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Revenue Cycle Starts at Intake: How efficient is your workflow for revenue cycle?

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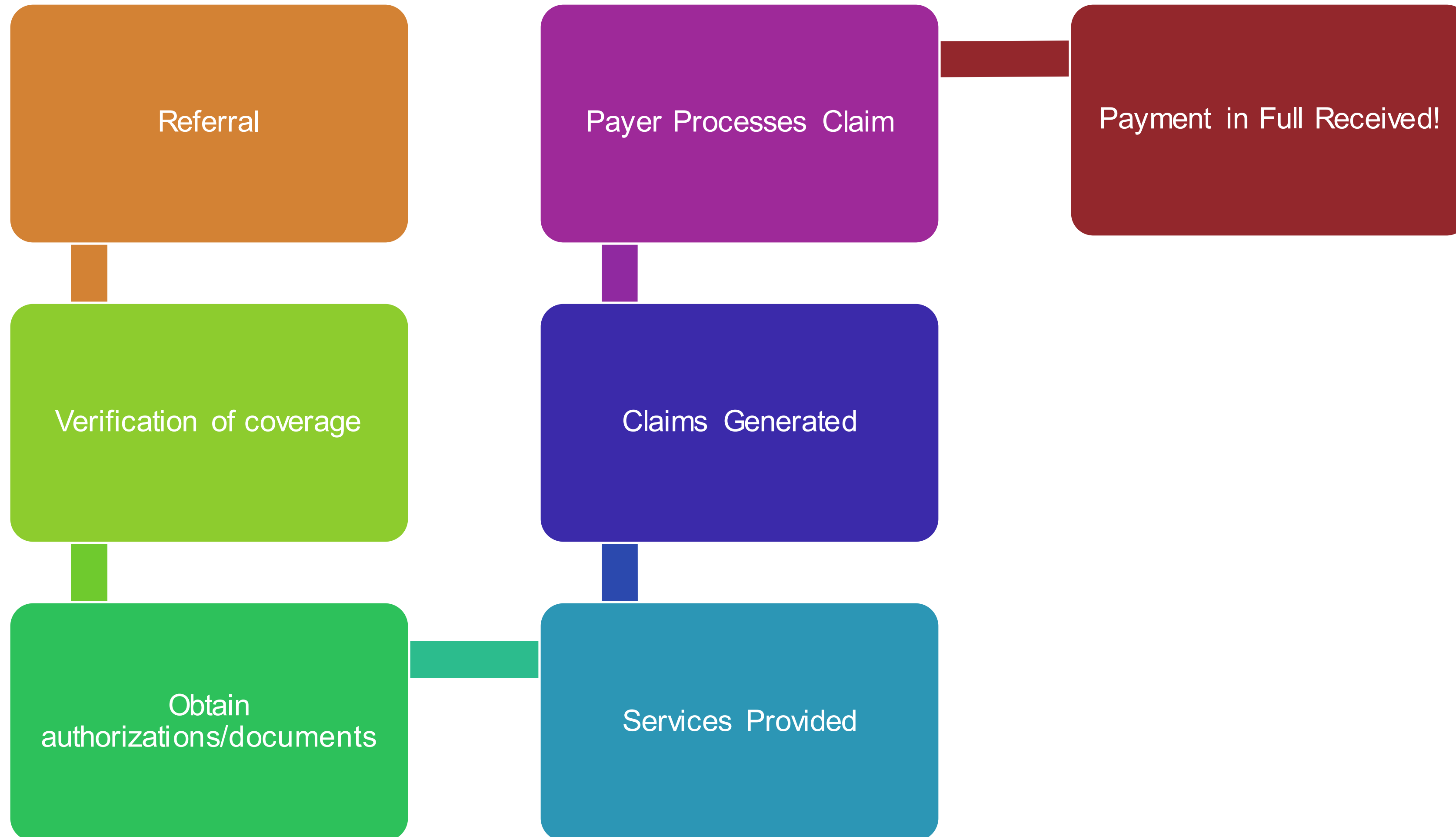
9/13/2022

