HealthManagement Consultants, LLC

BILLING & COLLECTION PROCESS

I. Identification and Screening

Objectives:

- Identify all clients who have MA or PAC or who are eligible for MA or PAC.
- Identify client's payer prior to providing first service to capture reimbursement for initial service.

Guidance:

- Establish screening mechanism to identify clients with MA or PAC or who may be eligible.
- Distribute or make Medicaid and PAC applications available to clients.
- Establish mechanism to solicit needed information (MA #, name as appears on MA card, MCO, MCO #, MA or PAC) at first contact from referral source (including self-referral) and/or at Intake.

Procedures:

II. Eligibility Verification

Objective:

- Ensure client is still eligible for MA or PAC and still enrolled with MCO prior to delivery of each service.

Guidance:

- Every day verify and document eligibility for each client scheduled for services on the next day who is enrolled with MCO.
- Day before Intake verify and document eligibility for all clients scheduled for Intake.
- Contact Maryland's Eligibility Verification System (EVS) using either:

    Phone at 1-866-710-1417 (must be touchtone phone)

        Enter 9-digit provider number, press pound.
        Enter 11-digit recipient number & 2-digit name code (first 2 letters of last name converted into numeric touchtone number), press pound (use digit 7 for letter Q & digit 9 for letter Z).
        If recipient number is unknown, press zero, pound, pound (0##); at prompt, enter recipient's 9-digit SSN & 2-digit name code).

    Web at www.emdhealthchoice.org (must be enrolled in WebEVS)

Procedures:

III. Authorization

Objective:

- Ensure authorization was issued by MCO for services requiring pre-authorization prior to service delivery.
- Ensure re-authorizations are obtained in a timely fashion as to not interrupt service delivery.

- Ensure unauthorized services are not provided.

Guidance:

- Develop policy and procedure for approving delivery of unauthorized services.
- Maintain system for tracking authorizations that monitors time elapsed and number of services delivered.
- Establish policy and procedure for requesting re-authorizations prior to dates authorizations are scheduled to expire and prior to dates number of authorized services are scheduled to be delivered. Sufficient time for the request and receipt of re-authorizations needs to be factored into procedure. Establish a tickler or reminder point indicating when re-authorization needs to be initiated for each client.
- Establish mechanism for keeping scheduler informed of authorizations so appointments are not scheduled in excess of authorization.

Procedures:

IV. Billing

Objective:

- Ensure clean claims are submitted in timely manner for all billable services.
- Maximize collections and revenue.
- Maintain healthy cash flow.

Guidance:

- Obtain billing forms (CMS 1500) at www.cms.hhs.gov/providers/edi/cms1500.pdf
- Establish mechanism to transfer information regarding delivered services from clinicians to biller in timely manner. Information includes date of service, duration of service, type of service and diagnosis.
- Review billing forms prior to submission to minimize errors.
- Track submission of bills to ensure timeliness.

Procedures:

V. Management and Analysis

Objective:

- Maximize revenues and apply process improvements as needed to maximize collections.
- Enhance cash flow by monitoring billing process to maximize number of clean claims submitted on first attempt and time frame between dates of service and dates claims submitted.
- Review Explanation of Benefits (EOBs) to correct and resubmit denied claims ASAP.
- Maximize number of clients maintaining their eligibility and enrollment.

Guidance:

- Establish timely review process for every EOB.
- Identify claims that were denied due to keying or scanning error, correct and resubmit.

- Analyze reasons for denials (such as not eligible on date of service or no authorization for service). Review processes and make necessary process improvements.
- Track number or percentage of clean claims submitted on first attempt.
- Establish review process for submitting claims that compares dates of service and dates claims are submitted.
- Monitor accounts receivable with each payer (MCO) in terms of dollar amount and time elapsed.
- Develop supports to assist clients with maintaining eligibility and enrollment.

Procedures: