Welcome

Fee-for-Service, Level I

January 2012

Project Funded by CSAT

Reduce Waiting Times & No-shows • Increase Admissions & Continuation

Overview

What to expect in the next two days?

Housekeeping

Information to assist you with your comfort

Geography is destiny……..

Why here?

Why now?

How does geography change your billing destiny?

*Pair up and **share your expectations for the workshop**. **Add a wild prediction** of the best possible outcome for the collaborative should your expectations be met.*

Current State

The Change Process

Desired Future

1. Your Name/Organization/Role
2. If the bike represents your organization's current "change process", what part of the bike are you?

Health Care Reform

Leading Change: A Plan for **Substance Abuse and Mental Health Services Administration (SAMHSA)** Roles and Actions 2011 - 2014

Behavioral health is an essential part of health. Individuals and families cannot be healthy without positive mental health and freedom from addictions and abuse of substances. Behavioral health, prevention and treatment services are important parts of health service systems and community-wide strategies that work to improve health status

SAMHSA Strategic Initiatives

- *Prevention of Substance Abuse and Mental Illness*
- *Trauma and Justice*
- *Military Families*
- *Recovery Support*
- *Health Reform*
- *Health Information Technology*
- *Data, Outcomes and Quality*
- *Public Awareness and Support*

www.samhsa.gov

SAMHSA Definition of Behavioral Health

- State of mental/emotional being and or choices and actions that affect wellness
- Includes substance use, misuse, alcohol and drug addiction, serious psychological distress, suicide mental and substance use disorders
- Range of problems from unhealthy stress to diagnosable chronic disease treatment and recovery oriented
- Systems: promotion of emotional health, prevention of mental and substance use disorders, treatment and recovery support

Drivers of Health Care Reform

- Greater attention to preventing illness and promoting wellness
- Primary focus is on the prevention of **Chronic Illnesses**
- Increased access to care
- Increased focus on the coordination/integration of services between primary care and specialty services
- Increased focus on quality and outcomes
- Increased provider accountability
- Greater emphasis on home and community based services and less reliance on institutional care

(Adapted from SAMHSA, John O'Brien)

Aims of Health Care Reform

- Increase the number of individuals that have health insurance
- Increase accountability through the expansion of primary care, medical homes and accountable care organizations and financing structures
- Increase access to preventive services to improve health outcomes

Aims of Health Care Reform (cont.)

- Expanded Populations
  - Newly Medicaid Eligible--133% of the Federal Poverty Level (FPL)
  - Health Insurance Exchange Participants--Individuals and Families at or below 400% of the FPL

Implications of Health Care Reform

- Buy what is good and modern
- Focus on coordination between primary care and specialty care:
  - Significant enhancements to primary care
    - Workforce enhancements
    - Increased funding for Federally Qualified Health Centers
  - Bi-directional
    - MH/SUD in primary care
    - Primary care in MH/SUD settings

Implications of Health Care Reform (cont.)

- More Incentives to identify MH/SUD
  - SBIRT—huge focus by SAMHSA and HRSA
  - Coverable service—enhanced Medicaid match
- More payment strategies
- Payment on successful episode of care

Parity and Affordable Care Act

- Affordable Care Act includes Behavioral Health as an essential benefit
- Parity legislation requires coverage same as physical health coverage

How Does Behavioral Health Fit?

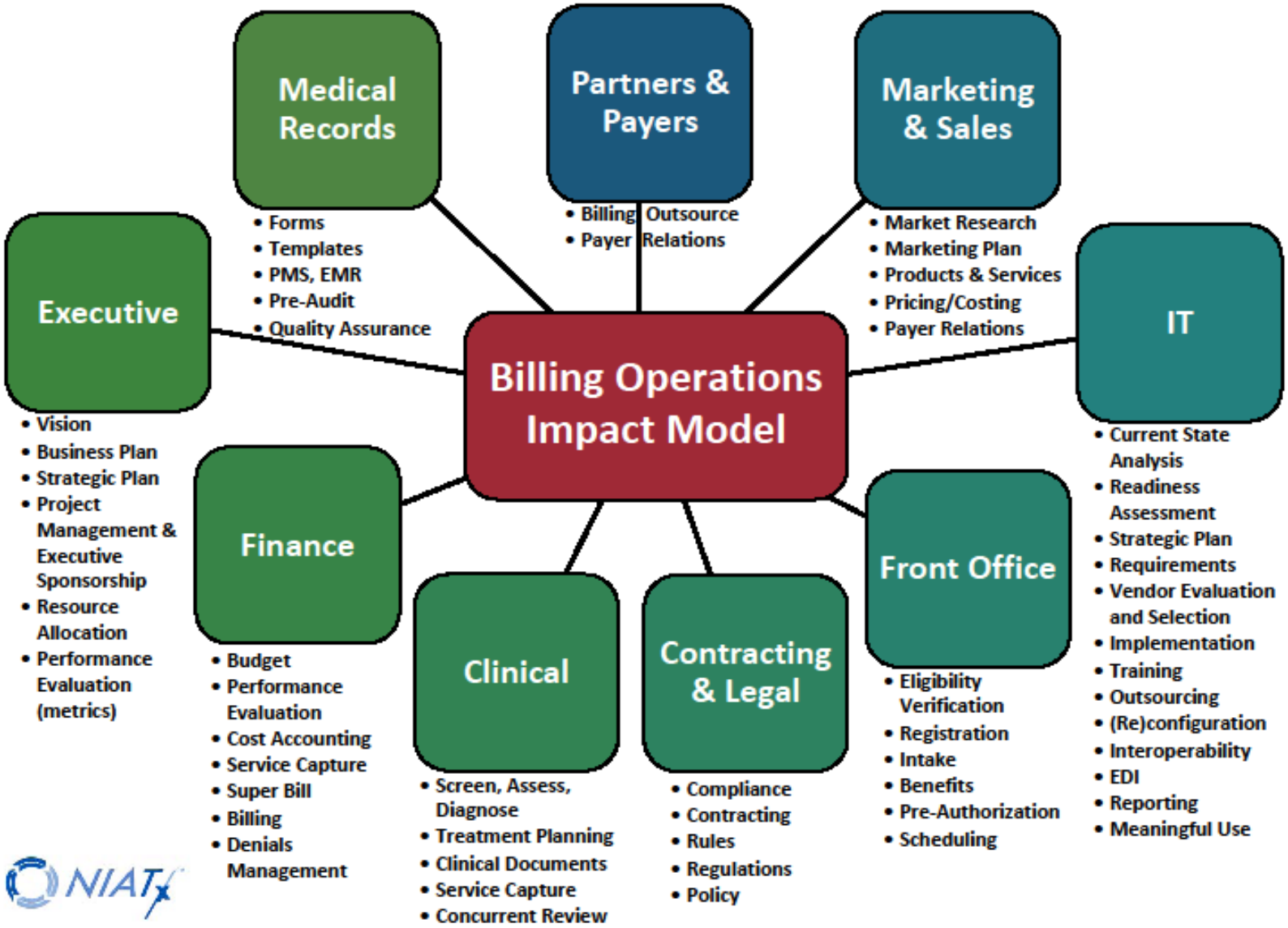
- Become valuable partners with primary care or become one themselves
- **Establish your niche**
- Demonstrate value to insurers, medical providers and others
- Rapid effective access!
- Super Easy to work with!

Opportunities

- Opportunity to broaden your financial base
- Opportunity to have good data to fine tune and improve care
- Opportunity to partner with primary medical care and improve overall health of your target groups
- Opportunity to form new alliances and establish community supports for what you do
- Opportunity to invest in prevention


So What Does Health Care
Look Like in ??