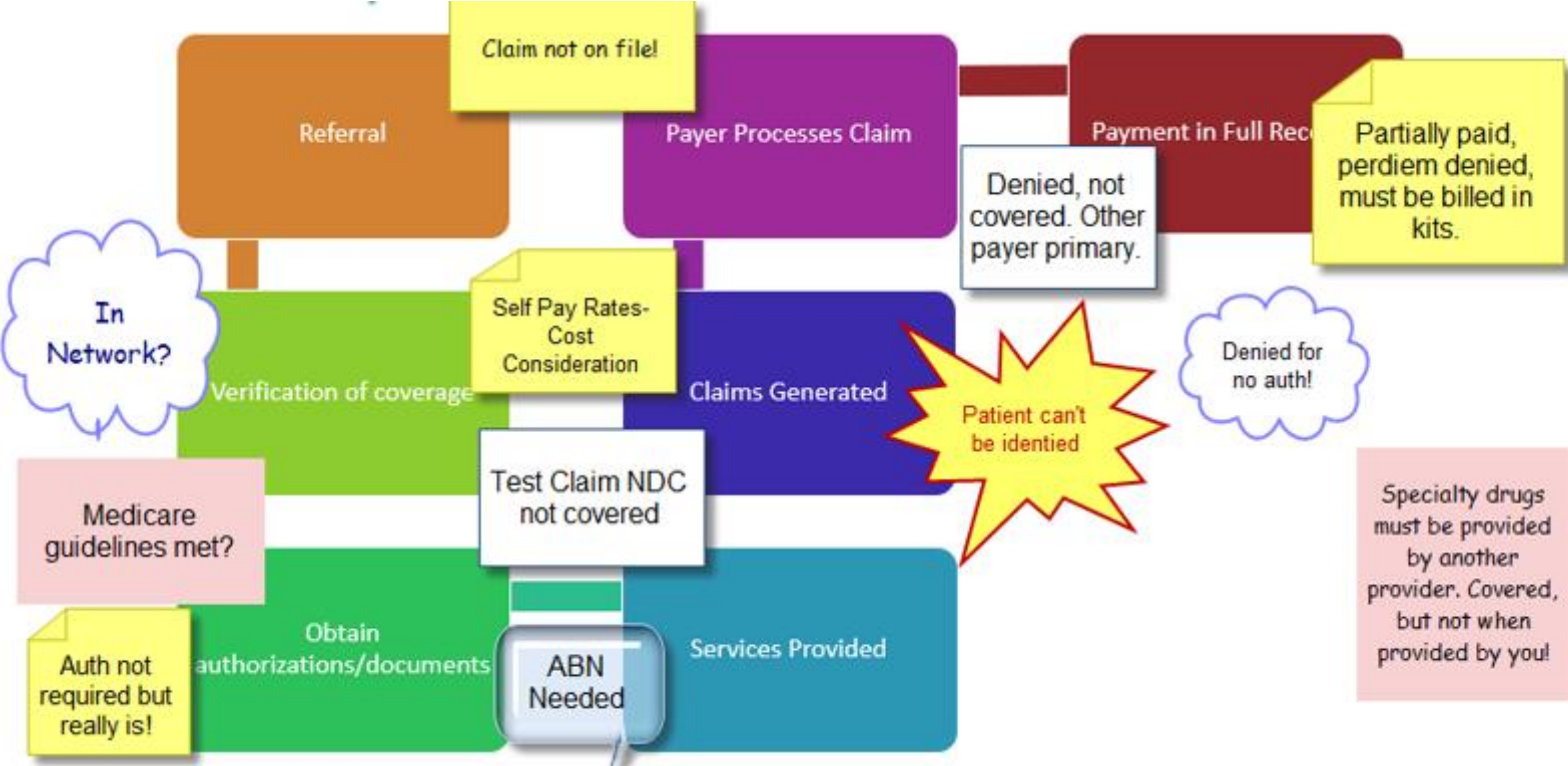
Agenda

- Basic Intake Process –
  - New Referral
  - Referral attained
  - Payer Verification
  - Authorization
  - Documents
- Intake Specialist Knowledge
  - Payer Contracts
  - Home IV Knowledge
  - Medicare Knowledge
  - What could possibly go wrong?
- Reimbursement Coordinator Responsibilities
- Key Set Up Areas using CPR+ and Caretend
- Denials – The importance of logging them
- Revenue Cycle Process Flow
- Reporting

Basic revenue cycle process



Reality revenue cycle process



New referral

- Notification Process
  - Email – Fax – To Do – Phone Call - Teams
    - Designated intake staff
      - Email/Fax groups – To Do Departments Set Up -
  - Acknowledgement that it is received and being worked.
    - Is there a specific time frame for this?
      - We strive for 1 hour to respond. Sometimes it is outside of our control, but we do our best to respond within 1 hour. If we don't have an answer, we at least acknowledge receipt and provide a status.

New referral (cont'd)

- Demographic Entry
  - Reference to hospital EMR and the patients MRN# in that EMR.
  - Diagnosis and Diagnosis Code(s)
  - Clinical Information
  - Physician Information
    - Add existing physician
    - Adding a new physician
    - NPI
    - PECOS Enrollment

New referral (cont'd)

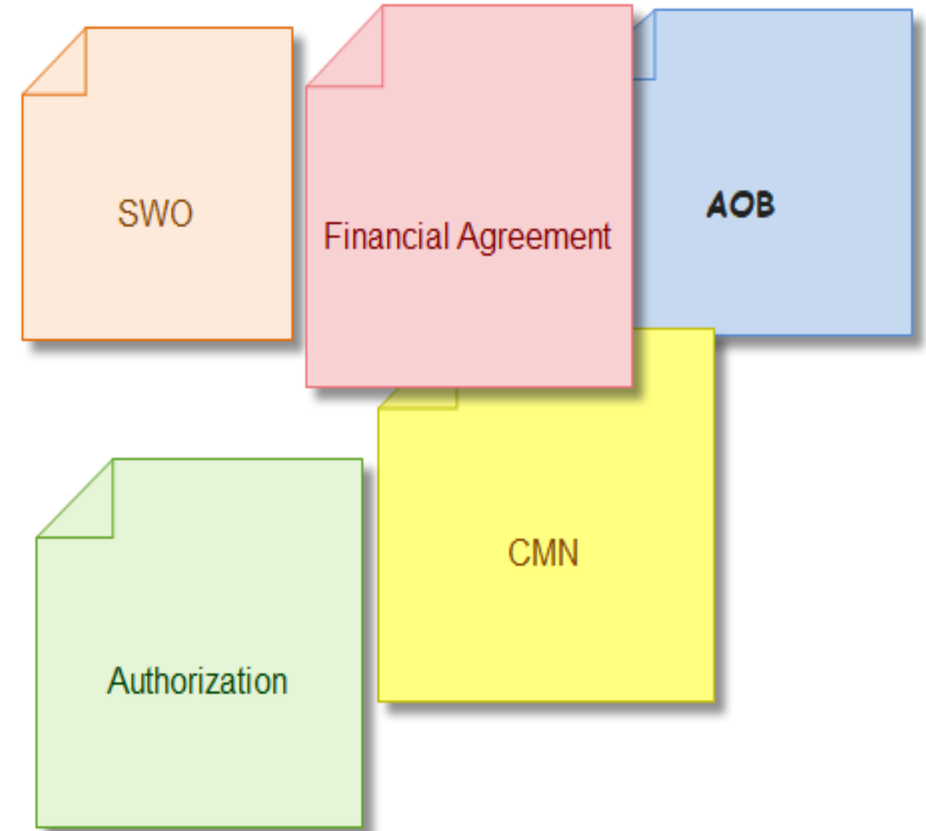
- Payer Information regarding coverage
  - Where is the information regarding the payer and your organization stored?
    - Job Aides (Reference Sheets – Cheat Sheets)
    - Contract information
      - In network or out?
      - Contract Exclusions
  - Adding a new payer
    - Validation of general billing information and contract information is needed.
  - Is access to your contacts an issue with your contracting department?

