The NIATx Third-party Billing Guide

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ACTION CAMPAIGN
FINANCIAL STRENGTH IN A CHANGING WORLD

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Why We Created this Guide

Parity legislation was signed into law in 2008 and health care reform in 2010, and the two are converging now to profoundly affect addiction treatment. By 2014, many more people will have health insurance that covers addiction treatment. Recent estimates show that 30 million of the 45 million people who currently lack insurance soon will have insurance with parity for addiction treatment.

Addiction treatment agencies will not only have many more potential clients. They will also have to shift from relying on grants to billing payers for their services. According to the 2008 National Survey of Substance Abuse Treatment Services (N-SSATS), 35 percent of treatment providers have no capacity to bill insurance for care. Only 53 percent of agencies nationwide can bill Medicaid, and fewer than half have a contract with at least one third-party payer.

This guide is intended to help agencies make the transition to billing for their services. It provides step-by-step help for agencies with no third-party billing capacity. (See pp. 3-20) For agencies that have some or even extensive experience with billing, the guide gives suggestions for improving collections and strengthening the business practices that are essential to stability and growth. (See pp. 21-35)

Terms in bold throughout the text are defined in a glossary at the end of the guide. We've also included an appendix with samples of forms that you can adapt for your organization as you set up your system for working with third-party payers.

Introduction

In a grants-based reimbursement system, the revenue side of the balance sheet is fairly constant. You can expect payment based on your contract or grant agreement (except when government payments are late due to budget negotiations or government process issues). Making the transition to billing for services will change your organization. You'll need to dedicate more time and attention to the business practice of fee-for-service billing: verifying coverage, obtaining authorization for services, setting up policies and procedures for accounting, collections, and compliance with payer requirements.

While different business processes and work flows will be required, the new billing environment will create new opportunities and allow you to diversify your revenue stream. As providers like St. Christopher's Inn in New York **(http://www.niatx.net/toolkits/provider/StChristophersInnIncreasingAdmissions.pdf)** and Prairie Ridge in Iowa **(http://www.niatx.net/Story/StoryDetails.aspx?id=285)** have found, adding new payers increases financial stability and creates growth opportunities—even during difficult economic times when some organizations may be reducing services.

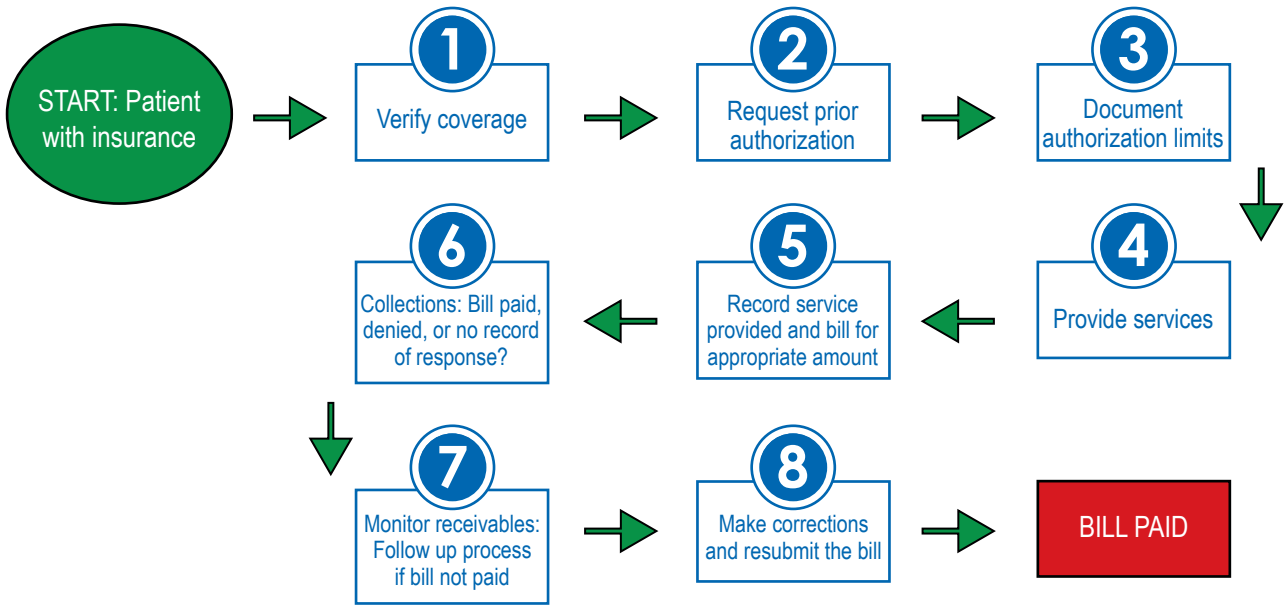
While you look for new ways to generate revenue, you will most likely continue to provide care to those who lack insurance or the ability to self-pay. A benefit of working with third-party payers? The fees that you will be collecting can stabilize your income flow, making it easier to provide charity care.

What happens when a client who has insurance comes to your agency? Let's get started with the simple pilot test that follows.

Part I: A Pilot Test

Assign one person in your agency to conduct this pilot test: try to get paid for services for the next client who has insurance coverage.

Steps to the Billing Covered in the Pilot Test



Verify coverage

You probably already gather information from clients at first contact. Your "pilot tester" can add another question to the process: Do you have insurance? Your pilot tester should ask the next client that says "yes" to bring their insurance card to their first appointment.

All insurance cards include a phone number to call for benefits information. Have the person you have assigned the task of this pilot test call the number and request benefit information.

Gather and document the client's insurance benefits. Make a note of questions or information the insurance company requests regarding the client's treatment.

2 Request prior authorization

Your client may be enrolled in a **Preferred Provider Organization (PPO),** or a **Managed Care Organization (MCO)**, or a **Health Maintenance Organization (HMO)** where services have lower copays if the member sees an in-network provider. Most plans also require prior authorization for services.

Prior authorization is the process of obtaining approval of coverage for a treatment service or medication. It's sometimes called pre-authorization, precertification, or prior approval. Each third-party payer may use a different term and has a different process. No matter what term is used, you will need to obtain this approval before treating a patient in order to get payment for the service.

Have your pilot tester explain to the third-party payer that your agency would like to be able to bill for the client's services as an **out-of-network provider**. The third-party payer will ask some standard questions.

3 Document authorization limits

If the service is authorized over the phone, your pilot tester must be sure to record the date and the name of the person who authorized the service. Record the authorization number, the number of units authorized, the next review date, and areas of interest for the next review. Give information to the treatment program providing the services that will allow them to collect the needed data and clinical information for the continued stay or discharge review.

That's it for the first part of your pilot test. Did services get authorized? Why or why not? If not, what do you need to do differently next time? Run the pilot again, making changes based on the first pilot test.

4 Provide services

The next step in the pilot test is to provide the services that were authorized. Reauthorizations or "concurrent or continued stay" reviews will continue for Steps 3 and 4 until the client is ready for discharge.

5 Record service provided and bill for appropriate amount

Now that you have authorization and have provided the authorized service, you can bill for services rendered. Commercial payers and Medicaid use standard billing forms: either the UB – 04 or the HCFA 1500. You can purchase these forms online or at your local office supply store.

For detailed instructions on completing the forms, visit:
http://nucc.org/images/stories/PDF/claim_form_manual_v5-0_7-09.pdf

Reminder: you will need to submit bills in a timely manner. Most payers require submission of a "clean" bill (a bill with no errors or missing information) within 30 to 60 days of discharge. Check the payer's website for details.

Results of your Pilot Test

Did you get paid? Did you get a denial?
What was the reason for the denial? Is it something that you can correct and resubmit?

Collections: Bill paid or denied

If you received payment—congratulations!
If the claim was denied, don't despair. Third-party payers often deny claims because of problems with the bill rather than problems with the service. You can correct these errors and then resubmit the bill. Problems with the service are harder to correct since it has already been provided. But since this is a pilot test, you can learn from the experience. Make note of the corrections needed so you avoid the same problem next time.

Monitor receivables: Follow up with the third-party payer

If there were issues with the service—for example, the clinician did not have the appropriate credentials—your claim may be denied. Many third-party payers want people with higher levels of licensing than the state may require. For clinical and billing guidelines, visit the payer's website and look for "Information for Providers." You can make a change for the next billing opportunity that arises and run another pilot test.

Make corrections and resubmit bill

If you bill for just the first session, you can complete this pilot test within a three- or four-week time frame from beginning to end. This pilot test will give you valuable information about what you need to know in order to set up a billing system, even if you do several rounds of the test with slight modifications. Third-party payers typically have up to 90 days after the submission of a "clean" claim to pay the invoice.

Part II: Creating a Billing System

With the experience of the pilot test, you will have learned a lot about the information and processes required to work with third-party payers. You'll have to assign new tasks and develop new procedures and policies.

Adding Medicaid or commercial insurance billing to your payer mix is sure to raise mission questions that you will need to address with your staff and board. You may experience "founder's tension" between people who have worked for a long time in the organization, board members who may have helped create the organization, and executive management who are trying to lead the organization into a new payment environment.