Iowa FFS – 10:45


Billing Operations Impact Model
Medical Records
• Forms
• Templates
• PMS, EMR
• Pre-Audit
• Quality Assurance
Partners & Payers
• Billing Outsource
• Payer Relations
Marketing & Sales
• Market Research
• Marketing Plan
• Products & Services
• Pricing/Costing
• Payer Relations
Executive
• Vision
• Business Plan
• Strategic Plan
• Project Management & Executive Sponsorship
• Resource Allocation
• Performance Evaluation (metrics)
IT
• Current State Analysis
• Readiness Assessment
• Strategic Plan
• Requirements
• Vendor Evaluation and Selection
• Implementation
• Training
• Outsourcing
• (Re)configuration
• Interoperability
• EDI
• Reporting
• Meaningful Use
Finance
• Budget
• Performance Evaluation
• Cost Accounting
• Service Capture
• Super Bill
• Billing
• Denials Management
Clinical
• Screen, Assess, Diagnose
• Treatment Planning
• Clinical Documents
• Service Capture
• Concurrent Review
Contracting & Legal
• Compliance
• Contracting
• Rules
• Regulations
• Policy
Front Office
• Eligibility Verification
• Registration
• Intake
• Benefits
• Pre-Authorization
• Scheduling
NIATx

Fee-For-Service * Deeper Dive

We will cover the following:

Executive

Vision, Business Plan, Resource Allocation, Metrics

Financial

Budget, Performance Measures, Service Capture Level II Creating a Super Bill, Denial Management

Clinical

Screen, Assess, Diagnosis,Treatment Planning, Clinical Documents,Service Capture,

Contracting

Compliance, Rules and Regulations

Front Office

Eligibility Verification, Registration, Intake Benefits, Pre-authorization, Scheduling

Law of Supply and Demand

Unlike some business
models there are plenty
of customers and lots of demand

Thinking About Your Business

Where does the revenue come from?

Do you provide easy access to services?

What do you do better than your competition?

What do you need to improve?

Patient Flow

- Billing starts with your first interaction with the patient and ends when all possible payments have been posted and any balance has been written off.

- Everybody in the organization plays a role.

Gervean Williams, National Association of Community Health Centers

NIATx Key Principles

1. **Understand and involve the customer**
2. Focus on key problems that keep the CEO awake
3. Pick a powerful Change Leader
4. Get ideas from outside the organization or field
5. Use rapid-cycle testing

Iowa Fee for Service Aims

1. **Decrease 3rd party denial rates**
2. **Decrease service to payment processing time**
3. **Increase co-pay and deductible collections**
4. **Other ideas**
    1. **Establish billing policy and procedures**
    2. **Increase billable service time**
    3. **Increase staff expertise**

The NIATx Third Party Billing Guide

Reduce Waiting Times & No-shows • Increase Admissions & Continuation

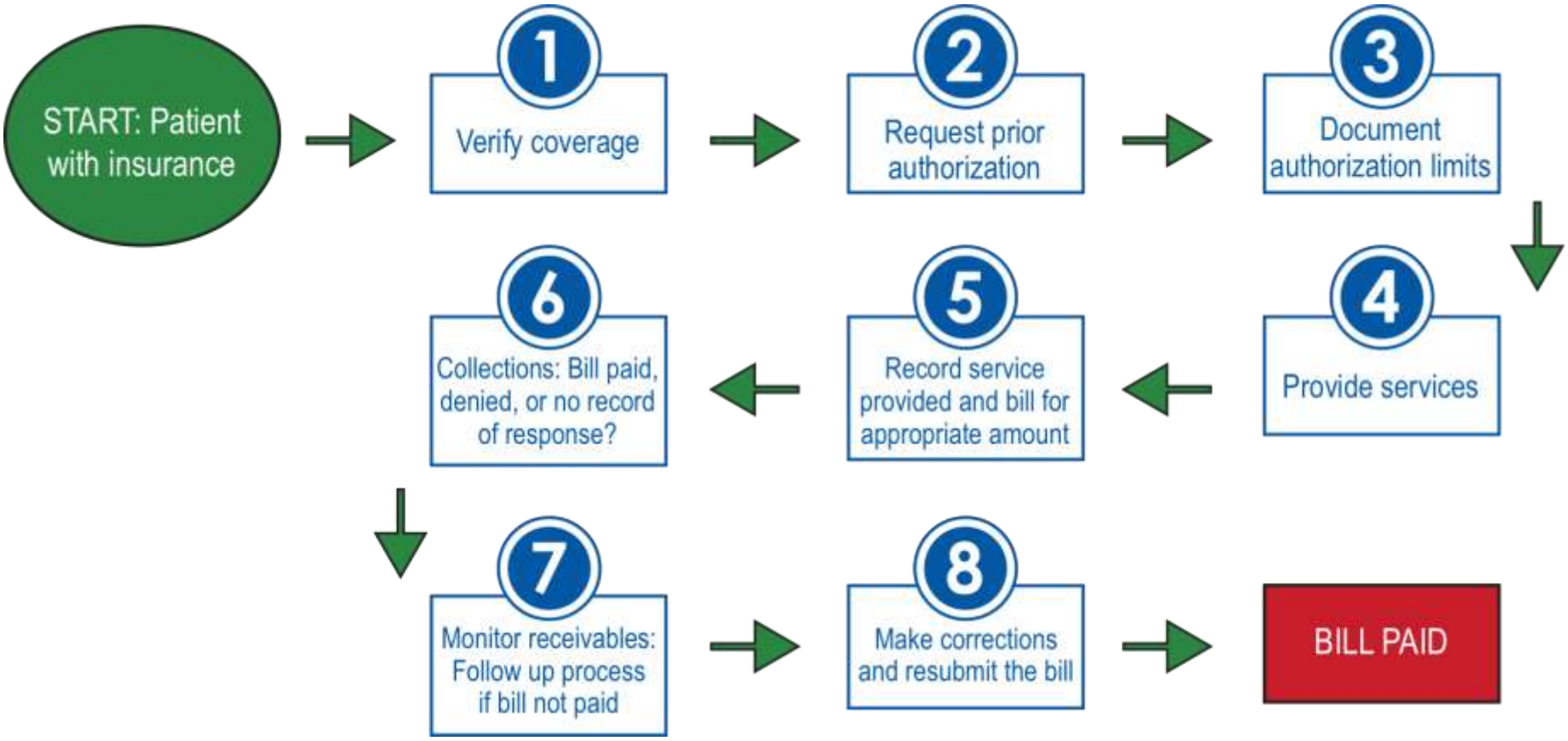
Creating Your Billing System

NIATx Billing Guide Overview

Eric Haram, Director OPBH-MidCoast Hospital
David Moore – Director Fayette Companies
and NIATx Coach

The Vast Unknown?

- Looking into your billing processes can be daunting.
- Where to start….


START: Patient with insurance
1
Verify coverage
2
Request prior authorization
3
Document authorization limits
4
Provide services
5
Record service provided and bill for appropriate amount
6
Collections: Bill paid, denied, or no record of response?
7
Monitor receivables: Follow up process if bill not paid
8
Make corrections and resubmit the bill
BILL PAID

Page 10-14
Checklist page 10

You will need to verify:

- Patient Co-Pay (PCP)
- Total benefits covered
- Calendar year and lifetime max status
- Deductible: amount met and how much overall
- Co-Pay: all levels of care
- Claims address
- Certification (Pre-Authorization) numbers and phone #
- Policy effective and termination dates
- Authorizations required and the name of the person who gave you the information.