New referral (cont'd)

- Payer Verification
- Direct from CPR+, Caretend or another platform such as Waystar, Availity, etc.
- Phone Call to payer
  - Basic coverage can be obtained through many online resources, but most Home IV benefits need to be validated via a phone call.
- Questions to ask?
  - Verification Sheets
  - Billing/Progress Notes
  - User Defined Field

New referral (cont’d)

- Authorization
- Pharmacy Test Claim
- Documentation
  - Is the software platform set up to auto generate these?
  - ABN (Advance Beneficiary Notice)
  - Patient Financial Liability
  - AOB (Assignment of Benefits)
  - SWO (Standard Written Order)
- Qualifying the patient – Final approval to service patient
  - Pharmacist – Nurse – Nutritionist Involvement



Intake specialist knowledge

- So many areas of Home IV are not cut and dry and there are many factors that can impact coverage that your Intake Specialist needs to be aware of.
- How do you ensure that they have the tools and training that they need?
  - On-line training with Medicare – Medicare has many different parts, so it is important to understand the differences.
  - Payer specific training
  - NHIA is also a great resource
- Payer Contracts – You need to know what your organization can provide and in what billing format that needs to be?
  - Issue can be carved out Specialty Drugs – Enteral Services
  - Requesting an auth for a Per Diem S code versus a Kit A code.
- Home Infusion Knowledge – This is crucial to obtaining accurate coverage as often the payer representatives do not have Home IV knowledge.

Things to consider….

- All insurance plans provided should be validated for coverage. Stop and start dates are crucial.
- If the patient has Medicare and another plan, validation of which plan is primary is important.
- If the services are not covered by Medicare, will the secondary plan pay or is it only supplemental picking up the Medicare coinsurance and deductible?
- Validation of authorization requirements for all plans should be done and obtained.
- Ensure that coverage is being requested for *Home Infusion* and not *Home Care*.
- Are services billed through major medical or do the drugs need to be sent through the patient's pharmacy plan?
- Is your organization contracted to provide both Home IV and DME services or one or the other. (Enteral is often considered under DME.)
- Validate if the plan is under COBRA or Market place as premiums are paid monthly and there is typically a grace period for the enrollee to pay.

What could possibly go wrong?

- **Scenario 1**:
  - Referral for a Medicare chemotherapy patient.
  - Medicare eligibility is validated as active.
  - Drug code is listed in the LCD (Local Coverage Determination) so Part D coverage is not validated.
  - Patient has AARP that will pick up the coinsurance.
  - Services were provided.

  - ***Based on the basics above, what was not noted on the referral form that is of a great deal of importance?***

What could possibly go wrong?

- **Answer to Scenario 1**:
  - While chemotherapy is covered by Medicare;
    - The use of a mechanical infusion pump is needed. If the drug is administered through an elastomeric pump, services are not covered.
    - Also, validation that the patient had both Medicare A and B as some patients only have A. If no Medicare B, then there is no coverage for this service by a Home Infusion Provider.

What could possibly go wrong?

- **Scenario 2** :
  - Referral for an existing patient, currently receiving antibiotic services in the home with commercial insurance for a new drug, Humatrope. Online coverage was verified, and authorization was obtained through major medical.
  - ***Based on the basics above, what was not noted as verified on the referral form that is of a great deal of importance?***

What could possibly go wrong?

- **Answer to Scenario 2 :**
  - While the patients' antibiotic charges are paying with no issues;
    - Humatrope is a high-cost specialty drug that per a clause in the patient's insurance plan, must be obtained through a specialty pharmacy and billed through the patient's pharmacy plan.
    - Even though an authorization was obtained, there is that infamous disclaimer "Authorization is not a guarantee of payment, please refer to the patient's insurance plan for more coverage information."
    - Had coverage been obtained through a phone call to the payer, information regarding this drug would have been provided.