- How will this shift in reimbursement affect the people you serve? If needed, will you change your service mix to adapt to what third-party payers are willing to purchase? Some of the people you serve will have insurance for the first time. How can you help them understand their coverage?

- How does this shift in reimbursement affect who you are as an organization, what you say about who you serve, and your role in the community?

- Does your fee policy need to change in light of **copays** and Medicaid and third-party papery requirements?

Consider all these questions and the clients you serve as you create your billing system.

In the pilot test you learned the basic steps involved in billing a third-party payer. In the pages that follow we'll go through the steps in greater detail.

But first you'll want to think about roles and relationships.

Who does What?

As in any NIATx change project, you want to engage and involve your staff in making the transition to third-party billing. You also want to let your staff know that the executive management team is committed to making the change and supports all efforts to work effectively with third-party payers.

Creating a billing system or improving an existing one will change people's jobs. New positions, new workflows, and changes in communication patterns will affect your staff at all levels—even those who you would not think would be affected. Allow time for training staff on new processes. You'll also need to adjust and adapt those processes until you have a smooth system.

Engaging staff in the process helps ensure a successful transition. People need information about why the change is necessary, the proposed process of the change, and how it will affect their daily work. Ask for staff input on how to assess the new processes and procedures as they are implemented.

Changing the way you charge for services will change the intake/assessment, clinical service delivery, and discharge processes. You will add or change administrative processes such as obtaining prior authorization for services, **utilization review**, and billing for services.

In addition to providing information and engaging staff in the change process, rewarding people for achieving system aims creates a strong motivator for embracing change. For example, some agencies pay bonuses based on collections. Helping employees enjoy the benefits of a new system will encourage them to support the change.

"Who does what" chart

Step in the Process	Who is assigned?	When is this task done?	Who is it handed off to?	Who else needs this information?
Verify coverage				
Request prior authorization				
Document authorization limits				
Provide services				
Document service provided				
Bill for appropriate amount				
Collections: bill paid or denied				
Monitor receivables				
Make corrections and resubmit				
Monitor cash flow				

Steps in the Billing Process

In the pilot test you learned what information third party payers typically request. Now we'll go into more detail, guiding you through each step so you can create a process and develop forms and checklists that work for you.

Verify coverage

The first step of efficient billing is to learn everything you can about the coverage the third-party payer provides. Check the back of the patient's insurance card for contact information. You'll also need to know:

- Primary care physician information
- Total benefits covered
- Calendar year and lifetime max status
- **Deductible**: any met, and if yes, how much?
- **Copay** for all levels of care
- Claims address
- Certification (pre-authorization) phone number
- Lifetime max: amount met
- Policy termination date
- Effective date
- Authorizations required
- Name of person you spoke with

Some organizations have administrative staff make the verification calls and complete the insurance verification form. In other organizations, the staff member obtaining authorization for services also verifies insurance coverage.

Different insurance companies will have different procedures, but using a worksheet like the one that follows to gather standard information will help you as you start to work with these new payers. You can adjust the worksheet as you learn each third-party payer's requirements.

Checklist to Verify Coverage

Client Information

☐ Patient Name: _____ M ☐ F ☐

☐ Address: _____

☐ Home Phone:_____ ☐ Other phone:_____

☐ Social Security Number: _____ ☐ Date of Birth: _____

Primary Care Physician: _____

Primary Care Physician's Phone: _____

Insurance Information

☐ Insurance Co: _____

☐ Policy No: _____ ☐ Group No: _____

☐ Insurance Co. Phone: _____ ☐ Fax:_____

☐ Policy Holder' Name: _____ ☐ Date of Birth: _____

☐ Policy Holder's relationship to client: _____

Client Eligibility and Benefits Information

☐ Date Coverage Effective: _____ ☐ Date Coverage Ends: _____

☐ Benefits for SA/MH treatment: _____

☐ Co-Pay Amount:_____ ☐ Deductible Amount:_____

☐ Prior Authorization Required for SA/MH? Y ☐ N ☐

Most plans also require prior authorization for services. Prior authorization is the process of obtaining approval of coverage for a service or medication with a specific provider and network. It's sometimes called pre-authorization, pre-certification, or prior approval. No matter what term is used, you will need to obtain this approval before treating a patient in order to get payment for the service.

You will base your client's bill on the treatment and services you have provided that the payer allows. Most third-party payers now require you to get authorization before you deliver services.

What information do you need to obtain authorization? Check the third-party payer's website for guidelines and expectations for the services provided. Using their terminology will assist in getting services authorized.

Frequently, the clinical team must actually see the prior authorization for the inpatient stay. For outpatient treatment, prior authorization may be completed prior to the first session.

Information requirements vary for each payer. Some companies will authorize an initial course of four to six outpatient sessions with minimal information. Others may want a full bio-psycho-social evaluation and diagnosis before authorization. Find out by talking to the provider relations service representative for the third-party payer, and then create a checklist so that your clinical or intake staff are guaranteed to collect the information needed for authorization.

See the example checklist on the following page.

Checklist for Prior Authorization

☐ Date of call: _____ ☐ Time of call:_____

☐ Third-party payer: _____

☐ Prior Authorization Contact Name: _____

☐ Prior authorization contact phone: _____

☐ Fax: _____

☐ Prior Authorization Approval No.: _____

☐ Reauthorization required? Y ☐ N ☐

Services authorized: _____
_____
_____
_____

Authorization Limits: _____
_____
_____
_____

Notes: _____
_____
_____
_____

☐ Call completed by (name) _____

Developing Relationships

Most third-party payers, including Medicaid, have a provider relations department that you can contact with questions. Check the organization's web site or the client's insurance card for contact information. In time, staff members who obtain verification and authorization will develop invaluable relationships with service representatives at the third-party payers you work with the most. While a third-party payer may provide a member seeking treatment with three referral options, you can increase the odds that your agency is one of them by building positive relationships.

Payers will refer clients to your organization based not only on the quality of care you provide, but also on the quality of your working relationship. A mutually respectful relationship will benefit your organization and the clients that both you and the third-party payer serve.

As your relationship grows, so will the third-party payer's confidence in your treatment integrity. Your staff will learn exactly what clinical information the payer requires, leading to an increase in treatment certifications and revenue. Over time, the positive working relationship with the third-party payer will increase staff efficiency, which also has a positive impact on revenue.

This relationship is constantly developing, and it's important for you to get to know the key contacts at the third-party payer. You'll get to know the person who you worked with to establish the contract. You also want to build a relationship with the staff members who refer clients to your organization, as well as those who provide authorizations.

Make a point to stay in contact with those individuals. Call to thank a payer for a referral. Check in on reviews of past referrals and ask if the payer is seeking anything specific for its members. Tell the payer about any new services you're providing and keep them up-to-date on the evidence-based practices that you're implementing. This regular contact serves a dual purpose: it keeps your agency in the forefront and allows you to find out about opportunities for growth.

There may be times when you feel that the payer's requirements are demanding or counter-productive. But the key to this relationship building is to focus on the client. You and the third-party payer are both working for the client; you both want to make sure the client gets the best treatment possible. You're on the same team. With great teamwork and effective communication, you'll help the clients you serve reclaim their lives.

Case Study

Through monthly check-in phone calls with a third-party payer, Agency "W" learned that the payer had ended its contract for partial hospitalization with another organization. This opened the door for Agency W to examine its programs. Agency W determined that it could add this service level, with a cost of $30,000 annual salary for a group leader. Agency W contracted for this service with the payer and over the next year brought in $78,000 from the payer, not counting copays.

STEP 3

Document authorization limits

Determine who will be responsible for obtaining the authorization. Some agencies prefer to make this the responsibility of the clinician seeing the client. The clinician knows the most about the client and is committed to making sure that the client obtains appropriate services. On the other hand, this takes up time that the clinician could be using for billable services.

- Many small agencies make this an additional requirement for the clinical supervisor or program manager and reallocate some other administrative duties to administrative staff or the executive director.

- Other agencies centralize this process, designating a single person or a small team to obtain authorization. This allows the individual or team to develop better skills and closer relationships with the claims representative they contact regularly.

- Having a full-time staff member responsible for obtaining authorizations may be more realistic for a large agency rather than a small one. However, some organizations find that having staff devoted to the authorization process increases revenue collection to justify the cost of added staff.

Operation PAR in Florida hired a single staff person to obtain authorizations. This increased their third-party collections from $129,000 to $436,000 within one year, more than justifying the investment of $30,000 for the staff salary.

Information Sharing: Internal Communication

Once all the required information is gathered, it must be communicated to the appropriate internal systems:

- Scheduling
- Registration
- Treatment/case provider
- Business office
- Utilization Review staff

Identify who will disseminate information to all the people that need it. The authorization information must get to everyone who has a hand in the billing process. The service delivered and the bills generated for the service must reflect all payer's conditions, such as level of care, units of service, and clinician's credentials.