Page 12-13
Template page 13

- Process of obtaining approval of coverage for a treatment deliverable. (before the treatment occurs!)
- Each payer may use a different term and has a different process.
- Prior Authorization may be obtained at the time of benefits verification. Requesting auth. for the upcoming assessment, eval., session.
- You may request to bill out-of-network if you do not have an in-network contract.

Operation Par in Florida hired a single staff person to obtain authorizations. This increased third party collections from $129,000-$436,000 within one year

- Record the authorized date and name of the person who granted the service.
- Record the authorization number. (if they tell you no prior auth. is needed, ask for an authorization number for administrative purposes).
- Record the number of authorized units, date range, and next review date.
- Include the contact name and direct phone number of the source for on-going reviews.

AIM

Increase Medicaid third party payments from 0 to 15 by March 31, 2011

Current Billing or *Baseline* = 0 or $0.00

Target = 15 clients with Medicaid

$1000.00 billed and received.

Muskingum
Behavioral Health
Zanesville, Ohio

Plan

- Having no experience with Third Party billing, work with change team and billing person on familiarizing ourselves with the NIATx billing Guide
- Start Documenting our process for third party billing information
- Ask each person who calls if they have any insurance
- Record results on a tally sheet

Muskingum Behavioral Health - Zanesville, Ohio

Results

- The first step was to establish a process and being to document each step.
  - Ask everyone who came in if they had insurance?
  - Copy the insurance card when they arrived
  - Document coverage using the NIATx pre-authorization template
  - **Work with one clinician for one month to begin to track each service and match authorization and billing codes for that treatment plan**

- Not everyone was willing to ask for insurance cards.
  - Needed to train staff, create a tally sheet,
  - Educate customers about insurance - understand if they had possible insurance coverage
  - Practice by role playing
  - and then documenting the process and the results. Not everyone verified insurance every time.

- Worked on establishing and improving process for 3 months. Kept working with the one clinician

- In April of 2011, we had 15 clients who were covered by Medcaid.
- In 5 months we collected $1,875 in Medicaid revenue. Though this may not be a large amount of money, it is for a small organization. That's $22,500 . per year more than we were getting before the project started!

- Clients with third party payers have gone from zero to 10 per month.

Muskingum Behavioral Health - Zanesville, Ohio

Next Steps

- Make the current billing processes more formalized
- Continue to foster relationships with third party payers.
- Establish protocols for addressing denials
- Increase marketing effort to people who have third party reimbursement.

Muskingum
Behavioral Health -
Zanesville, Ohio

- Provide the services that were authorized.
- Within the specified date range for approved units of service?
- Provided by appropriately credentialed staff member?
- Does the payer require specific deliverables? UDS, MAT, 12-Step, Family

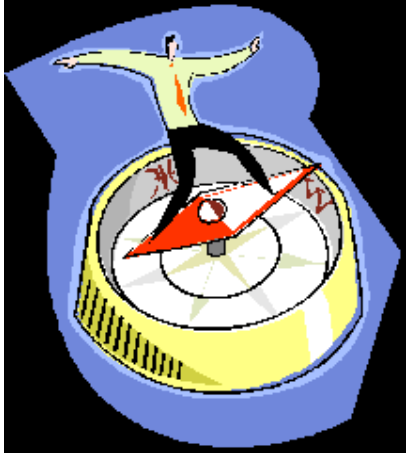
- Services documented in the clinical record?
- Dates of service match dates of charge?
- Correct demographic information?
- Correct billing form? UB-04 or the HCFA 1500

That’s it for the second part of your billing pilot. Did you get paid? Did you get a denial?

TAKE AIM

Reduce the number of claim rejections to 5% or less. The current baseline measure is 39 rejections within one quarter or 6.5% of all claims. Of those rejections 10 resulted from the client being scheduled with a non-independently licensed staff.

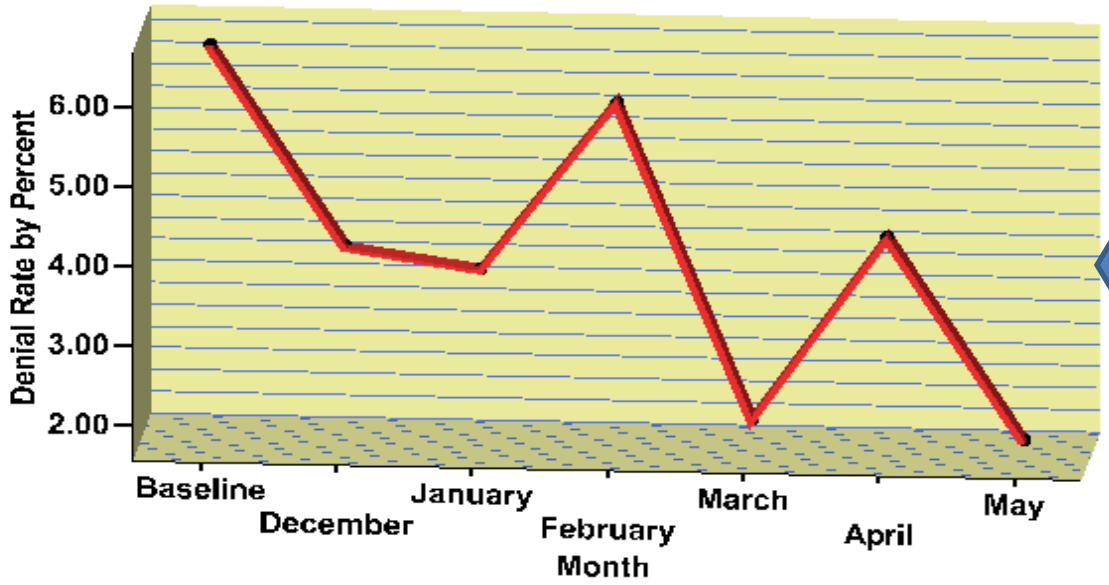
Time for a Change!



Incoming assessment clients who disclose insurance at the time of scheduling will be scheduled with independently licensed staff only for assessments.

- *Reception staff will be notified that clients with insurance will be scheduled in the diagnostic assessment slots of independently licensed staff only.*

- *The Intake Coordinator will continue to monitor insurance billing to assess if rejection rate is reduced. This monitoring will include analysis for the reason of rejection.*



Denial Rate

Value of Denied Claims

THE RESULTS

Month	# of Denials	Total # of Claims	Value of Denied Claims
Baseline	39	600	$1014.00
Dec	3	75	$298.05
Jan	9	240	$1381.84
Feb	9	153	$1185.42
Mar	4	207	$394.17
Apr	8	188	$796.86
May	3	172	$287.83

IMPACT AND LESSONS LEARNED

- Decreased insurance denial rate
- An increased sensitivity by all staff regarding the need to incorporate insurance as a viable source of funding which requires special accommodations.
- The finding that the current system within the organization is already efficient and provides for a relatively low denial rate but is flexible enough to allow for change projects that may enhance further.