What could possibly go wrong?

- **Scenario 3 :**
  - Patient is Medicare FFS primary, drug coverage for the Nafcillin is through the patients Part D plan, test claim was run and NDC was covered. Patient has a true secondary plan that will pick up Medicare denied charges.
  - ***Based on the basics above, what was not noted as verified on the referral form that is of a great deal of importance?***

What could possibly go wrong?

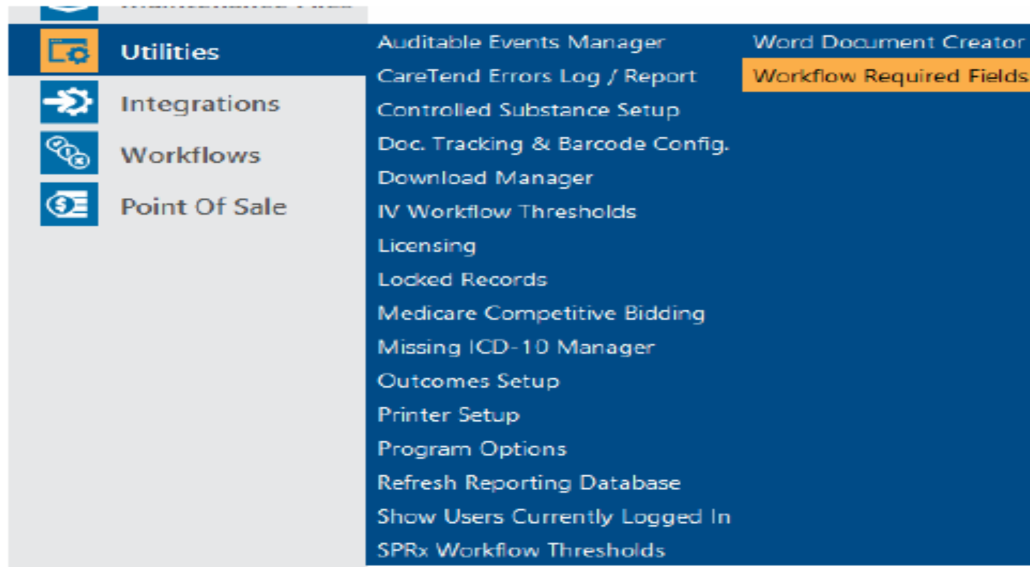
- **Answer to Scenario 3 :**
  - There is no mention of how the drug is to be administered. If the drug is administered via a mechanical infusion pump, then an ABN (Advance Beneficiary Notice) must be obtained or noted in the patient chart that it was discussed with the patient, prior to the services being rendered.
  - Without this signed form, or no discussion with the patient about the services not being covered, the billing team is not able to bill Medicare for the appropriate denial that is needed for the secondary payer to cover supply and equipment charges.
  - Also, the patient should be informed of their financial obligation for the Part D copay which is not covered by the secondary payer.

Reimbursement coordinator responsibilities

- Billing Staff
  - Is billing done each day or on specific days?
    - Are reports run for any delivery ticket or claim that is being held?
    - Who monitors the claims queues to ensure claims are sent timely?
  - Who ensures that the claims sent make it to the payer?
    - Often the invoice is sent out of CPR+ or CareTend only to deny at Waystar or Change HealthCare.
- AR Staff
  - Are they structured to work from AR manager, denial reports, partial pay reports, etc. (Providing the appropriate tools for them to succeed is a must)
  - What time frame are they given to work these key areas. (We ensure our staff follows up within 7 days from a follow up due date, partial payment or denial.)

Key set up areas – CareTend - Utilities

- Workflow Required Fields
  - Provides your organization with control over the information that is necessary to enter for patients to ensure information is complete.



Workflow Required Fields

Filter Search

Drag a column header and drop it here to group by that column

Entity	Description	Active
Patient	Primary Address must be set	☑
Patient	Primary Address City must contain a value	☑
Patient	Primary Address State must contain a value	☑
Patient	Primary Address County must contain a value	☐
Patient	Primary Address Postal Code must contain a value	☑
Patient	Primary Address Directions to Address must contain a value	☐
Patient	Patient Allergies must be checked	☑
Patient	Emergency Contact must be set	☐
Patient	Primary Contact must be set	☐
Patient	Responsible Party primary address City must contain a value	☐
Patient	Responsible Party primary address State must contain a value	☐
Patient	Responsible Party primary address Postal Code must contain a value	☐
Patient	Culture/Sensitivities must be set	☐
Patient	Current facility must be set	☐
Patient	Admission Date must contain a value	☐
Patient	Discharge date must contain a value	☐
Patient	Room Number must contain a value	☐
Patient	Current Prescriber must be set	☑
Patient	Acuity on Admission must contain a value	☐
Patient	Site of Service must contain a value	☐
Patient	Patient Height must be set	☑
Patient	Patient Weight must be set	☑
Patient	Access Order must contain a value	☐

Key set up areas – CareTend - Demographics

- If a field is required, it will be in red.

Demographics | Insurance | Prescribers / Providers | Medical Info | Diagnosis / History | Orders | Addresses | User Defined

First Name
Last Name
Address
Zip
Time Zone (GMT)
City, ST
County
Home Phone
Mobile Phone
Work Phone
Email
Gender
Date of Birth, Age — Select a date
Date of Death — Select a date
SSN
Referral Date — 7/13/2022
Referral Source
Information Complete
Enrolled in Engagement Module

Patient Status — Pending
Company
Start of Care — Select a date
Primary RN
Biller
Sales Rep
Site of Service
Marital Status
Drivers License#, ST
Advance Directives
Preferred Method of Contact

Team
Service Area
Ins Coordinator
Collector
Category
Code Status
Language — English
External MRN
Track SHP Patient
Track Catheters

Contacts

Name	Home	Work	Cell	Relationship	Contact Type	Primary

Print | Cancel | Save & Close

Key set up areas – CareTend Demographic – Financial

Insurance

Demographics | Insurance | Prescribers / Providers | Medical Info | Diagnosis / History | Orders | Addresses | User Defined

Policies

Rank	Payer Type	Payer Name	Policy #	Group #	Policy Owner	Status	Effective	Termination	Eligibility
1	Medicaid	Medicaid (Rx)	123456789		Anna Smith	Active	1/1/2018		
2	Medicaid	Medicaid (Medical)	123456789		Anna Smith	Active	1/1/2018		

Policies for Anna Smith

Rank	Payer Type	Payer Name	Policy #	Group #	Policy Owner	Status	Effective	Termination	Eligibility
1	Medicaid	Medicaid (Rx)	123456789		Anna Smith	Active	1/1/2018		
2	Medicaid	Medicaid (Medical)	123456789		Anna Smith	Active	1/1/2018		

Close

Edit, Delete, or add policy

Anna Smith - Demographics (MRN: 200422)

Lab Orders / Results
Medication Profile
Orders
Outcomes Processing
Patient Account
Patient Record
Pharmacy Utilities
Physicians Orders
Prescription File / Labels
Progress Notes
Supporting Documentation
View Delivery Ticket History
View Patient Documents
Visit Report / Assessment

Activities

Discharge Summary
Height and Weight
Map & Directions
Patient Equipment
Patient Transfer Summary
Status History
Synagis
View Authorizations

Check Eligibility
Copay Assistance
Patient Verification
Resequence Policies
View Eligibility History

Patient Policies Sequence

Anna Smith Policy Sequence

Payer Type	Payer Name	Policy #	Group #	Policy Owner	Status	Effective	Termination	Eligibility
Medicaid	Medicaid (Rx)	123456789		Anna Smith	Active	1/1/2018		
Medicaid	Medicaid (Medical)	123456789		Anna Smith	Active	1/1/2018		

