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FNCE 2008

Billing & Coding 101: Steps for Successful Billing
October 26, 2008
1:30-3:00pm

Presenting:

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Moderating:

Keith Ayoob, EDD, RD, FADA, Post-Chair, Coding & Coverage Committee

Objectives

1. Understand the different types of codes included on claims.

2. Learn how to correct common errors that lead to rejected claims.

3. Learn strategies for collecting complete claims-related information from patients and health care professionals to minimize claim errors.

Question 1

How do I start the process and get support for billing MNT in my outpatient facility?

Question 1:
How do I start the billing process?

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Education…Knowledge is Power!

- ADA MNT website: www.eatright.org/mnt
- Join the Reimbursement Community of Interest (CoI)
- Utilize State Reimbursement Reps (Leadership Directory)
- DPG List serves (CNM, DCE, WM, NE…)
- Nutrition Entrepreneur DPG Mentor Program
- ADA Nutrition Services Coverage Team: reimburse@eatright.org

Question 1:
How do I start the billing process?

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How to start the process

- Discuss with facility leadership
  - Direct Manager, Dept Director, or Vice President
- Arrange a well planned meeting
  - Ask your leadership how to approach key decision makers from other departments
  - Meet face to face! Do not email what you want to do! Create a relationship with the decision makers

Question 1: How do I start the billing process?

Prepare a business strategy

- Develop a mini business plan in excel
  - Expenses
    - Labor (benefits), supplies, rental space, non-billable time, marketing, phone calls to patients/physicians, etc, visit a program to gauge if you remembered what you need to include for your facility
  - Revenue
    - Remember "write-offs" and determine facility average
  - Benefits to facility/community

Question 1: Who do I need on my team?

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Initial Core Team Members

- Patient Financial Services-Billing Manager
- Health Information Mgt-Coding Manager
- Dept Leadership
- Charge/Service Master Manager
- RD

Question 1: Hospital Billing Flow Diagram

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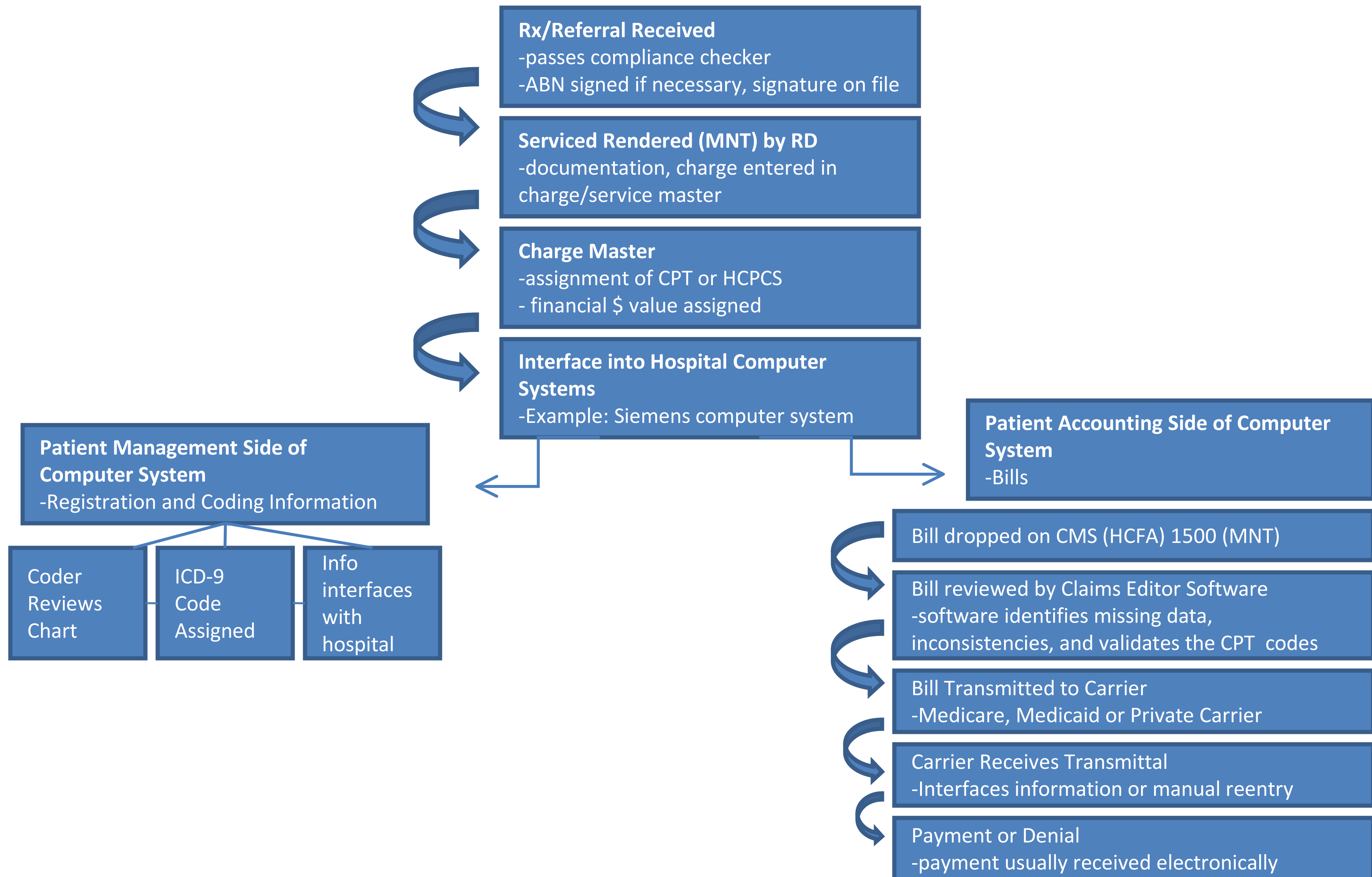

Question 1:
Who do I need on my team?

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Who are the financial decision makers?

- Patient Financial Services-(technically)
- Try to consider core team as ultimate decision maker in most situations

Question 2

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How do I start billing insurance companies?

Question 2:
How do I bill insurance companies?

Determine your billing status

- Am I an individual entity billing under my social security number?
- … or a business entity billing under my Federal Tax ID?
- Contact your accountant regarding tax laws

Obtain an NPI number

- National Provider Identification Number
- https://nppes.cms.hhs.gov/NPPES

Question 2:
How do I bill insurance companies?

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Research insurance carriers

- Visit web sites
- Contact provider relations representative
  - Currently accepting RDs?
  - Fee schedule?
  - Utilize CAQH (Council for Affordable Quality Healthcare): universal credentialing data source
  - Register with the carrier to obtain a CAQH number

Log onto CAQH.org and complete universal credentialing packet

Question 2:
How do I bill insurance companies?

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Establish your fee schedule

- 97802 - initial visit (per 15 minute unit)
- 97803 - follow-up visit (per 15 minute unit)
- 97804 - group visit (per 30 minute unit)

Forms and documents

- Patient registration form
- Superbill
- HIPAA compliance policy

Billing method

Question 3

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What information should be collected from a patient to minimize claim errors?

Question 3:
What info should I collect?

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Information to Collect from Patients:

- Patient name
- Address
- Telephone number
- Date of birth
- Social security #
- Copy of insurance card (front and back)
- Insured subscriber name
- Policy #
- Insured date of birth
- Insurance referral and/or authorization
- Rx from referring MD (including diagnosis)
- HIPAA waiver

Question 3:
What info should I collect?

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At the initial outpatient visit:

- Confirm information
- Copy insurance cards
- Issue ABN if necessary

Question 3:
What is the referral policy?

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Policy on Rx (Prescription) and Referral:

- Referral could be from a friend
- Rx is signed order from treating physician
  - Reid policy is for a Rx
  - See sample policy
  - Exception: Adult Weight Mgt Classes

Question 3:
What info will minimize claim errors?

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CMS 1500 (HCFA 1500) Form

Important Information:

- Correct diagnosis (utilize an EZ coder $69.95)
- Procedure code and number of units
- Policy number and group number
- Authorization or referral number
- Referring MD's NPI number
- Provider NPI number

Question 3: Sample CMS 1500

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EMPIRE MEDICARE
P.O. BOX 69202
HARRISBURG, PA 17101

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA | CARRIER

1. MEDICARE [X] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 123456789A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): JONES, MARY

3. PATIENT'S BIRTH DATE MM DD YY: 02 12 1961 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME

5. PATIENT'S ADDRESS (No., Street): 10 HAPPING LANDING TRAIL

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): SAME

CITY: WEST MILFORD STATE: NJ

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY STATE

ZIP CODE: 07480 TELEPHONE (Include Area Code): (973) 999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: None

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 08/10/2008

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

PATIENT AND INSURED INFORMATION

Question 3: Sample CMS 1500

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14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
JOHN BROWN, MD

17a.