Billing Practices
Organizational Level

“Who Does What”

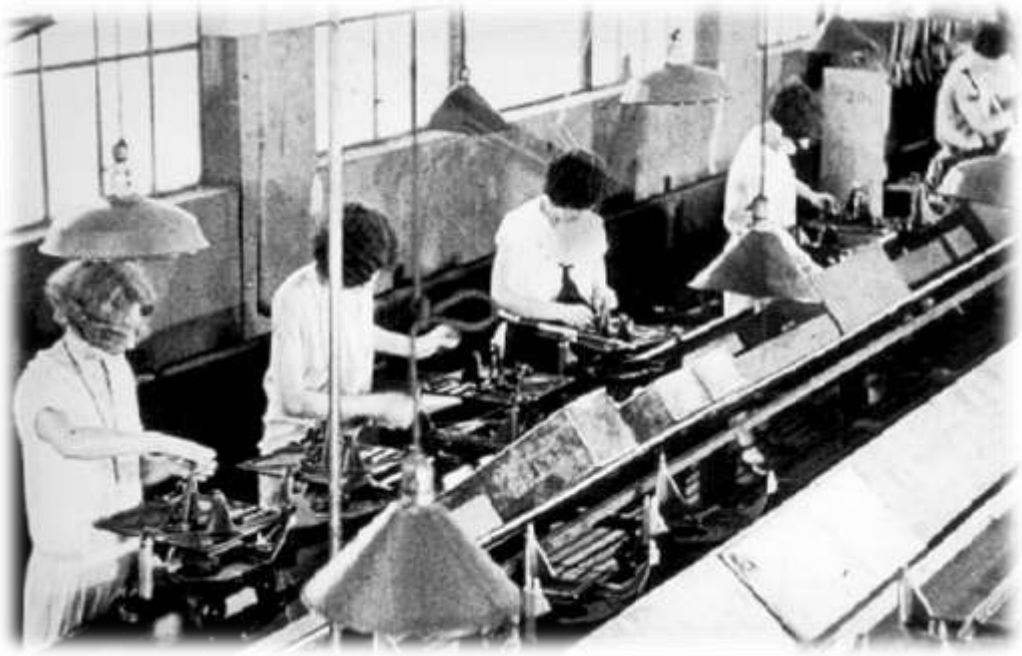
Workflow - Assessment

The Patient Experience (Flowchart)

- What is it like to be your patient?
- Perform a detailed walkthrough and document your patients experience
- Evaluate your findings and improve on the process
- Tie in the ultimate patient experience with the ultimate revenue cycle

What is workflow?

"The flow or progress of work done by a company, industry, department, or person."



What is workflow?

Ingredients…

Events (tasks, decisions, phases)
Resources (labor, documents, technology)
Relationships (transferring, sequencing)
Responsibilities (ownership)
Information
Inputs/Outputs

Other Terms…

Flow
Process
System

How do you capture workflow?

- Process Map
  - A picture of all service steps provided to the client within a process and identifying responsibility for each.
- Flowchart
  - A picture of process steps in sequential order, including materials or services entering (input) or leaving (output) the process, decisions that must be made, people who become involved, time involved at each step and/or process measurements. Swim-lane diagram is uniquely formatted flowchart.
- Spaghetti Diagram
  - A picture that uses continuous flow line tracing the path of an item or activity through a process. The continuous flow line enables process teams to identify redundancies in and expedite workflow.
- Value Stream Map
  - A picture of a process that identifies (1) value added and (2) non-value added activities. Typically involves current vs. future states.

American Society of Quality (ASQ), www.asq.org. Visited on April 28, 2010.

Why Flowchart?

Flowcharting is useful for:

1. Providing a starting point to understand the process as it is today.
2. Identifying key problems/bottlenecks
3. Showing where to test ideas for most impact
4. Adding interactivity & fun - gets the team together
5. Creating a simple & succinct visual process overview

Setting up a flowchart

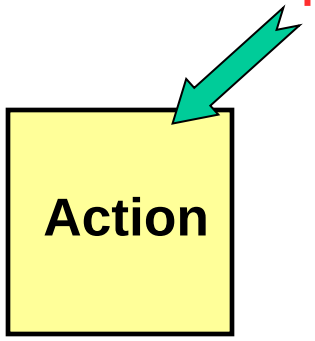
Where does the process **begin**?

Where does the process **end**?

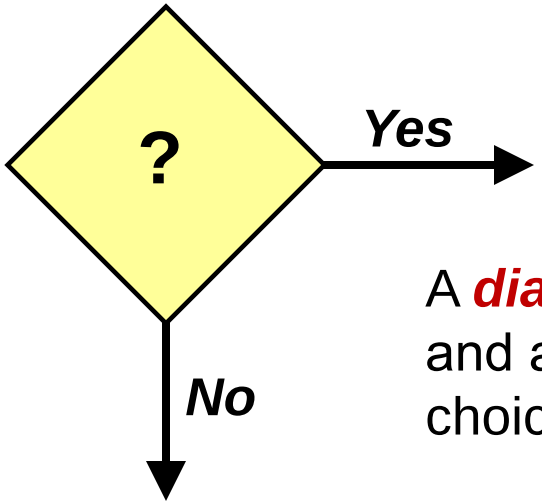
Title the process you are flowcharting.

Key Symbols for Flowcharts

Post-It Notes are great for flowcharting.



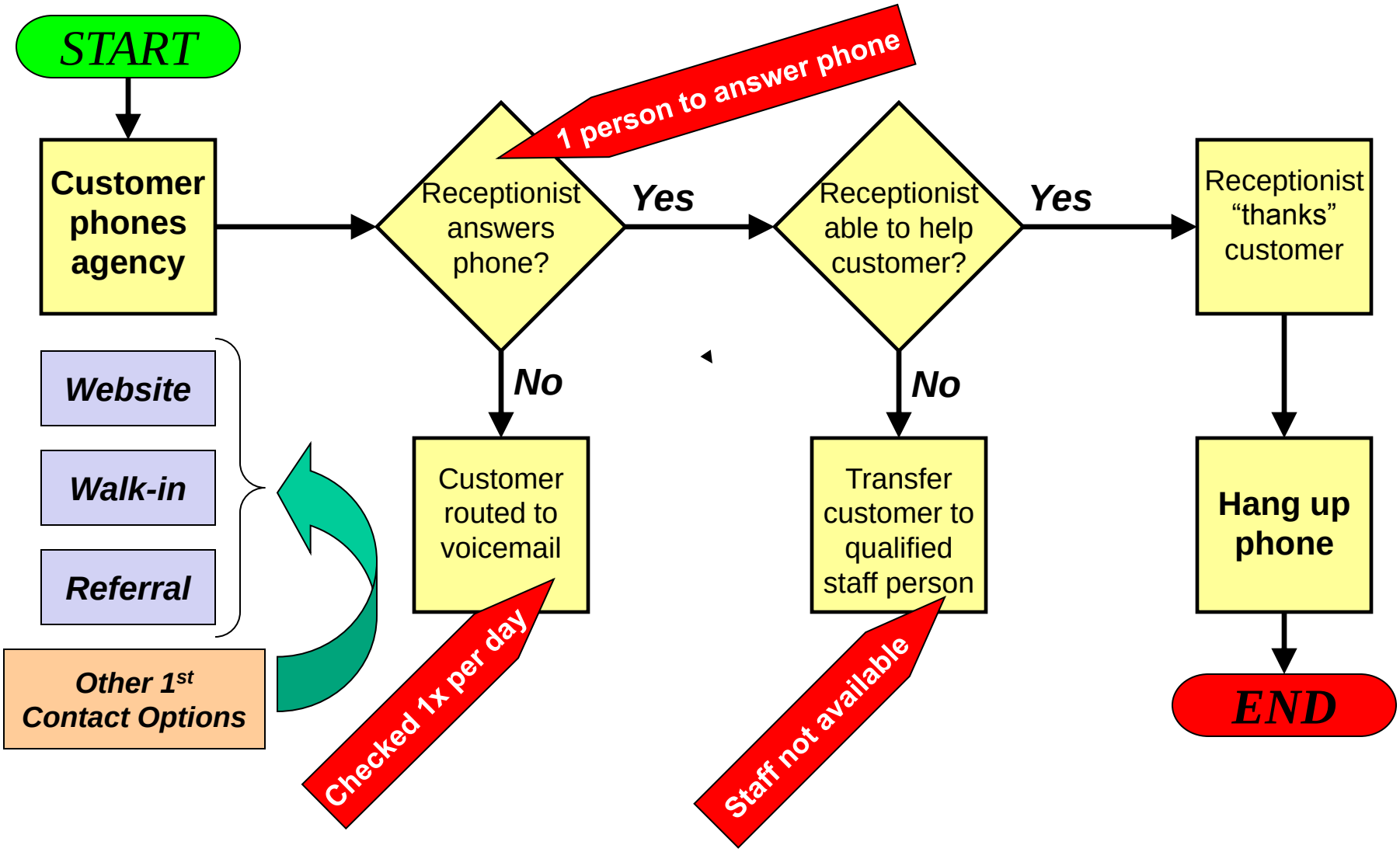
A ***square*** identifies a step in the process



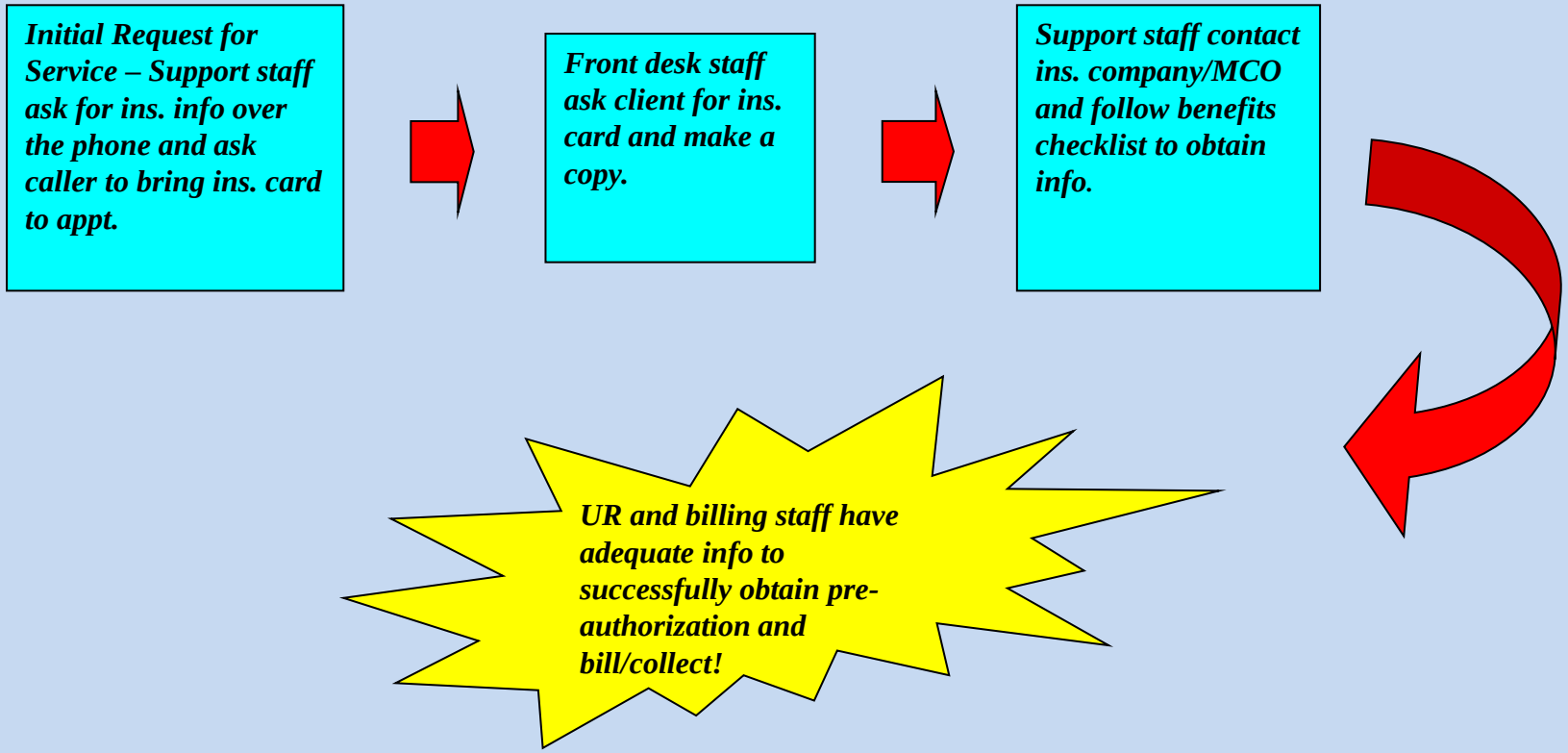
A ***diamond*** is a decision point in the process and asks a “yes or no” question or offers a choice of direction in the process.

Sample Flowchart

Process name: *Customer 1st Contact (phone call) to Agency Response*



Example of "Verify Coverage" Process Flow



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				

Page 9 in the NIATx Billing Guide Workbook

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	Support Staff complete checklist	Completed prior to admission	Utilization Review	Billing Staff
Request prior authorization	Utilization Review	Prior to admission or w/in 24 of detox admit	Clinical Staff	Utilization Review
Document authorization limits	Utilization Review	Throughout tx process	Clinical Staff	Billing Staff
Provide services	Clinical Staff	Post Discharge	Other clinical staff	Clinical Team
Document service provided	Clinical Staff	Post Discharge	Other clinical staff	Clinical Team
Bill for appropriate Amount	This occurs electronically – service doc	At time of service	Billing – FOCIS	Clinical staff are
Collections: bill paid or denied	Billing Staff	When Bill is Collected on	Coordination between FOCIS and Billing	Process for monitoring the system and flow between support staff, clinical staff, UR staff and billing staff.
Monitor receivables	Accounts Receivable Staff	When revenue is recognized	Agency's Comptroller Reviews	Regular meetings between clinical, UR and billing to strategize
Make corrections and resubmit	Central Access Manager fills this role	Claims that have been in process for over 6 months due to appeals	Comptroller and VP of Quality are involved if contracts need to be changed	Feedback loop to clinical, UR and billing staff so that patterns of errors can be addressed
Monitor cash flow	Comptroller	Continuous	President, CEO	Executive Committee

Assignment

Using your who does what chart from the billing guide, flow-chart your billing process.

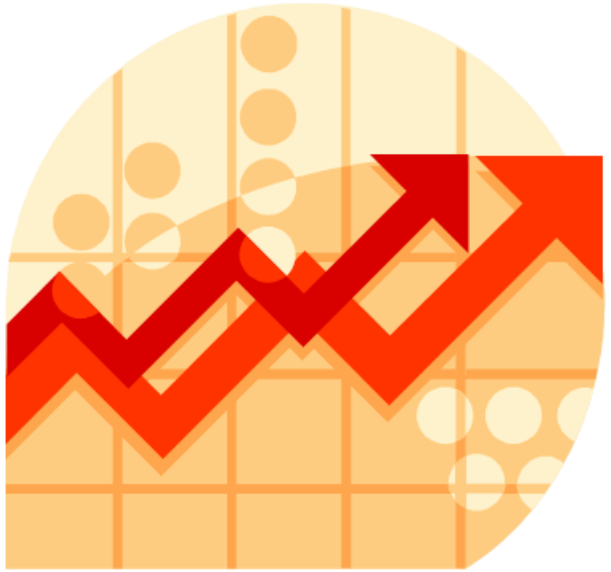
Large Group Discussion

1. While flowcharting, what did you learn about the steps you took while conducting your walk-through?

2. How could you use your flowchart to help engage your organization in the change process?

Why is capturing workflow important?

