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LeadingAge New York Managed Care Billing Seminar

Achieving the Goal of "Clean Claims"

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Michael H. Lewensohn
Manager
Health Care Medical Reimbursement Services
mlewensohn@odpkf.com

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Discussion Topics

- Clean Claim
- UB-04 Form
- CMS1500 Form
- Electronic Billing
- Clearinghouse Services
- Procedure and Diagnostic Coding
- Pre-Authorization Process
- Denials and Appeals

Clean Claim

- Contains all required data as per plan's billing manual
  - Form
  - Procedure codes
  - Diagnostic codes
  - Patient information
    - Validated at an authorized patient eligibility site
  - Provider information
  - Provider credentialing
  - Pre-authorization number, as applicable

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Clean Claim (Continued)

- Units of service
  - Reflects volume or time
- Patient eligibility verification
  - Validate patient insurance enrollment
  - Validate patient specific identifiers
- Type of bill
- Condition codes
- Occurrence codes

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Clean Claim (Continued)

- Billing NPI
- Rendering NPI
- Provider tax identification number
- Billing period
- Appeal period

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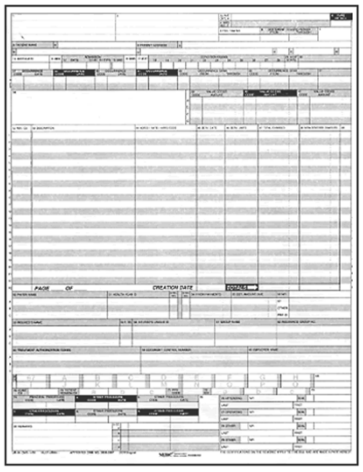
UB-04 Form



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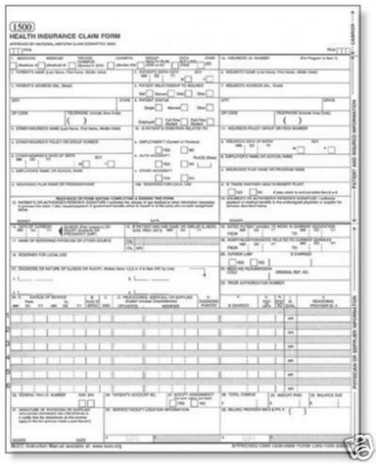
CMS1500 Form



Electronic Billing

- Faster payments
- More accurate payments
- Earlier detection of errors
- Gateway to electronic remittance advice and electronic funds
- HIPAA compliance

Clearinghouse Services

- An intermediary used to direct the flow of bills from provider to payer
- Transmitted data from the provider is analyzed to verify required fields are complete and or accurate
- Clearinghouse reports to provider reflect successful and failed claims
- Successful claims forwarded to appropriate payer; failed claims to be “repaired” and re-billed

Clearinghouse Services (Continued)

- Selecting a clearinghouse
  - Cost
  - Sufficient base of insurance plans
- Reports to provider reflecting claim submission status
  - Patient eligibility verification
  - Electronic remittance advice
  - Customer support

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Clearinghouse Services (Continued)

Sample EDI Payer List

Payer ID	Payer Name	ENR	TYP	ST	LOB	RTE1	RTE2	RTS	ERA	SEC	Note
27094	Simply Health Care Plan	N	C/P		M	N	N	N	N	Y	
13162	1199 National Benefit Fund	N	C/P		M/H	N	N	N	Y	Y	IVR Phone Number:(888) 819-1199
59069	21st Century Health and Benefits	N	C/P		M/H	N	N	N	N	Y	
51028	21st Century Insurance and Financial Services	N	C/P	MN	M/H	N	N	N	N	Y	For Minnesota only
20413	3P Admin	N	C/P		M/H	N	N	N	N	Y	
74234	8th District Elec	N	C/P	UT	M	N	N	N	N	Y	Customer Service Phone Number:(800) 628-6562

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Procedure and Diagnostic Coding

- HCPCS codes
  - Level I - CPT-4
  - Level II – Non physician services, not covered by CPT-4
  - Level III – Local codes developed by governmental and private payers for use in specific programs or jurisdictions
- Diagnosis codes: ICD-9 or ICD-10
- Revenue codes

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Pre-Authorization Process

- Services requiring pre-approval
- Requesting pre-authorization, as applicable
  - Start and end dates
  - Renewing or extending a current pre-authorization
  - Blanket pre-authorization or need for service specific approval

Denials and Appeals

- Analyze denied services
  - Identify reason for the denial
  - Append appropriate changes to the bill
  - Refer to the billing manual and or contract to better understand basis for the denial
  - Work with plan to resolve denied cases and to better understand how to avoid future denials
  - Submit appeals within the contracted appeals timeframe
  - Retain all documentation related to the original invoice and appeal attempts
    - Name of representative, date of contact, etc.

Denials and Appeals (Continued)

- Claim adjustment reason codes (CARC)

12	**The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 09/20/2009*
13	**The date of death precedes the date of service.** *Start: 01/01/1995*
14	**The date of birth follows the date of service.** *Start: 01/01/1995*
15	**The authorization number is missing, invalid, or does not apply to the billed services or provider.** *Start: 01/01/1995 | Last Modified: 09/30/2007*

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Denials and Appeals (Continued)

Examples of Remittance Advice Remark Codes

Code	Informational Message
M1	X-ray not taken within the past 12 months or near enough to the start of treatment
M2	Not paid separately when the patient is an inpatient
M3	Equipment is the same or similar to equipment already being used
M4	This is the last monthly installment payment for this durable medical equipment
N1	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents
N112	This claim is excluded from your electronic remittance advice

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Denials and Appeals (Continued)

Examples of Claim Adjustment Reason Codes

Code	Financial Information
1	Deductible amount
2	Coinsurance amount
3	Copayment amount
4	The procedure code is inconsistent with the modifier used or a required modifier is missing
5	The procedure code/bill type is inconsistent with the place of service
6	The procedure/revenue code is inconsistent with the patient's age

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