Cancel | Save & Close

Key set up areas – CareTend Demographic – Financial

Orders

Demographics | Insurance | Prescribers / Providers | Medical Info | Diagnosis / History | Orders | Addresses | User Defined

All / Drug / HME — Include Discontinued

Rank	Order Date	Therapy Type	Description	Start	Stop	Status	Stat	Primary Payer	Secondary Payer	Current Workflow Queue	Last
1	6/1/2018	Antibiotic	Vancomycin Hcl 10 Gm IV	6/1/2018		Active	No	Medicaid (Rx)		IV - Order Entry / Order Completion	

Order Info

- Written Item: Vancomycin Hcl 10 Gm
- Dispense Item: Vancomycin Hcl 10 Gm
- Frequency: — Route: IV
- Order Date: 6/1/2018 — Start Date: 6/1/2018
- Stop Date: Select a date — Therapy Type: Antibiotic
- Status: Active — Discontinue Date:
- Integrations: TherigySTM

Billing Info

- Company:
- Billing Provider:
- Team: Infusion
- Referral Source:
- Sales Rep:
- Prescriber: Doctor Smart
- Per Diem:
- Primary Payer: Medicaid (Rx)
- Secondary Payer:
- Authorization: Automatic
- Bill For Denial

Rx Format: IV

- Requires Authorization
- Rx Present (checked)
- STAT Order

Diagnoses

ICD-10	ICD-9	Description
L03.90	682.9	Cellulitis, unspecified (L03.9

Key set up areas – CareTend – Lookup Editor

- Price Codes
  - Crucial in setting up Payer Pricing and Billing Rules
  - These are set up based on your contracts
  - Many times, your billing staff is manually manipulating rates and codes when creating a claim, reach out to them to see what they are doing and set it up, so the flow is more efficient.

- Price Codes – Defines an item type
  - Standard – Drugs – Supplies – Per Diems – Equipment - Nurse Visits
  - More Specific – Flushes – Diluents – Enteral Formula – Mic Tubes – Drugs with AWP above $100.00/Vial – Non Billable Nursing Visits – Billable Nurse Visits

Code	Category / Name	Sale Formula	Sale Multiplier
01	Drugs	AWP per Each	1.50000
02	Supplies	List Price per Each	1.00000
03	Per Diems	List Price per Each	1.00000
04	Equipment	List Price per Each	1.00000
05	Diluents	List Price per Each	1.00000
06	Flushes	List Price per Each	1.00000
07	Nurse Visits	List Price per Each	1.00000
08	Enteral Formula	List Price per Each	1.00000
09	Mic Tubes	List Price per Each	1.00000
10	Non Billable Visits	List Price per Each	1.00000
11	Drugs AWP over $100.0	AWP per Each	1.30000
12	User Defined	List Price per Each	1.00000
13	User Defined	List Price per Each	1.00000
14	User Defined	List Price per Each	1.00000
15	User Defined	List Price per Each	1.00000

Key set up areas – CareTend – Lookup Editor

- Adjustment Codes
  - Being able to run reports on the adjustment reason is a key step to your Revenue Cycle Process.
  - Standard X12 claim adjustment reason codes are installed.
  - Special adjustment reasons based on your organizations reporting needs should be added. (Referred to a collection agency, arbitration settlement, Charity, etc.)

Adjustment Codes

Freq. Code	Description	Active
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.	☑
P6	Based on entitlement to benefits. To be used for Property and Casualty only.	☑
P7	The applicable fee schedule/fee database does not contain the billed code. To be used for Property and Casualty only.	☑
P8	Claim is under investigation. To be used for Property and Casualty only.	☑
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.	☑
[illegible]	[illegible]	☑
COLL	Referred to Collections	☑
OPL	Overpayment Liability	☑
CADJ	Contractual Adjustment	☑
REF	Refund Sent to Payor/Patient	☑
PT EXP	Patient Expired (BD)	☑
SM BAL	Small Balance Write Off (BD)	☑
SEQ	Medicare 2% Sequestration	☑
ASC-CT Self	CareTend Self-Pay Balance Transfer	☑
BILLING ERR	Billing Error (BD)	☑
PTF	Past Timely Filing (BD)	☑