- Visualize & Understand
- Identify opportunities
- Support process improvement
- Educate others



Iowa FFS – 1:00 (E-Billing)

Quick Overview of E-Billing

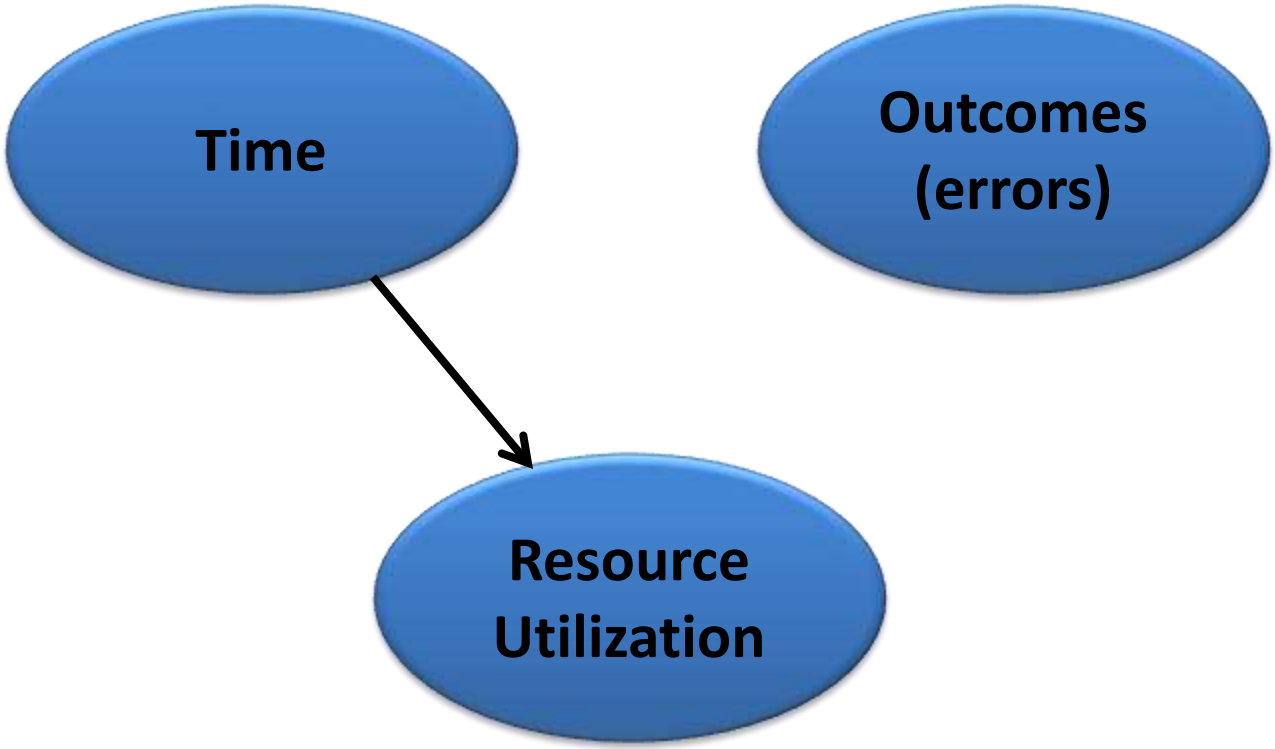
- **Electronic billing** is the electronic delivery of invoices (bills) and related information by a company to its customers
- E-Billing has a higher rate of clean claims.
- E-Billing will help reduce errors (denials, eligibility, unauthorized service
- 68% of providers in Round 1 said that they used electronic invoicing

http://en.wikipedia.org/wiki/Electronic_billing

E-Billing

- Single entity (clearinghouse) vs. best of breed (combination of clearinghouse and direct submission packages)
- Direct submission –
  - Produces multiple bills
  - Direct submission to insurer w/o middle man fees
  - Hidden costs (software, hardware, infrastructure)
  - Interpret different reports
- Single entity
  - One file to one place
  - Lower upfront costs
  - Re-occurring cost ($ per claim, monthly fees)

How can you measure the impact of E-Billing on workflow?



Billing

AGENCY	Process Evaluation				
	# of Steps	# of Decision Points	# of E-Steps	% Non Decision or E-Steps	% E-Steps
A	18	6	0	67.0%	33.0%
B	22	3	1	81.0%	14.0%
C	39	7	7	64.0%	18.0%
D	14	3	4	50.0%	21.0%
E	9	1	1	78.0%	11.0%
F*	32	7	11	44.0%	34.0%
Non-EHR Avg.				67.0%	20.0%
EHR Avg.				44.0%	34.0%

* Agency uses electronic health records

** CAUTION: utilization calculations based on number of events, not time

Some Examples

E-Billing

Non E-Billing

Outsourcing

What do Others have to say?

How does EHR change workflow?

Benefits…

- Reduces information management time
  - Generating, storing, retrieving, sharing
- Reduces opportunities for human error
  - "What is the *cost* of error?"
- I
  - "What is the *cost* of error?"

But note…

- EHR does not equal 100% automation
  - Staff input still required by processes
- EHR does not equal 100% paperless
  - Government transactions

Iowa FFS – 1:45

- If the claim was denied, this may be because of problems with the bill not the service.
- You can correct these and re-submit.
- Staff responsible for collecting payment must become familiar with the rules for payers and the payers' rules.
- Each company has it's own set of rules & departments often operate in silos.
- Negotiating the communication barriers within payer systems can be challenging.

- Accounting staff or managers will need to monitor receivables.
- Aging reports from your local accounting system are best for monitoring this activity.
- An aging report lists accounts receivable balances by customer, detailing the current status or delinquency of the balances owed or owing.
- Pay attention to accounts that are more than 69 to 90 days overdue. This will impact your cash-flow.

- Why is the claim not being paid?
- Billing error?
- Rejected claim?
- Define the rejected claims specifically

✓ Identify and document the reason, this will enable you to identify the processes you need to adjust and systems that you need to improve.

- What are your reasons for denial?

Denial Reasons

- Not authorized
- Same day service
- Missing or invalid information on claim (e.g., patient relationship, alpha prefix)
- Services after client dropped insurance or coverage cancelled
- Non participating provider
- Client covered or services paid by another payer
- Information requested was not received
- Not eligible or not a covered service
- Maxed out benefits

Category of Denial	Example
Physician/Medical Provider Billed Incorrectly	The wrong diagnosis, procedure code or place of service was billed Wrong revenue code (Wellmark)
Health Plan Processed Claim Incorrectly	The health plan paid the wrong person or medical provider
Denials related to Prescription Drugs	Drug is not on the health plan's formulary
Timely Filling Denials	One of the most common health insurance claim denials are those that are denied for being submitted late.
Lack of Authorization Denials	Non participating services received without a referral or authorization
Medical Necessity	Denial due to lack of medical necessity
Policy Limitations	The claim was filed late, causing a timely filing denial The claim was appealed late, causing a timely follow up denial

http://www.healthsymphony.com/bluenote.htm

AIM

- Increase revenue collected from third party payers.
- Decrease insurance claims error rate.

Changes

- Register clinicians on CAQH.
- Create a list of insurance providers and the credentials needed to allow for reimbursement for services provided.
- Work with our insurance clearing house on
  - why we have claims errors
  - how to fix the errors
  - how to resubmit corrected claims
- Create a checklist with information needed to collect from insurance companies when calling to verify coverage.

Results

- Our claim error rate has decreased from baseline of 33% to 16%.

- Insurance reimbursements are increasing from 10% of total charges the beginning of the fiscal year to current 17%.