You can include the authorization information in the part of the patient file that all necessary people have access to. Or, create an information sheet that gets copied to all appropriate staff. Some organizations use a central database or a simple spreadsheet.

An electronic health record (EHR) offers an efficient way to disseminate the required information to the appropriate people, but other processes also work. (See p. 30 for more information on electronic records.)

Effective internal communication at your organization is just as important as your communication with the third-party payer in obtaining authorization, and eventually, payment for services.

The clinical team needs to be informed of authorizations, as well as the areas the third-party payer will be examining at the next review. Your business office or billing office needs to know what to bill, for how much, and how and where to send the bill. The client needs to know what the third-party payer is going to pay for. Staff who will be doing the next review or discharge planning need to be fully informed. Getting the information to the right people can be a challenge in organizations where each team member may be doing more than one job. How can you make sure that the right people have access to the right information?

Take a look at how information flows in your agency.

- Does everyone use e-mail and have access to a shared calendar?
- Do you use Excel or other spreadsheet programs?
- Micorsoft Access or other relational database programs?
- An electronic medical record program? A dry erase board? An Intranet site?

Consider setting up a shared calendar system (like Micorsoft Outlook) that all staff can view. You can set up separate calendars for each program or clinician. This calendar should be the same one that clinicians or programs use for scheduling appointments.

Whenever your organization provides a billable clinical service, you will need to capture or record the service in a way that will generate a charge. Clinical staff will need to keep progress notes current so that services can be appropriately billed. Services must match authorizations in type, quantity, and be delivered by a clinician with the required certification. Make sure that appropriately credentialed personnel provide the services authorized.

Part of developing a billing process is designating a person to be responsible for collecting information on services rendered and then generating an invoice or bill. Electronic health records (EHRs) were initially created for the purpose of capturing this information and generating a service invoice. Efficient billing has been the primary reason that organizations have adopted an electronic system.

However, many agencies cannot afford to purchase an electronic system at this time. You will need to identify who is responsible for collecting the information on services provided and turning it into an invoice/bill for services. That person will need to have a list of billing codes that match the CPT codes for the services you provide and instructions on how frequently to gather the information. For an overview of the HIPAA regulations and development of billing codes, visit: **http://hipaa.samhsa.gov/hipaacodes2.htm**

Ensuring that the clinical encounter matches the services authorized is one of the biggest headaches of setting up a billing system. In a fee-for-service system, doing this well is critical. Agencies that have been billing for many years have established procedures for ensuring that the service matches the authorization. They have also established entire quality assurance processes for reviewing the success of their process.

Reauthorization (Concurrent Review or Continued Stay Reviews): Payers initially authorize services for a short period of time: four to six sessions of outpatient counseling, for example. Designate a member of your team to obtain and document reauthorization for clients who need continued treatment.

Insurance companies vary in establishing authorization limits. With experience, you will learn the language necessary to obtain re-authorization for additional services. Typically, you will need to be able to describe:

- Course of treatment so far
- Treatment plan
- Why more service is necessary
- What you expect to do in the additional time you are requesting
- Need for level of care based on the client's severity
- Anticipated end date

The more clear and specific you can be, the more likely you are to get additional services authorized for your client. All appropriate staff will need to be informed of the reauthorization. In many organizations, the same person who obtained the initial authorization also obtains the reauthorization.

STEP 5

Record service provided and bill for appropriate amount

You have obtained authorization, you've provided a service, and now you can finally send a bill. It's time to set up your billing system.

First, you need to decide if you want to create an in-house billing system or contract with an outside vendor.

Using a billing service may be preferable (and economical) for a small agency. Associations that certify medical billing vendors in some states include: **http://www.ambanet.net/AMBA.htm** and **http://www.e-medbill.com/** The Healthcare Billing and Management Association **(http://www.hbma.org/)** is an association of medical billers that lists members by the type of billing they do.

Contract with billing vendor

Vendors may charge a flat fee per bill, a percentage of fees collected, or a graduated rate based on volume. Vendors have experience with billing systems, will deal with all of the follow up necessary to get a bill paid, and sometimes guarantee collection rates. The downside may be that for providers with large volume, an in-house system may cost less.

When you contract for billing services, you'll need to add the vendor to the list of people that receive information about authorization and services delivered. Since a billing vendor will not be able to review a client record like someone in house, you'll need to set up a communication system so they get the information necessary to generate bills on a frequent and regular basis. Some vendors have web-based systems that allow you to enter data electronically. Others will help you design the communication system that works for your organization.

How do you handle your accounting? If an external organization is keeping your books, it probably makes sense for you to contract for the billing work as well. Your accounting firm/bookkeeper may also do medical billing, or may be able to recommend a reliable service. If you are doing your own accounting/bookkeeping, you may have the internal capacity to develop your own billing system.

When considering an outside vendor:

- Determine your billing needs
- Talk with potential vendors
- Speak with other agencies that outsource
- Request and contact references
- Select a vendor

In-house billing

If you choose to do your own billing, you will have to create a billing system. Electronic medical records or practice management software offer an efficient but expensive option for electronic billing. We'll discuss the benefits of an electronic system later.

Medicaid and some private insurance companies use standard billing forms: the UB-40 or the HCFA 1500. You can purchase these forms on line or at your local office supply store. For detailed instructions on how to complete the forms, visit: **http://nucc.org/images/stories/PDF/claim_form_manual_v5-0_7-09.pdf**

Some Medicaid and private third-party payers have online forms that allow you to enter the billing information directly into their system. This way, you avoid the time and cost of a paper system.

Establish a regular billing schedule to keep consistent cash flow. Your billing success is tied to the accuracy of billing and invoice content, as well as to the steps in the process described in the previous pages:

- Verifying coverage
- Obtaining and documenting authorization
- Making sure that services are provided by appropriately credentialed personnel
- Communicating service delivery information in an accurate and timely manner to all people engaged in the billing process

If you use a billing vendor, you'll establish a system for communicating authorization and service delivery information to them.

Generally Accepted Accounting Principles (GAAP) is a collection of rules and procedures and conventions that define accepted accounting practices. Organizations typically use GAAP when setting up a billing system. However, many states have their own accounting rules that will affect you if you continue to accept grant funds. States also issue different reporting requirements. Each organization needs to establish internal procedures for detailing revenue recognition. Consult an accountant experienced with these issues as you adapt your accounting practices.

With a billing system, collection rates become important. If your accounting system is **accrual-based** (the most commonly used accounting method, which reports income when earned and expenses when incurred), you will record income when it is billed, not when it is received. Then you have to watch cash flow and keep an eye on receivables to make sure that you don't have too many accounts more than 60 days in arrears, or your income, which will seem to be growing with all of this new revenue, will be an illusion.

An agency must realistically assess its business office operation and capacity. In the past, you may have been able to keep overhead rates low by limiting business office operations because you didn't have to focus on revenue generation. In a new environment where billing third-party payers is key to survival, the business office must manage revenue sources, cash, and develop an understanding of the unit cost of services.

Generating Bills

Who will generate the bills/invoices and send them to the correct payer? Your accounting software probably already has the ability to generate charges with appropriate data entry. The person responsible for the bookkeeping function in your office can collect the information on which company to charge for which client. This staff person will also verify how many units of service were authorized and at what rate from the information gathered during intake.

A smaller organization may have a weekly or monthly billing cycle. In a large organization, billing may be a daily task and the sole responsibility of an individual or a team of billing clerks.

If you contract for bookkeeping services, be prepared to renegotiate your contract for the additional bookkeeping work. In addition, you will need to add the contracted bookkeeper to your list of people who need to receive the information on services that have been billed.

Staff responsible for collecting payments must become familiar with the third-party payers' rules and payment behaviors. They must know the turn-around times and gain an understanding of how length of stay, level of care, patient volume, patient acuity, and billing volume affect collections. Each insurance company has its own set of rules, and departments within a company often operate as silos. The "eligibility" group operates independently from the "authorization" group and each operates separate from **accounts payable**. Negotiating the communication barriers can be challenging.

STEP 7

Monitor receivables:
Follow up process if bill not paid

Accounting staff or a member of the management team will have a new task in monitoring receivables. To best monitor accounts receivable, generate aging reports from your accounting system. An aging report lists accounts receivable balances by customer, detailing the current status or delinquency of the balances owed or owing. Initially, you will want to pay attention to claims that are more than 60 or 90 days overdue. **Note that you'll have to keep an eye on your cash flow. Make sure you don't have too many accounts more than 60 days in arrears or you won't be able to cover all your expenses.**

Sample Aging Report:

Agency ABC
A/R Aging Summary
As of June 29, 2010

	Current	1 - 30	31 - 60	61 - 90	91 and over	Total
Company I					9,000.00	9,000.00
Company II			9,400.00			9,400.00
Company III					7,125.00	7,125.00
Company IV		1,340.89				1,340.89
CompanyV		1,411.00	1,911.00		16,510.48	19,832.48
Company VI					2,641.00	2,641.00
Company VII	2,895.00	3,151.50	1,964.00		5,892.00	13,902.50
TOTAL	**$2,895.00**	**$5,903.39**	**$13,275.00**	**$0.00**	**$41,168.48**	**$63,241.87**

STEP 8

Make corrections and
resubmit the bill

You'll want to understand why a claim has not been paid. Is it due to billing errors or rejected claims? Define the rejected claims specifically. Does a particular third-party payer routinely reject a certain service? In identifying the reason that claims are rejected, you will be able to identify processes you need to adjust and systems that you need to improve. You will also begin to identify which companies you want to continue to work with, based on payment performance.