17b. NPI 1909999999

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)
1. 250.02
2.
3.
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 08 10 2008	08 10 2008	11		97802	1	240 00	6		NPI	2223334445
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
123456789 [ ] [X]

26. PATIENT'S ACCOUNT NO.
5054

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO

28. TOTAL CHARGE $ 240 00

29. AMOUNT PAID $ 0 00

30. BALANCE DUE $ 240 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
CAMILLE DESIMONE, RD
SIGNED DATE 08/10/2008

32. SERVICE FACILITY LOCATION INFORMATION
CAMILLE DESIMONE
7 EVERGREENN ROAD
HEWITT, NJ 07421
a. b.

33. BILLING PROVIDER INFO & PH. # (973)853-4353
CAMILLE DESIMONE
7 EVERGREEN ROAD
HEWITT, NJ 07421
a. 9876543210 b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

Question 4

From an outcomes management standpoint, who do I go to in my hospital facility to discuss billing procedures and follow up on processed claims (denied claims, revenue tracking, etc.)?

Question 4:
Who do I turn to in my facility?

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- Billing Procedures-Patient Financial Services(PFS) Manager
- Denied Claims-PFS billers
- Revenue Tracking-Information System (IS) and PFS billers
  - IS reports
    - Billed $, third party payer $ received, $ wrote off, $ paid by patient, delinquent accounts

Question 4:
Who do I turn to in my facility?

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Reid Patient Financial Services

- For ABN problems
  - ABN needed and wasn't supplied or dx data is missing
- When denials involve referral missing data
- If a patient is complaining

Question 4:
How can an RD assist the billing dept?

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How can an RD assist the hospital billing department in appealing a claim?

-Call physician or office staff

- Collect missing data, send to coders so chart can be recoded and bill can be dropped again

-Physician letter of medical necessity

-Know the rules surrounding use of codes you are using and follow them

Question 5

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When you send a claim to a payer, what happens?

Question 5: What happens after you send in a claim?

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- Carrier acknowledges receipt of clean claim
- Review of claim information
  - -Are there any mismatches or incorrect data?
- Verification of benefits
- Claims adjudication
  - -Last step prior to claim payment
- Carrier issues payment
- Explanation of benefits (EOB) sent to patient

Question 6

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What could speed up the process of a claim being paid?

Question 6: What could speed up the claims process?

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Electronic versus paper

- E-claims
  - Paid quicker (21 days)
  - Clearinghouse acknowledgement within 24 hours of submission
  - Carrier acknowledges or returns claims within 72 hours of submission (e.g. eligibility, diagnosis, etc.)
- Paper claims
  - 28 days for processing

Question 6: What could speed up the claims process?

- Editor billing program
- Daily charge entry by RD
- Timely documentation
- Timely chart review by Health Information Management (HIM)
- Screening charts for needed ABN's, diagnosis, signatures

Question 7

What are the most common errors made on claims in hospital outpatient facilities and in private practices?

Question 7: What are the most common errors?

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Common errors on claims:

- Incomplete data
  - Rx not signed
  - No dx selected or service ordered
  - Incomplete or inaccurate insurance information presented or entered on a patient
  - Inaccurate coding
  - Missing charges by the RD
  - NPI # not available for out of town physicians

"good upfront work yields payment"

Question 7:
What are the most common errors?

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Common errors on claims:

Valid Rejection

-Incorrect policy #
-Incorrect NPI #
-Truncated diagnosis

Take Action:

- Correct error
- Resubmit to carrier as "corrected claim"

Invalid Rejection

-Policy excludes MNT
-Not medically necessary
-Provider not privileged to provide services

Take Action:

- Call carrier
- Send written appeal with office notes

Question 8

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How can a private practitioner find out why a claim was rejected?

Question 8:
Why was my claim rejected?

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What do I do?

- Read the explanation of benefits (EOB) to determine reason for denial
- Call carrier
  - Example: If benefits were verified prior to the visit, relay this to the claims representative.
- Request that claim be reprocessed
- Obtain reference #, representative's name
- Send written appeal with office notes

Question 9

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What are the incurred costs involved in setting up a billing system for MNT?

Question 9: What billing software best meets my needs?

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What sort of billing system should I use?

- Research software vendors
  - -What are the capabilities of the system?
  - -Electronic submission (additional cost)
  - -Electronic patient statements (additional cost)
  - -Posting payments electronically
  - -Tracking claims history and referral sources
  - -Are the patient statements easy to read?
- Cost could range from $1500 - ?
- Plan for the future!

Question 10

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What are the pros and cons of using a biller?

Question 10:
Should I use a billing service?

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Research billing services

- Knowledge of MNT billing?
- Knowledge of insurance carriers?
- Method of submission?
- Follow-up with rejected claims?
- Payment posting
- Patient statements
- Fees

Questions?

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