Next Steps

- Create a system for collecting co-pays once we have implemented our new E H R.
- Research how to bill IOP services in order to receive adequate reimbursement.
- Research how to direct insurance clients to properly credentialed clinicians when in group and IOP sessions. Can supervisors sign off?
- Track progress on insurance claims so we are aware when we need to recertify visits.
- Monitor V code diagnosis codes since insurance companies don't usually pay for these codes.
- Pursue inclusion on insurance panels.

Impact

- By tracking claim activity we were able to better analyze the responses and make necessary billing adjustments for future claims
- Able to make the necessary claims corrections so the claims could be sent on to the insurance companies.
- Understanding of contract stipulations allowed us to follow more efficient procedures in obtaining authorizations
- Realized the importance of having personnel dedicated to insurance.

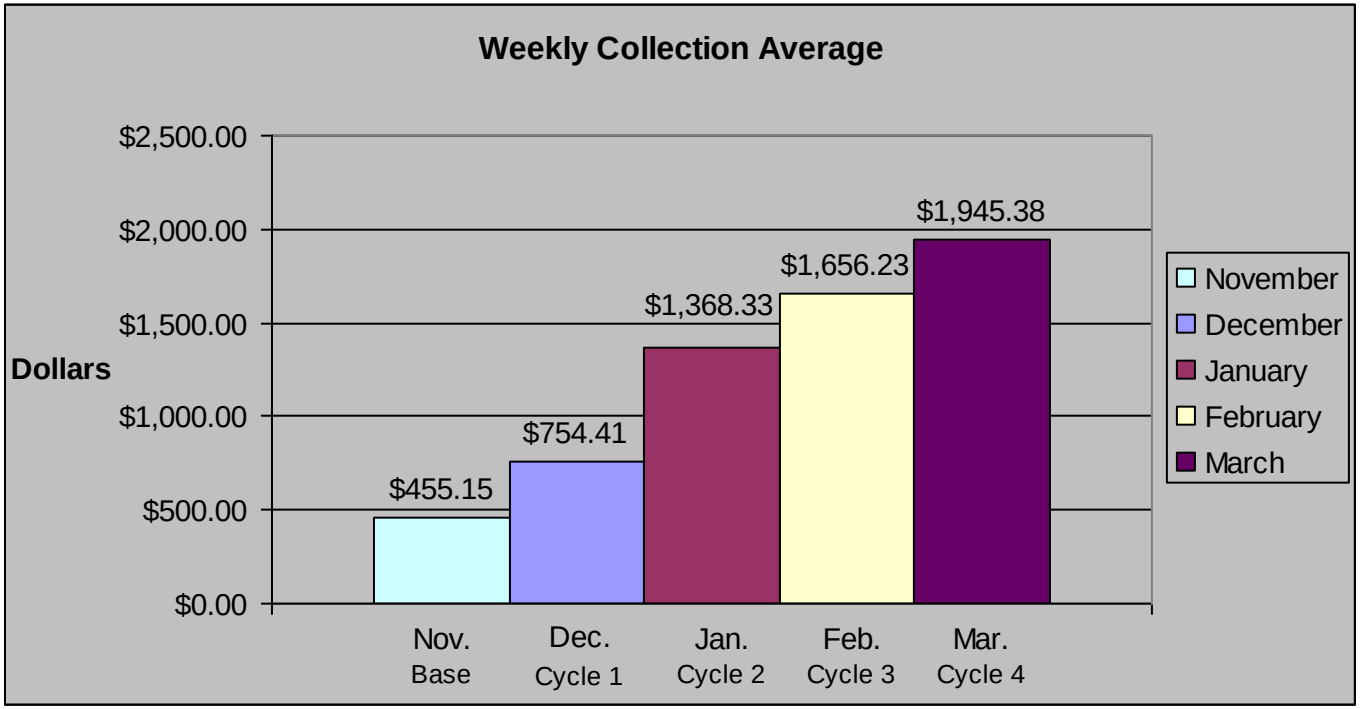
Next Steps

- Get together with key members of your team.
- Review your walk-through and share examples of the presentations you hear with them.
- Get familiar with the Billing Guide
- Pilot the 8 steps from the Billing Guide
- Allow your PDSA process to point you in the correct direction for maximizing your efforts on this work.

Co-Pay Action Team

Annualized: weekly collections have improved from $23,660 to $101,140/yr.

How: Signage, e-mail ticklers to counselors, batching opportunities.



Keep At It

Exploring New Business Models

Discussion at each table

What services do you provide that are most profitable?

Which third party payer do you work with and have the most denials? Why?

Which third party payer is easiest to work with? Why?

Do you provide the right services? Which services are actually billable?

Do you have staff dedicated to complete each step of the billing guide? If not why?

Iowa FFS – 2:45


Chalk Talk

Chalk Talk

- A silent way to do reflection
- Generate ideas
- Check on learning
- Develop projects
- Solve problems

Now……

Write your answers to the following questions:

- I think our agency does the best job providing the following service
- In relationship to billing practices we are champions at doing the following
- Our biggest barrier to creating a billing process will be

Reflections, solutions, ideas, draw connecting lines to other questions, pictures etc……

Step 7 – 2 minutes

Final voting on ideas:

- Each participant casts one final vote
- Record all ideas for future reference and possible PDSA Cycles

Iowa FFS – Ideas from Outside the Field

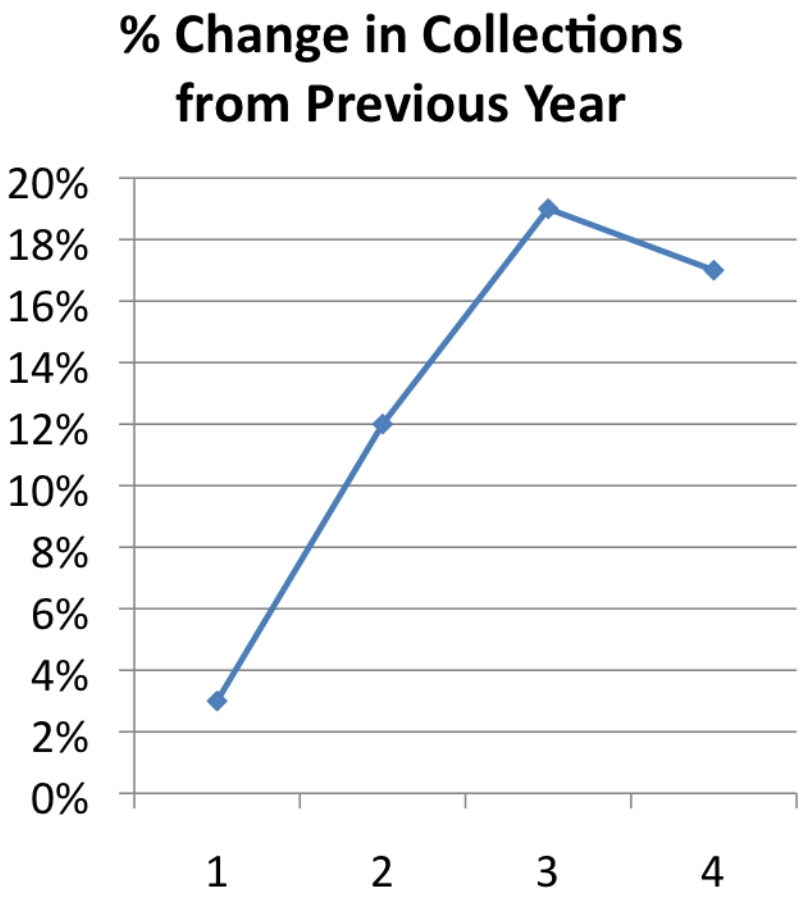
Patient Account Representative

- Average of 500 to 800 accounts per month
- Multiple insurances with different requirements
- Applying deductibles, co-pays and co-insurance correctly
- Out-of-network challenges

http://www.physiciansnews.com/business/1204mehta.html

Help Staff via Training

- Sensitive to clients who cannot pay
- Effectively use HIT reports
- Recognize that each insurance company is different
- Use health insurance carrier's online provider tools
- Achieve American Association of Healthcare Administrative Management Certification