In Part III: Improving your Billing System, we'll briefly cover some of the business practices that can help increase your collections from third-party payers.

Part III: Improving Your Billing System

Business practices that influence collections

Once you have set up a billing system, the next step is to look at how to increase collections in your system. The billing operation itself does not stand alone as the source of successful payment. The qualities required for successful collection exist in the agency's business and clinical processes and practices. Some of the non-billing influences that directly affect collections include:

- Utilization management
- Compliance
- Metrics
- Seeking contracts for your services

Utilization Management

With prior authorization, you and your team have an initial impression of the client's immediate services needs, the estimated length of stay or treatment, and what the client will need upon discharge. You actually start your discharge planning at admission. Each third-party payer will provide you with its clinical guidelines. These will allow you to prepare for the standard reviews of your services. The guidelines also describe the payer's requirements for continuing care. In many cases, third-party payers require that your organization schedule the continuing care appointments before the client's discharge.

Knowing the third-party payer's continuing care and discharge criteria is just as important as knowing the payer's clinical criteria for admission to a level of care. This allows your agency to ensure that client is getting the level of care most appropriate for the symptoms demonstrated. This also gives your utilization management staff the correct clinical information. Again, requirements for clinical care authorization as well as continuing care will vary by third-party payer.

Level of care guidelines

Many third-party payers post their level of care guidelines online.

United Behavioral Health Plan, California is just one of many third-party payers that offers online access to its guidelines, detailing what a program needs to provide for a specific level of care, along with the clinical information to justify that level of care:
https://www.ubhonline.com/html/guidelines/levelOfCareGuidelines/index.html

This online information helps you prepare for treating clients covered by a particular payer. It will often list the providers that are part of the payers network. By examining this list, you can find out what services other providers offer. If they offer a service you don't offer, you can begin to build a relationship by making referrals (which in turn can lead to receiving referrals from them.)

Medical Necessity or Level of Care Guidelines

Medical necessity or level of care guidelines ensure that the client receives the most appropriate and least-restrictive level of care necessary. The continuum of care for substance abuse treatment is fluid; clients may enter treatment at any level and move to less or more restrictive treatment based on their clinical need.

Magellan Behavioral Health defines medical necessity as "Services by a provider to identify or treat an illness that has been diagnosed or suspected." The services are:

- Consistent with the diagnosis and treatment of a condition and the standards of good medical practice
- Required for other than convenience
- The most appropriate level of service

When applied to inpatient care, medical necessity means the needed care can only be given safely on an inpatient basis. Medical necessity guides both the provider and the third-party payer reviewer to the most appropriate level of care for the client. All medical necessity decisions are made after reviewing the description of the client's current clinical condition gathered from a face-to-face evaluation. Since not all levels of care are available in all areas, many third-party payers will support the client's treatment through extra-contractual benefits. Or, the payer may authorize a higher level of care to ensure that client receives all necessary services for safe and effective treatment.

Codes to match services

A system for identifying your services is key. The billing codes that you use need to match the codes for the service that has been authorized.

Know the expectations for discharge and continued care

A client has been authorized for services. You've provided some services, and the client demonstrates a need for additional treatment. What now? Your team already has the answer to that question, since during the initial authorization (pre-certification) your staff asked the third-party payer what clinical information was expected for further review, and who to call. Plus, you have the guidelines for medical necessity and level of care available for review.

The third-party payer will expect that only medically necessary services are delivered. The reviewer will have guidelines for the symptoms and situations that demonstrate medical necessity. Learn and adopt their language to assure continued appropriate care for your client. You will also need to ask:

- What clinical information will you be looking for the next time we speak?
- When do we need to review again?
- What additional information about the client do you need for the next review?

Know the requirements if services are denied

You attempted to authorize a session and the third-party payer denied the case. What do you do? Find out why they denied the authorization. Here are a few steps to help. Understanding these steps and learning what was missing can help prepare for the next case, so you won't get denied. Remember, you can appeal a denial. If there is a strong clinical case, there is a good chance that your agency will be able to overturn that appeal and get paid. Questions to ask the third-party payer:

- What exactly was missing that the case was denied?
- Was the reviewer looking for clinical information?
- Was this information asked for at the last review?
- Are there certain things the reviewer would like reported on from the previous authorization?

A key part is documentation. Document every step you take. Remember, if it is not written it did not happen.

Ask for an expedited peer-to-peer or doctor-to-doctor appeal. Appeals should be available within 48 hours of the denial. This level of appeal is often called a "Doctor-to-Doctor," which may in fact involve the third-party payer's medical doctor speaking with a staff member at your agency.

Continued denial

A payer that continues to deny the certification is required to provide alternative recommendations. At this point, the client or the client's family can decide whether to continue services or to accept the third-party payer's recommendation.

The client may want or need to continue treatment at your agency. Many third-party payer contracts indicate that clients cannot be billed for services that have not been authorized. The provider agency is required to notify the client of the denial and the reason for the denial. The client then can sign a form indicating they desire to continue the treatment and will be responsible for the fees.

Ask for the steps for a written appeal

Upon discharge, review the clinical chart. Is there clear documentation that the client needed this level of care? If no, don't appeal. If yes, take the next step. Does your clinical documentation clearly describe the care the client received in your program? Be sure to include outreach to the client for no show appointments, coordination of services, etc.

- Copy the clinical chart and send it with an appeal letter.
- Clearly outline in your letter (using the payer's guidelines and terminology) why the client met the criteria for the services you are appealing. Refer to specific areas in the clinical chart to justify the level of care.
- Consider using FedEx or US Postal Service with return receipt to mail the letter, so you know it was delivered.
- Follow up: two weeks after sending the letter, call to follow up on the status of the appeal. Continue to call until you receive a determination.

Claim paid or denial upheld

What did you learn? What do you need to change to avoid denials in the future?

All agencies get denials, so don't feel bad. The key is to view this as a learning experience. Was the case upheld, because the information provided in writing did not match the information provided over the phone? Does documentation for detox indicate a client with normal vital signs and resting comfortably, thus not demonstrating in the clinical chart a need for that level of care?

Compliance

Contracts with third-party payers create a heightened attention to compliance with payer requirements. If your state licenses or certifies treatment providers, you already know the madated rules and regulations. Third-party payers have their own rules and regulations as well; ideally, they do not contradict state regulations.

Review the requirements before you sign a contract. The American Medical Association offers a guide on contracting with insurance companies:
http://www.ama-assn.org/ama1/pub/upload/mm/368/15questions.pdf

After you have a contract, set up a system to monitor compliance. You'll need to ensure that you are in continued compliance as an organization, as well as for each service you provide to an individual covered under that contract.

Since you probably already have a process to monitor compliance for state licensing/certification/ contracting, you will need to add the items mandated by your new contract(s) to the list of activities you monitor.

This is where quality assurance and utilization review become a stronger part of your standard operating procedure. Not only are you monitoring to ensure that records are kept according to regulation and that facilities meet standards. Now you need to add adherence to the payer's reimbursement rules.

- Are client services pre-authorized when necessary?
- Do services get reauthorized in a timely fashion?
- What is the rate of denial for reauthorization?
- What is the reason for denial?
- Are the clinicians assigned to a particular client approved by that client's payer?
- Are clinical notes kept up-to-date so that billing is done in a timely fashion? Are bills completed and submitted properly?
- What is the collection rate?
- What is the reason for non-payment?

New Tasks to Assign for Compliance

Utilization review

A person or group of people will need to be responsible for reviewing client records and ensuring that your agency is meeting standards. Establish a scheduled for reviews and a process for addressing issues that result from the reviews. Develop a utilization review checklist.

Claims review

Assign a person or a group to stay on top of staying on top of payment denials and the reasons for them. The information this person or team gathers will help you identify and address the most common reasons for denials. Payers often deny claims because treatment services were not authorized properly or were performed by a clinician without the required credentials. Other reasons include incorrect service codes or patient information.

Revenue Management

A person or group needs to monitor cash flow and collections. Accounting staff needs to meet with this the team regularly to examine and improve the processes related to revenue management.

Metrics

The metrics you monitor should cover financial, quality, customer outcomes and satisfaction, and employee performance measures. By measuring key areas and communicating the information with program staff, every program is able to develop quality improvement projects.

Contracting with a third-party payer will provide a powerful incentive to monitor customer satisfaction, access, retention, and outcomes. Third-party payers use these criteria to determine who are the best providers available for their members.

