Solutions Specialist, working to enhance and expand upon the revenue cycle operations of clients with the new managed care organizations resulting from the Patient Protection and Affordable Care Act.

He is known for being persistent in delving into the core problems that providers and payers present. By coordinating with facility staff, provider relations representatives, as well as management within claims processing and other payer organization teams, he has been instrumental in leading the resolution of large-scale problems within both the provider and payer claims management processes. He continues to work toward forging positive relationships between providers and payer relations teams in an effort to resolve errors and disagreements of the revenue cycle.

Cracking a tough nut in accounts receivable: Balance-due paid claims *(continued from page 1)*

Unpaid accounts are often younger than paid accounts and have a higher probability of resolution. It makes a lot of sense to focus on them, but not to the extent of ignoring balance due accounts. Finance, the CFO, and ultimately the board of directors would want to know if there is that much money on the table.

Having aged accounts receivable is also a detriment to performance on HFMA MAP keys, such as aged AR as a percentage of total AR and net days in AR.

These aren't just arcane performance indicators. Accounting's responsibility is to determine the value of open accounts receivable. Paid accounts pose a challenge because accounting needs information on whether the balance remaining has value. If accounting fails to accurately predict the value of AR, the provider may over- or underestimate the amount of money it can expect to receive, which affects financial decisions.

Patient accounts needs to be a good partner to finance and accounting by ensuring that the AR is clean – meaning only collectible balances remain open in the AR.

Balances remaining after payment are often collectible. There are many areas to look at, some of them fairly straightforward:

- **Split billing:** Services for some payers must be billed separately on two claims, such as one for emergency room and another for inpatient stay. The ER bill gets paid, but the inpatient claim might just sit unpaid on the books.
- **Line-item denials:** If a portion of a claim is denied, an appeal may be possible on the balance remaining. (Salud identifies line-item denials by obtaining claim statuses robotically.)
- **Underpayments:** Some insurers simply don't pay what they are supposed to.
- **Patients are not charged.** It is amazing how often this happens. With the patient share of total health spending on a sharp rise, this is a real area of focus today.

Many accounts with significant balances reflect process breakdowns on the part of providers and payers.

- **No secondary insurer is contacted.** We see many cases where there is a secondary insurer, but the balance is never transferred.
- **An incorrect copayment, coinsurance or deductible is recorded.**
- **Either automated remittance posting systems or manual payment posting do not recognize and take appropriate contractual adjustments.** Some providers take contractual adjustments for major payers at the time of billing, then do not take additional adjustments at the time of payment posting. When the estimated contractual rate is modeled incorrectly, and the payment doesn't match, an inappropriate balance remains.
- **Billing errors:** A provider may have errors in claims data, resulting in a payments that are different than expected. For instance, missing a modifier can impact reimbursement negatively, while unbundling CPT codes may suggest a higher reimbursement than what the provider is entitled to. A procedure code/bill type may be inconsistent with the place of service. A procedure/revenue code may be inconsistent with the patient's age or gender.

Some billing errors may show up as denials, but some will just result in a different payment.

The most effective solution, of course, is doing everything possible to prevent inappropriate balances on the front end. I cannot emphasize enough the important of setting up the 835 Electronic Remittance Advice posting accurately, including information about the payee, the payer, the amount and any payment identifying information. The patient accounts department needs to evaluate each CAS and remark code to figure out which should result in a contractual adjustment, a balance transfer (to a patient or secondary insurance) or no further action, leaving the balance on the account. Many organizations focus on estimating contractual adjustments at the time of billing, but if the 835 process does not handle remittance appropriately, that effort is for naught.

This takes organization and planning. You need a strategy for each bin of AR. Analyze paid account balances. Search for root causes. Segment work so that staff focus on collectible bins. Make decisions on adjustments. Fix your payment posting processes.

Our experience shows that this granular, intricate work can pay off in a healthier bottom line. And it shows the patient accounts team is doing its part to keep the organization financially strong.

Correctly coding the remote interprofessional consult

By Jennifer Swindle, Vice President, Quality and Service Excellence

The remote interprofessional consultation is a great example of healthcare achieving new efficiency and getting paid for it. Often, a primary care doctor or specialist will seek advice from a specialist, subspecialist or another kind of consultant via telephone, Internet or electronic health record. There is no face-to-face service; the goal is to eliminate the need for separate, costly and often inconvenient specialist appointments. In many cases providers may be able to sufficiently address the patient's needs through digital communication.

Sound simple? Well, the concept is, but getting paid for it has been another matter – until this year.

The Centers for Medicare and Medicaid Services has unbundled the four existing CPT codes for Interprofessional Consultative Services – 99446-99449. It also created two new codes in 99451-99452 under Interprofessional Internet Consultation services. The new codes further allow the treating provider to be paid for the efforts made in initiating the consultation.

The first series of codes are all based on the amount of time required to provide the consult and information to the treating provider. These can be billed by the consultant provider. Included services are the assessment and management needed and the expertise of the consultant to assist with the diagnosis and/or management of patients' chronic conditions, including heart disease, diabetes, respiratory disease, allergies and others.

The consultative discussion must last at least five minutes, and a verbal and written report to the treating provider should be provided. If the service is less than five minutes, it should not be reported. Individual codes identify the time components required.

The consultative services should be provided by someone with specific knowledge of the condition. The consultant may not have seen the patient within the previous 14 days. The communication should not result in a transfer of care or a scheduled appointment with the consultant within the following 14 days.

The specialist can assist in care management without seeing the patient and it most often occurs when the situation is urgent or complex in nature. It can be a new or established patient and can be a new problem or exacerbation of a current problem. Discussion should include review of diagnostic findings, medications and pathology results as available based on unique patients. More than half of the time should be in actual discussion, not just the time spent reviewing the patient's information. If there are multiple interactions via phone or internet, the time should be added together and reported with one code.

It is important that the treating physician document the request for the consultation to prove it is medically necessary. The consultant can also report CPT code 99451 for services of five or more minutes that include only a written report from the consulting provider.

The treating provider than can also capture reimbursement with CPT 99452 for initiating the interprofessional consult and utilizing this information in the care of the patient. The 99452 can be reported when the treating provider spends 16-30 minutes preparing for or communication with the consultant. These codes for interprofessional services are limited to providers who can independently report evaluation and management services. While the code descriptors do indicate "consultative physician," other qualified healthcare providers are eligible to report the codes, as long as they are providers who can independently report evaluation and management services. They include nurse practitioners, clinical nurse specialists, certified nurse midwives or physician assistants.

Patients must be made aware that the interprofessional consult is going to occur and give verbal consent, which also must be documented, as there is applicable cost-sharing of the services. There would be requisite copayment due from the patient for each service billed as with all Medicare Part B services. These services should only be undertaken for the benefit of the patient and must be medically necessary. Interprofessional discussions held for edification of a provider, continuing education or shared as a professional courtesy will still occur and should not be separately billable services.