Improve Practice Collections

Where in the Process	Examples
Front Office/Reception	Verify that all demographic insurance information is correct Review and verify information on insurance card at each visit Collect co-payments and outstanding balances at check-in Verify insurance eligibility prior to patients 1st visit
Check-out/Discharge	Post and balance charges daily Staff access to information
Billing Office	Submit electronic claims at least 3 times per week and paper copies twice per week Work insurance denials as received Appeal unjustified denials Audit insurance fee schedules in system for accuracy
Other Ideas	Start credentialing at least 3 months prior to start date Complete charts within 3 days of seeing clients Involve staff members in bonus plan to reduce billing errors

http://www.healthcarestrategygroup.com/newsletters/article.php?show=improving_practice_collections

Organizational Changes

- Collect fees at beginning of group
- Understand and learn
  - New billing procedures
  - How claims are processed
  - How to use HCFA vs. UB forms
- Track clients with high deductibles & no coverage
  - 9% increase in client fee payments
  - 9% increase in 3rd party billing
  - 200% increase in out-of-state billing (approx 4 to 5K)

Organizational Changes

- Trained counselors to
  - Complete the forms and
  - Talk to their clients about money
- Develop a uncollectible accounts write-off policy with our accountant .
- Implemented pre-authorization for Medicaid and all insurances.
- Hired a new person with a focus on marketing.

E-Billing

- *Be sure to have proper IDs for e-billing.*
- *Obtain authorization information at the time of making the appointment.*
- *Verify eligibility prior to the visit. Do it electronically.*
- *Prevent charges from slipping through the cracks by running a missing charges report.*
- *Check your claims for missing information.*
- *Make sure you actually* send *your electronic claims file!*
- *Always, always, always obtain a report (required 277 report) after sending your file!*
- *Follow up! Diligently track and manage your billing/reimbursement cycle.*
- *Run an unbilled charges report to identify unbilled claims.*

http://www.physiciansnews.com/business/1204mehta.html

- Video “Leadership Lessons from the Dancing Guy”

Here is the link http://sivers.s3.amazonaws.com/DancingGuy-ff.m4v

The final slides will have the power point embedded

Final Check-in

- How did we do?
- What can we do to improve (for tomorrow)?
- Tomorrow we will begin at 8:30 and out by 12:30

Increasing Revenue Options by Billing Third Party Payers

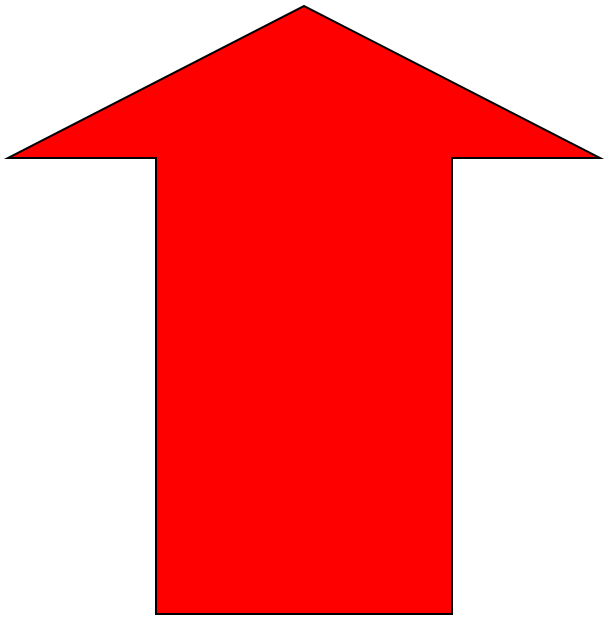
One Provider's Experience

David Moore, MPA

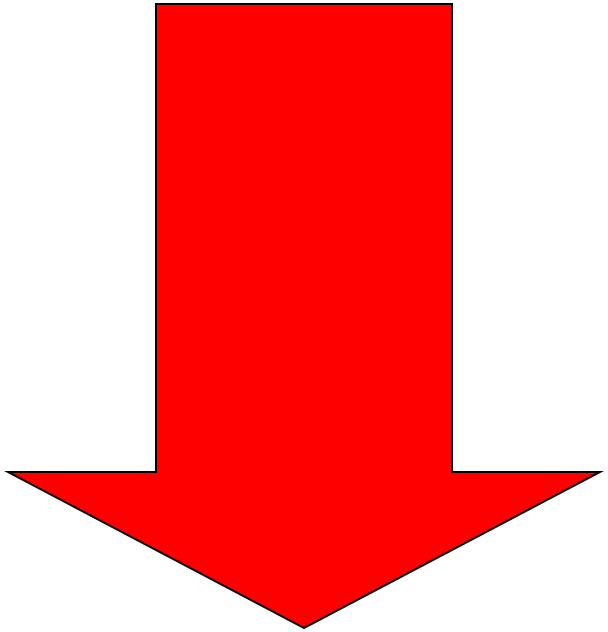
Background on Fayette

- Fayette Companies/Human Service Center is located in Peoria, IL.
- Majority of revenues come from state contracts.
- Have been contracting with third party private payers over 20 years.
- Have both outpatient (group contracting) as well as inpatient (facilities contracting) services.

Increase in Denials

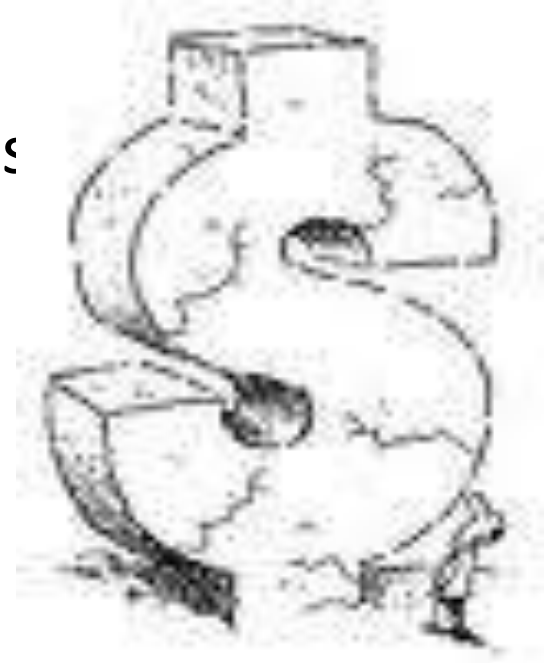


Decrease in Collections



What was Broken

- The way we addressed contracts & credentialing had become fragmented and decentralized.
- Front door process for checking benefits was hit or miss at best.
- Little to no communication existed between staff responsible for benefits checks/pre-authorizations and billing/collections.



Thinking Differently

- System of Ownership and Responsibility
- Changing the way we view financial documentation at the front door.
- Recognizing Ins. Company/MCO/EAP as a part of the treatment team.
- Recognizing that establishing medical necessity is much easier if we do a more thorough job of reviewing the case.

Results and Next Steps

- Decrease in denials and increase in collections recognized.
- Have begun to recognize revenue gained from appealing denials.
- Have added MCO contracts and gotten more staff credentialed with existing contracts.