Performance criteria must be kept simple and clear. An individual or a committee should monitor the compliance indicators and generate benchmarks for performance improvement. The essential benchmarks focus on mistakes that cost money and mistakes that cost time.

For ideas on how to measure and improve quality, visit the NIATx Provider Tool Kit:
http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=16

Seeking Contracts for Your Services

Once you have the capacity to bill, contracts become the next big driver for growth in collections. Many managed care companies discourage their members from seeking services outside of the network. They may pay a lower rate to out-of-network providers, if they pay at all. Having contracts with selected payers will generate referrals and improve collections for your agency.

Steps in the process:

Step 1: Know the state requirements for operating your business and providing treatment services.

Step 2: Conduct a service coverage analysis. Who are the largest insurance organizations in your area? In some parts of the country, one insurance agency provides the bulk of coverage; in others there is more choice. Are they accepting new providers? Is there a service that they are low on that you could offer?

Step 3: What are the workforce requirements? Depending on the level of contracting, the third-party payer may look at individual providers or at the facility as a whole. The third-party payer may require that individual therapists be licensed for the state in which the client resides. Many agencies opt to contract as a facility, so their internal requirements and credentialing are the standards. Facility contracting is not limited to inpatient programs, but can also be used for day treatment, intensive outpatient and outpatient services (including e-services).

Third-party payers may have stricter education or experience requirements than those that the state mandates. Do you have the workforce with the certifications required to deliver the services you want to contract for? What changes can you make, either through getting credentials for existing staff or through changing hiring practices?

Another example is contracting services at a case rate. In this scenario, the client receives services for a set amount of money while they are in need of services. This means that the third-party payer would pay the same amount regardless of the number of treatment sessions the client attends.

Think big when contracting a the third-party payer. If you provide ambulatory detox at a site, does that also provide services meeting the criteria for day treatment? If a client did not meet the third-party payer's medical necessity criteria for ambulatory detox, could you get days authorized as day treatment while the client attended the services?

Step 4: Contact the third-party payers or managed care companies you have identified in this process. Ask for a benefits manager, provider relations representative, or a medical director. Ask about their philosophy, mission, and requirements for providers. Find out how you can get on their "panel."

Identify payers whose mission and reimbursement policies align with those of your organization. This will help you select the payers most likely to provide reimbursement with the least hassle. This exercise will also help you recognize where you must make internal changes to maximize reimbursement.

Step 5: Fill out the payer's application form. The payer may have specific requirements, but information requested may include:

- Description of your agency, its services, and treatment protocols
- Resumes for key staff highlighting their credentials
- Accreditation/licensing credentials (JCAHO and CARF often required)
- Insurance/malpractice information
- Admissions and discharge criteria
- Utilization review (UR) data
- Licensure
- Program description or calendar for daily events, evidence-based programs, variable lengths of stay

Providing 30-, 60-, and 90-day treatment outcome, access and retention data may also be useful.

Step 6: Site visit: the third-party payer may schedule a time to visit your organization during the application process. Assign an individual or an internal committee to manage the site visits. Internal awareness will contribute to a successful site review. Many third-party payers may request a copy of a chart, your policies and procedures, and your licensure review. Some will also call former clients after their discharge. Some may ask your state for the last audit of your program and any outcome studies. This may not be required if you are JCAHO or CARF accredited.

Step 7: The contract process centers on negotiating rates of service. Unfortunately, rate variations exist across and even within states. Your goal in negotiating rates is to have the insurance company or third-party payer buy all services at "normal rates." What does this mean? You want to have the rate cover the cost of providing the service plus a cushion or small profit. If you have never figured out the unit cost of service, you will have some calculating to do.

In some states Medicaid rates represent the base for reimbursement, while the higher rates set by certain large third-party payers become the ceiling. The person negotiating for your agency must be knowledgeable about services and rates and have the authority to agree or disagree with the third-party payer's rate range. It is easier to have agreement about common services than custom services.

Collection rates from third-party payers can vary significantly. A Massachusetts agency attributes its 98 percent collection rate to multi-year experience with third parties, strict processes in billing and collection procedures, and stringent internal rules on contracting with third parties. In contrast, the collection rate for an Illinois agency new to third-party billing was only 45 percent. For both agencies, negotiating the contract is just one aspect of the "contract impact."

Daniel Mumbauer, President and CEO of Highpoint Treatment Center in Massachusetts, describes how his agency works with insurance companies. Highpoint Treatment Center has used third-party billing successfully, with a 98% collection rate.

"The usual first step is a conversation with the insurance company's provider relations representative. This first contact is to uncover as much information as possible about how to become a preferred provider. If the representative is not helpful, request to speak with the "supervisor" (usually the Regional Medical Director). It is usually beneficial to have the conversation exchange between utilization review (UR) professionals in order to accomplish the appropriate "degree of control." The objective is to understand all of the written requirements, the parameters of in network/out of network, the application process, and any other pertinent information necessary in order to become a candidate for a contract. The application requirements will include information such as data available on covered lives served/turned down, basic organization, services, key personnel and their licenses and resumes, capacity, protocols, and program descriptions. The application process may take approximately four months from first contact. In some states accreditation organizations can facilitate the negotiation process."

Part IV: Taking It to the Next Level

Setting Goals

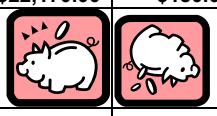
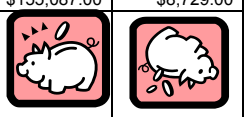
Set goals for the amount of revenue you want to generate through your contract with a third-party payer, and monitor you progress toward that goal each month. Let's say you set a goal for one of your programs to bring in $60,000 per year from a third-party payer. Your monthly revenue goal is $5,000. Within the first week of each month tabulate the expected revenue authorized from the previous month, the actual revenue received (you got check in hand), the variance for the month and for the year to date.

Utilization Management Report
Apr-06

SAMPLE OPERATION PAR - 727.499.2337

Projected Insurance Revenue for 2005-2006 based on Budget meetings.
* based on report from 5/01/06

Program	Detox	IOP
Projected Revenue - Yearly	$165,000.00	$29,000.00
Projected Revenue - Monthly	$13,750.00	$3,222.22

Estimated $ based on Precertification	$18,630.00	$120.00
$ due from client for copay	$3,540.00	$60.00
Total	$22,170.00	$180.00
Expected Revenue - MONTHLY		
Variance Monthly	$4,880.00	($3,102.22)
Expected Revenue - Yearly	$151,250.00	$35,444.42
Actual YTD revenue	$155,087.00	$8,729.00
		
Variance for Year to Date	$3,837.00	($26,715.42)

Operation PAR's "Piggy Report" shows program managers what progress they're making toward their revenue goals. The report provides exact numbers so managers can make adjustments to meet the goal.

Copays

Every service provider will eventually need to develop a clear and comprehensive fee policy that is sensitive to community norms. Many agencies discover that patients expect and are willing to pay for services. Most people do pay for services. Other agencies have discovered that concerns about copays drive patients away and that the organization is better off financially by not focusing on payment issues. Whatever the choice of your organization and be sure to convey a clear and consistent message.

If you are going to work on collecting patient payments, decide who will pursue those collections, and at what point. What happens when clients are not making payments during treatment? Who should initiate the discussion with the client? The clinician, the business office, or both?

Promising practices for collecting copays

CAB Health & Recovery Services in Peabody, Massachusetts increased collection of copay or self-pay fees from 40 percent to 90 percent by requiring clients to pick up a service sheet at the front desk, pay all co-fees, and update any insurance information when they entered the office. Then the client attended the scheduled service and provided the sheet to the clinician. The clinician verified that the client was in the right group, and verified attendance and service rendered by signing and returning the billing sheet to the billing supervisor. **http://www.niatx.net/toolkits/provider/cab-outpatient.pdf**

BestCare Treatment Services in Redmond, Oregon decreased the no-show rate for the initial intake appointment from approximately 40 percent to 25 percent in two different offices by waiving the fee for the initial intake appointment after learning that clients were not signing up for intake on the night of the orientation due to lack of money. The number of clients who scheduled intake appointments during orientation increased by 30 percent in the Bend office, and by 18 percent in the Redmond office. BestCare forecasts an additional 60 percent in revenue in the outpatient program from clients who come for a free initial intake appointment and continue in treatment. For further information, see BestCare's success story. **http://www.niatx.net/toolkits/provider/bestcare.pdf**

Genesis Behavioral Health in West Bend, Wisconsin increased copay collections from 45 percent to 92 percent and increased revenue from a budget deficit of $13,000 in the first quarter of the year to a budget surplus of $11,882 in the third quarter of the year by creating a tracking form to make it easier for counselors to track and collect copayments. Counselors met clients at the front desk with the tracking form to ensure that copayments were collected prior to the beginning of the session, instead of waiting until the end of the session. This change also increased continuation in treatment because they no longer were suspending clients because they didn't pay.

Billing as Part of Electronic Health Records

Electronic health records are coming to American medicine, in part because the government is offering incentives for adopting them. Billing can be part of such a system. This section will help you consider the value of an electronic system at your agency.

Frequently Used Terms

Electronic Medical Record (EMR): an individual's electronic record of health-related information. Authorized staff and clinicians within one health care organization can use the information.

Electronic Health Record (EHR): an individual's electronic record of health-related information in a form that meets national standards for interoperability. Authorized staff and clinicians from more than one health care organization can use the information.

Electronic Behavioral Health Record (EbHR): Just the same as the EHR (above), but for behavioral health information.

Electronic Practice Management (EPM): the part of the electronic health system that contains financial, demographic, and other non-medical information. Other terms used for this information include Enterprise Management System and Practice Management System.

Health Information Exchange (HIE): an electronic place for health care information from organizations within a community or region.

Health Information Technology (HIT): using computer hardware and software to store, retrieve, share, and use health care information to communicate and make decisions.

Interoperability: The ability of software and hardware on multiple pieces of equipment made by different companies to communicate and work together.

We'll use the term EHR in this section of the guide.

Financial benefits and costs of EHRs

Before investing in an EHR, ask yourself if the benefits you expect will exceed the costs you will incur. This section gives you a few billing-specific benefits and costs to consider.

To begin, ask system vendors to give you evidence about the improvements their system will produce. Ask for specifics—the setting, metrics, data collection, time horizon, analysis, and so on—so you can compare these improvements to what might be possible in your specific situation.

Financial benefits

EHRs produce savings mainly in administrative or business operations (billing) rather than in clinical operations (e.g., diagnosing, prescribing). For example, EHR vendors cite benefits such as fewer chart pulls; lower new-chart creation costs; reduced filing time, support staff, and transcription costs; and improved accounts receivable. The dominance of business and administrative benefits can pose a challenge in gaining support for a new system from clinicians—and their support is essential to the success of an EHR.

For billing, EHRs can increase coding accuracy and the number of services billed per client visit and make accounts receivable a more visible part of the agency. EHRs may also reduce:

- The accounts receivable period (the time between the service being delivered and the bill being paid)
- Bad-debt write off
- Billing overhead
- The cash cycle period (the time between the service being delivered and the money received being paid to staff)
- Claim correction time
- Claim denial rate
- Coding time per client

How do EHRs actually produce these benefits? The answer: task re-allocation, automation, health information exchange (HIE), and interoperability. Most EHRs shift the responsibility of assigning codes from billing and coding staff to clinicians. Coding takes place during the client visit as the clinician enters information into the EHR rather than afterward. EHRs usually ease this process by offering drop-down menus that list illnesses, treatments, and prescriptions. The EHR assigns, stores, and transmits the appropriate diagnosis and treatment codes required for billing. This automation essentially eliminates the need for support staff to wade through paper charts to identify billable activity.

After a service has been rendered and coded, an agency may bill for the service the same day. Billing staff normally review the data entry and coding done by the clinician and in the EHR to confirm accuracy and then submit an electronic request for payment to the appropriate third-party payer through a secure health information exchange. Interoperability standards are important to the functioning of health information exchanges because the standards ensure that separate, standalone health information systems work together.

As clinicians document services rendered and support staff submit payment requests, the EHR's business module automatically generates and organizes revenue information. Various stakeholders may then review and use this information for different activities, such as managing accounts receivable and cash flow and improving the revenue cycle. Most EHRs make it easy to create customized business and clinical reports that capture key performance indicators (KPI). For example, the single click of a mouse may show outstanding payment requests or denied claims, or calculate average accounts receivable. This feature of EHRs reduces or sometimes eliminates the costly task in paper-based systems of collecting, formatting, and presenting financial performance data.

Financial costs

The high cost of electronic health records presents the primary barrier to entry for most health care providers. You will want to figure out these costs, as well as when they will be incurred. The timing of the cost will influence your cost-benefit analysis and how you budget for the expense. The following list shows the main categories of expenses and examples of each.

- Hardware: personal computers (desktops, laptops, tablets), imaging (monitors, printers, scanners), servers (database, Citrix), security (high-capacity tape drives)

- Software: licenses (vendor, third party), server operating system licenses, electronic claims submission, integration (EHR & EPM), back-up software system/network monitoring software, integration with general ledger, virus protection, communication (e.g., MS Office, MS Outlook), firewall, upgrades

- Infrastructure and property: furniture (desks, chairs), office wiring (data, power), data center (closet, ventilation, power, uninterruptable power supply, racks), networking equipment (routers, switches), wide area connections to remote sites, back-up connections (DSL, cable), Internet connections

- Services: customization, training and re-training of current and future staff), user support, maintenance contracts, internal help desk (software supported), insurance

- Implementation labor: deciding, learning, analyzing, selecting, readying, planning, managing, designing, customizing, installing, testing, training, educating, supporting, upgrading, maintaining, certifying, improving

- IT labor: chief information officer (CIO), help desk support, EHR/EPM system analyst, PC/desktop support, network support, database administrator, report programmer

- Revenue loss: decrease in revenue incurred during implementation, when staff productivity dips

Non-financial benefits and costs

In addition to finances, EHRs also affect workflow and stakeholders. Understanding and addressing these "soft" issues is vital to the successful use of an EHR. If these issues are not addressed, agencies may experience staff resistance or exodus.

Workflow

The ingredients of workflow include: events (tasks, decisions, phases), resources (labor, documents, technology), relationships (sequencing), and information. Implementing an EHR standardizes workflows. Standardization, or conforming to a norm, reduces workflow variation and errors by forcing the way things get done and who does them. In the context of billing, the EHR will determine who participates in the billing process; what decisions must be made and information collected during the billing process; and how and when the billing process starts and ends. Put another way, the EHR ensures that your agency bills the same way—always. This seems to be a positive change. But what if the way the EHR bills differs from the way you currently bill? Be sure to consider this last point thoroughly before you select an EHR.

To avoid selecting an EHR that staff will resist, choose one that best aligns with your agency's "ideal" workflows. An ideal workflow is how something should get done, not how something currently gets done. By defining ideal workflows, you'll improve the chance of making a successful EHR investment and, at the same time, reveal how much adaptation will be required from staff and by customizing the EHR. Small gaps between ideal and current workflows and an ideal versus actual EHR will require less adaptation, which leads to greater acceptance and lower implementation costs. The assessment tool that follows presents a framework for defining ideal, current, and EHR-based workflows.

People

The staff of your agency determines the quality of care delivered to clients. This makes it critical to involve staff in selecting an EMR and address upfront the significant changes that will be required. For example, EHRs typically change how clinicians identify, frame, and solve problems; how clinicians diagnosis and treat illness; and how internal and external stakeholders communicate and coordinate activities. These differences result from how an EHR collects and shares information.

The job security of some staff may also be affected by adopting an EMR, constituting another consideration to weigh. Automated coding and electronic payment requests reduce the time required to bill payers. Oakwood Clinical Associates of Kenosha, Wisconsin, reported a 75 percent reduction in the time spent on billing. While the benefits of this reduction are clear, your staff may ask: "Will the EHR eliminate my job?" Address this question early. Otherwise fear and uncertainty will evolve into resistance and jeopardize your implementation strategy. To reinforce this point, consider the following quote by Peter Drucker: "Culture eats strategy for breakfast."

Assessment: Defining Current, Ideal, and EHR-based Processes

Complete the exercises sequentially with a multi-disciplinary team composed of internal and external (if possible) stakeholders. Exercise III must be done with the EHR vendor.

Exercise I—Current Billing Process: Start by asking the question, "What different billing processes exist within our agency today?" Next, apply the following questions to each separate billing process:

1. What is the objective or outcome of this process?
2. What event starts this process?
3. What event ends this process?
4. Who are the internal stakeholders of this process?
5. Who are the external stakeholders of this process?
6. What inputs does each stakeholder provide during this process?
7. What outputs does each stakeholder collect during this process?
8. How do we measure the performance of this process?
9. What problems or errors does this process encounter consistently?

Exercise II—Ideal Billing Process: Start by asking the question, "What different billing processes would we prefer within our agency?" Next, apply the following questions to each separate billing process:

1. What is the preferred objective or outcome of this process?
2. What event would we prefer start this process?
3. What event would we prefer end this process?
4. Who would we prefer as internal stakeholders of this process?
5. Who would we prefer as external stakeholders of this process?
6. What inputs would we prefer each stakeholder provide during this process?
7. What outputs would we prefer each stakeholder collect during this process?
8. How would we prefer to measure the performance of this process?
9. What problems would this process encounter consistently?

Exercise III EHR—Billing Process: Start by asking the question, "What different billing processes does this EHR offer?" Next, apply the following questions to each separate billing process:

1. What is the objective or outcome of this EHR-based process?
2. What event starts this EHR-based process?
3. What event ends this EHR-based process?
4. Who are the internal stakeholders of this EHR-based process?
5. Who are the external stakeholders of this EHR-based process?
6. What inputs does each stakeholder provide during this EHR-based process?
7. What outputs does each stakeholder collect during this EHR-based process?
8. How can we measure the performance of this EHR-based process?
9. What problems or errors will this EHR-based process encounter consistently?

Conclusion

NIATx developed the NIATx Third-party Billing Guide to help substance abuse treatment providers prepare for the changes that health care reform and parity legislation will bring. Because every treatment agency is unique, you will develop a system for billing third-party payers that's tailored to your needs. We hope that you find this guide helpful and welcome your feedback. Please send comments and suggestions to: **maureen.fitzgerald@chess.wisc.edu**

About NIATx

NIATx helps payers and behavioral health care providers remove barriers to treatment and recovery. We serve people facing the challenges of addiction and/or mental health disorders by making improvements to the cost and effectiveness of the care delivery system. The simple and easy to use process improvement model we developed specifically for behavioral health care allows payers and providers to make small changes that have a significant impact on outcomes.

As a learning collaborative within the University of Wisconsin-Madison's Center for Health Enhancement Systems Studies, we provide research, promising practices, and innovative tools that encourage and support the use of the NIATx model.

About the ACTION II Campaign

The ACTION II Campaign is a NIATx initiative focused on helping behavioral healthcare organizations improve services, reduce costs, and increase revenue. The campaign provides online toolkits, twice-monthly webinars, and peer networking to help you implement quick and effective solutions to your business problems. All Campaign materials and services are free to participants. The Campaign is possible through generous support from the Robert Wood Johnson Foundation, the Substance Abuse and Mental Health Services Association (SAMHSA), the California Endowment, and Magellan Health Services.

Glossary

Accounts payable: money a company owes to its creditors

Accounts receivable: money that a client owes you

Accrual-based accounting: the most commonly used accounting method, which reports income when earned and expenses when incurred (**investorWords.com**)

Aging schedule: a list of accounts receivable broken down by the number of days until due or past due. **(investorWords.com)**

Balance sheet: a statement of the assets, liabilities, and capital of a business or other organization at a particular point in time, detailing the balance of income and expenditure over the preceding period *(New Oxford American Dictionary)*

Block grant: a grant from a central government that a local authority can allocate to a wide range of services *(New Oxford American Dictionary)*

Copay: a payment owed by the person insured at the time a covered service is rendered. *(New Oxford American Dictionary)*

Contractual allowance: The difference between what an insurance company approves according to their contract and what the health care provider charges for the procedure. If the provider is under contract to accept the patient's insurance plan, the patient is generally not responsible for this difference. A contractual allowance shows up on a billing statement as an adjustment required and decreases the balance.

CPT® Codes (Current Procedural Terminology): Current Procedural Terminology codes, also known as CPT® Codes, is a set of five-digit codes used to describe the medical, surgical and diagnostic services done. CPT codes allow physicians, patients, counsel, insurance companies and others to communicate effectively throughout the U.S.

Deductible: a specified amount of money that the insured must pay before an insurance company will pay a claim *(New Oxford American Dictionary)*

Explanation of Benefits (EOB): A statement sent from the health insurance company to a member listing services that were billed by a health care provider, how those charges were processed, and the total amount of patient responsibility for the claim. (**http://www.ehealthinsurance.com/ehi/sitesearch.ds?q=glossary&sa=)**

Fee-for-service: providers are paid a specified amount for each service provided

Generally Accepted Accounting Principles (GAAP): A collection of rules and procedures and conventions that define accepted accounting practices. Organizations typically use GAAP when setting up a billing system.

Managed care: Managed care plans are health insurance plans that contract with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network. How much of your care the plan will pay for depends on the network's rules. Restrictive plans generally cost you less. More flexible plans cost more. There are three types of managed care plans:

- Health Maintenance Organizations (HMO) usually only pay for care within the network. You choose a primary care doctor who coordinates most of your care.
- Preferred Provider Organizations (PPO) usually pay more if you get care within the network, but they still pay a portion if you go outside.
- Point of Service (POS) plans let you choose between an HMO or a PPO each time you need care.

(Source: **http://www.nlm.nih.gov/medlineplus/managedcare.html)**

Out-of network provider: a provider or facility that does not have a contract with the patient's insurance company

Prior authorization: A cost containment measure that provides full payment of health benefits only if the hospitalization or medical treatment has been approved in advance. Sometimes called pre-authorization or prior approval

Third-party payer: an organization other than the patient (first party) or health care provider (second party) involved in the financing of personal health services. **(http://medical-dictionary.thefreedictionary.com)**

Utilization management: a set of techniques used by or on behalf of purchasers of health care benefits to manage the cost of health care before its provision by influencing patient-care decision making through case-by-case assessments of the appropriateness of care based on accepted practices. **(http://medical-dictionary.thefreedictionary.com)**

Utilization review: a review of the necessity, use, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities.

Appendix

Sample forms
Billing policy and financial agreement
Daily charges
Fee schedule
HMO benefits maxed
Insurance authorization tracking worksheet
Insurance verification form

Case Study
Life cycle of a bill at SSTAR

Useful resources
American Medical Association:
http://www.ama-assn.org/ama1/pub/upload/mm/368/15questions.pdf

The American Medical Billing Association: **http://www.ambanet.net/AMBA.htm**

Healthcare Billing & Management Association: **http://www.hbma.org/**

Health Insurance Portability & accountability Act/ Mental Health and Substance Abuse Procedure Codes:
http://hipaa.samhsa.gov/hipaacodes2.htm

Medical Association of Billers: **http://www.e-medbill.com/**

National Uniform Claim Committee:
http://nucc.org/images/stories/PDF/claim_form_manual_v5-0_7-09.pdf

The NIATx Provider Toolkit: **http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=16**

United Behavioral Health Level of Care Guidelines:
https://www.ubhonline.com/html/guidelines/levelOfCareGuidelines/index.html

Client Name: _____

Date: _____

Billing Policy & Financial Agreement

FEE SCHEDULE:

Outpatient Services	MD	Therapists
Court Evaluation	N/A	$300-$400
Initial Evaluation (1 hour)	$300	$175-$300
Medication Check (15 min)	$90	N/A
Individual Sessions (1/2 hour - 1 1/2 hours)	$150-$250	$70-$250
Family Sessions (1 hour)	N/A	$175-$250
Group Sessions (1 hour - 1 1/2 hours)	N/A	$70-$90

- A 10% discount will be given to all self-pay clients who pay in full on the date of service. All fees for dates of service not paid the same day will be billed out at the regular rate.
- A 10% discount will be given to all self-pay clients who have a credit card agreement on file to pay the balance in full every month, please contact the billing department for more information.

CANCELLATION/NO-SHOW POLICY FOR PSYCHIATRISTS AND THERAPISTS:
Provider requires all clients to give a 24-hour business day notice should they need to cancel or reschedule to avoid charges. If you do not give a 24-hour business day notice to cancel an appointment or simply do not show up for an appointment, you will be billed at the full session fee starting with the first missed appointment. All no-show/late-cancel fees need to be paid on or before the next scheduled appointment. Please keep in mind failure to follow the above policy may compromise services at Provider. Late-cancel/no-show fees cannot be billed to insurance.

_____
Initials

RETURN CHECK POLICY:
Checks returned for insufficient funds will be charged to you at $ 50.00 plus any additional bank charges.

FINANCIAL INFORMATION:
How will you be paying for services? ❑ Insurance ❑ Cash/Check ❑ Credit Card ❑ Fee For Service

Sample Daily Charges Form

Therapist: Joe Smith **Page 1 of** _____

Day of Week: Tuesday **Date:** 5/18/10

#	APPT TIME	NAME (Last, First)	DX Code (if new/changed)	CPT Code	Charge (if not standard)	X (if pd same day)
1	4	Doe, Jane		90806		
2	6	Doe, John		99949-LC	No Charge	
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

CPT Codes

90801=Initial Evaluation
90804=25-30 min therapy
90805=25-30 min med ck w/ therapy
90806=45-50 min therapy
90807=45-50 min med ck w/ therapy
90808=75-80 min therapy
90809=75-80 min ck w/ therapy
90846=family therapy w/o patient
90847=family therapy w/patient
90853=group (please indicate minutes after CPT code)
99949=no show/late cancel
***99998=miscellaneous - how many units=$10 per unit/10% discount not given,**
***note 99998 can be used for court evals**

Special Billing Instructions:

Sample Fee Schedule

Psychiatrist	CPT Code	Time	Full Price	10% discount
Initial Evaluation	90801	60 minutes	$300.00	$270.00
Medication Check	90862	15 minutes	$90.00	$81.00
Psychotherapy w/ Medication Review	90805	20-30 minutes	$150.00	$135.00
Psych w/ Med Review	90807	45-50 minutes	$200.00	$180.00
Psych w/ Med Review	90809	75-80 minutes	$250.00	$225.00

Therapists	CPT Code	Time	Level I	Level II	Level III	10% discount
Initial Evaluation	90801	60 min	$250.00	$200.00	$175.00	**$225.00/ 180.00 157.50**
Psychotherapy	90804	20-30 min	$100.00	$80.00	$70.00	**$90/72.00/ 63.00**
Psychotherapy	90806	45-50 min	$200.00	$150.00	$130.00	**$180/135.00/ 117.00**
Psychotherapy	90808	75-80 min	$250.00	$210.00	$180.00	**$225.00/ 189.00/ 162.00**
Group Therapy	90853	60 min		$70.00		**$63.00**
Group Therapy	90853	90 min		$90.00		**$81.00**
Family Therapy	w/client: 90847 w/o:90846	60 min	$250.00	$200.00	$175.00	**$225.00/ 180.00 157.50**
Court Evaluation	-----	variable	$300.00	$300.00	$250.00	**$270.00/ 270.00/ 225.00**

10% Discount

A 10% discount will be given to self-pay clients who pay in full on the date of service. Also a 10% discount will be given to self-pay clients who have credit card on file with the accounts manager and the entire balance is paid in full at the end of every month.

Payment Plans

All payment plans need to be set up with the accounts manager.

Late-Cancel/No-Show Appointment Policy

All appointment cancellations require a 24-hour notice. Late-cancel/No-show fees are billed at the full session price and are to be paid on or before your next scheduled appointment.

COMPANY LOGO

Date: _____

Client Name: _____

DOB: _____

Re: HMO Benefits Maxed – 2009-2010 Plan Year or 2010 Calendar Year

Type of Benefit: ____ Plan Year Benefit, Plan Year Dates: _____
____ Calendar Year Benefit
____ $2700 – one time Transitional Benefit

Benefits Max: ____ 20 visits (1 individual session = 1 visit, 1 group session =.5 visit)
____ $1800 per plan or calendar year
____ Other _____

This letter is to inform you that as of _____ our records indicate
(Date)

you are on/at _____of your Mental Health/Substance
(Visit Number or Dollar Amount)

Abuse Insurance Benefits with (this) HMO. This means that the maximum allowed amount has been met or is close to being met. As most insurance companies follow a calendar year benefit period, some do follow a plan year benefit period.

As a clinic we are committed to continue to provide services taking into account financial concerns. Please follow up with your primary therapist as to how this may affect your treatment plan.

Please call our billing department to discuss payment options, 000-0000 ext. 000

Thank you for your cooperation.

Sincerely,

Office Manager
CC:

(COMPANY LOGO) Insurance Authorization Tracking Sheet

Client Name: _____ DOB: _____

Date: _____ Primary Therapist: _____

Other Therapists Involved: _____

Insurance: _____ Visit Limit/Max Benefit Paid: _____

Visits Authorized: _____ Authorization Dates: _____

Visits Used Elsewhere/$ Amount Used Elsewhere: _____

Date Visits Maxed for Calendar Year/Plan Year: _____

Date Maxed Letter Sent: _____

Visit#	Date	Txpist	CPT code	Charge	Actual#/$	Notes:
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
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28						
29						
30						
31						

SAMPLE INSURANCE VERIFICATION FORM

Client Name _____ Chart # _____

Soc Sec # _____

Insurance Co. Name: _____

Phone: _____ Name of Contact: _____ Date: _____

Policy # / RID: _____ Employer: _____

Policy Holder Name, if not self: _____ Policy Holder DOB: _____

Policy Holder Social Security # _____: Policy Holder Relation to Patient: Self Spouse Parent Child Other

****

OUTPATIENT SUBSTANCE ABUSE/MENTAL HEALTH BENEFITS

Effective Date of Policy: _____

Does patient have a deductible?: Yes No If Yes, what amount $: _____ Per: _____ Has it been met? Yes No

Maximum number of sessions allowed: Per Year: _____ Per Lifetime: _____

If there is a maximum number of sessions allowed, how many have been used so far this benefit period? _____

Is there a maximum amt of $ per calendar Yr that the Ins co. will pay: _____ Has the client used this maximum amount? Yes No

Does the client have a co-Pay or co-Insurance or any other out-of-pocket expenses with this insurance company: Yes No

If yes, what is it, and what is the amount?: _____

_____

Primary Care Physician: _____ Telephone: _____

Address: _____

AUTHORIZATIONS

Intake Individual Group Psych Dates covered: _____ # of Sessions: _____

Auth number _____

Intake Individual Group Psych Dates covered: _____ # of Sessions: _____

Auth number _____

Intake Individual Group Psych Dates covered: _____ # of Sessions: _____

Auth number _____

Insurance Claims Submission Address: _____

_____

_____

Secondary Insurance Name, If any: _____

Policy # RID: _____ Employer/Group: _____

Policy Holder, IF different from Clients name: _____

The Life Cycle of a Bill at SSTAR

Stanley Street Treatment and Resources (SSTAR) is a non-profit health care and social service agency that provides a wide range of mental health and substance abuse treatment services to people throughout the communities of Southeastern Massachusetts and Rhode Island. SSTAR accepts Medicare, Medicaid, and most third-party insurance plans.

Intake
SSTAR staff complete 90 percent of the intake process over the phone, asking a series of questions that include: name, type of addiction, contact and insurance information, and whether or not the caller has been a client before. This information is entered into the agency database, called "Hill." The person doing the intake also check's the clients insurance information against the state's Department of Health and Human Services database, which is available to contracted providers such as SSTAR.

If this is a client's first appointment, we enter the service we expect to provide into the database. The service appears as an asterisked item on the documentation used for billing ("Superbill").

"Clinician not billable by pay source" is one of the primary reasons third-party payers reject payment requests. To minimize billing/collection problems, we schedule clients with a clinician whose credentials match the third-party payer's requirements.

First-time clients and those returning after their case had previously been closed are scheduled for an orientation. The orientation has several objectives, one of which is to fill out the various releases required by the state.

Insurance Verification
Our intake staff shares office space with the individual doing insurance verification. This facilitates a free exchange of information during the early stages of client contact, and minimizes billing errors.
Our insurance verification process consists of:

- Checking the client's eligibility on the insurance company's database
- Determining the number of sessions authorized, the number of sessions used, and the number of sessions available
- Establishing the client's policy number
- Reviewing the client's service type coverage
- Obtaining the initial authorizations from the insurance company

This process allows us to identify problems that may result in denial of payment. If a problem is uncovered, even a minor one, we phone the insurance company to resolve it.

Client Appointment
We create and introduce the "Superbill" to a client's file when we schedule them for an appointment. Our Superbill is a pink, multi-copy, one–page document that contains all of the information needed to bill the payer. It is populated using data previously entered into the agency database and holds the client's information as well as clinician information. It also outlines a client's ability or inability to pay the copay or deductible cost.

Although scheduled services are pre-populated and marked with an asterisk, the Superbill also includes a checklist of all the services we offer. This allows the clinician to check items off as needed. After the session, the clinician "checks" the services provided. These services should match the automated asterisk

next to the anticipated services for the session. The clinician can check a service other than the one asterisked, but this change must be accounted for on the Superbill. The clinician also notes the next scheduled appointment. The clinician places the Superbill in a bin where a clerical staff person retrieves it. That person then enters service information into Hill and follow-up appointments into Outlook, our scheduling software.

At this point, an administrator reviews the Superbill in Hill. That person corrects any service changes, no shows, or cancelled appointments, and "renders" the transaction. Rendering is the software vendor's terminology for allowing the agency to invoice the payer. The software pulls our standard or usual dollar value for that service from a master list (labeled "usual") and prints it alongside the payer's standard payment for that service (labeled "expected").

As an additional check to minimize errors on the Superbill, we print a monthly productivity report for each clinician. Our clinicians then verify that the service rendered in the report was the service provided to the client.

Open the Chart

Once we have rendered a transaction, we "open the chart." Opening a chart is the way we gather and separate all of the paperwork we have generated. We literally arrange them in a three-hole binder labeled with the client's name and intake identification number. The chart includes:

- All releases and consent forms
- Substance Abuse clients include a "Medicaid Reimbursable" form
- Intake sheet
- Insurance sheet
- Picture ID
- Superbill
- "Virtual Gateway" documentation (The State web portal requires that information be re-entered on-line)

We enter the clinical record into a separate database called "SATIS," the Electronic Health Record. Clerical and/or intake staff enters intake and demographic information, while providers enter all of their clinical notes. The record includes the clinician's name, the diagnosis, the date of service, whether domestic violence was involved, and the referral source.

Billing

Once we have done all of our checks for errors and rendered the Superbill, we can bill the third-party payer. At this point, the billing clerk runs a report that checks for fatal errors and potentially problematic invoices, by insurance company. We cannot bill third-party payers until all errors are fixed. Primary invoice problems include:

- Previously approved authorization is missing
- Clinician is not billable by the pay source
- Other missing documentation

Some third-party payers allow electronic billing. To accomplish this, the clerk runs a "billing schedule" which batches all claims ready to be billed, both inpatient and outpatient, by insurance company. We transfer this to a disc that is loaded onto the insurance company's website. The website supplies a confirmation of receipt. Approximately 70 percent of our billing is electronic. The remaining 30 percent of payers have no electronic data interchange. We bill these payers by paper.

Date_____

Date_____