Key set up areas – CareTend – Lookup Editor

- Billing Review Status
  - Creating unique codes to identify the reason charges are pending will allow reporting to be run to identify what the hold up is. Below are some examples.
    - BQ – Billing Question – the biller is unsure of something.
    - II – Insurance Issue – this points to a problem with the insurance, perhaps invoices in AR are not paying.
    - Auth – Pending Authorization
    - RxQ – Pharmacy Question

Key set up areas – CareTend – Lookup Editor

- Claim Hold Status – (Charges can be held in Bill Review – Ready to Bill or the Claims Queue depending on your organization's needs)
  - This provides are reason why claims are holding. Below are some examples.
    - SWO – Standard Written Order
    - DIF – DME Information Form
    - Initial – Pending initial claim payment
    - Auth – Pending Authorization
    - DOC – Pending documentation (Rx, Orders, AOB, etc.)

Key set up areas – CareTend - Payer Pricing Rules

- These are the rules that the system will use to price out the services being billed. These should be based on the contracts that you have with your payers or the payer specific fee schedules.
- Rules can be set up using: Explicit –when an item doesn't fit the norm.
- Price Code
- Fee Schedule –(Medicare)
- HCPC
- Item Category
- Default

Below is an example of an AWP + Per Diem

Pricing Rule - AWP + Per Diem - Active
Activities
History
Make Inactive
Rule Name AWP + Per Diem
Description 2017
Explicit
HCPC
Price Code
Default
Cancel
Save & Close

Key set up areas – CareTend - Payer Pricing Rules

- HCPC – All the per diem codes are entered with rates.

	HCPC	Description	Billed Price	Expected Price
—	S9500	Hit antibiotic q24h diem	0	125
—	S5497	Hit cath care noc	0	25
—	S5498	Hit simple cath care	0	25
—	S5501	Hit complex cath care	0	25

Price Codes – Drugs are entered based on AWP.

Filter Search ✕

	Name	CD	Billed Formula (List Price per Eac	Billed Multiplier (1.00000)	Expected Formula (AWP per Each)	Expected Multiplier (1.00000)
—	Drugs	01	List Price per	1	AWP per Each	0.75
—	Diluents	05	List Price per	1	AWP per Each	0.75
—	Flushes	06	List Price per	1	AWP per Each	0.75

Key set up areas – CareTend – Billing Rules

- **Billing Rules Define:**
  - Claim Type Billed –CMS 1500 –EMC –Generic –UB04 and others.
  - Billable State of item –Bill as 0 –Billable –Not Billable –Not Covered
  - Requires Authorization
  - Quantity Limits
  - Frequency Limits
  - Asset Price Type –Rental or Sale
  - Sales Modifier
  - Rental Modifier
  - NDC Unit Qualifier –(This can be set in inventory as well)
  - Max Rental
  - No Recurring Rental
  - Daily Bill Rental

Key set up areas – CareTend – Billing Rule Example

	Name	CD		Claim Type (Electronic Medic	Billable State (Billable)	Requires Authorization (N/A)
—	Drugs	01		Electronic Me	Billable	Yes
—	Supplies	02		Electronic Me	Not Billable	
—	Per Diems	03		Electronic Me	Billable	Yes
—	Equipment	04		Electronic Me	Not Billable	
—	Diluents	05		Electronic Me	Billable	No
—	Flushes	06		Electronic Me	Not Billable	
—	Nurse Visits	07		Electronic Me	Billable	Yes

Key set up areas – CareTend – Insurance Companies

General/Billing Info

General / Billing Info | Settings | Contacts | Claim Settings | Eligibility | Companies | User Defined

General

Field	Value
Organization	AETNA
Payer Type	Commercial
Identifier	AETNA
Opt. Org Name	
Address	P.O. Box 981106
City, State, Zip	El Paso, TX 79998-1106
Phone #'s	(800) 624-0756
Fax #	

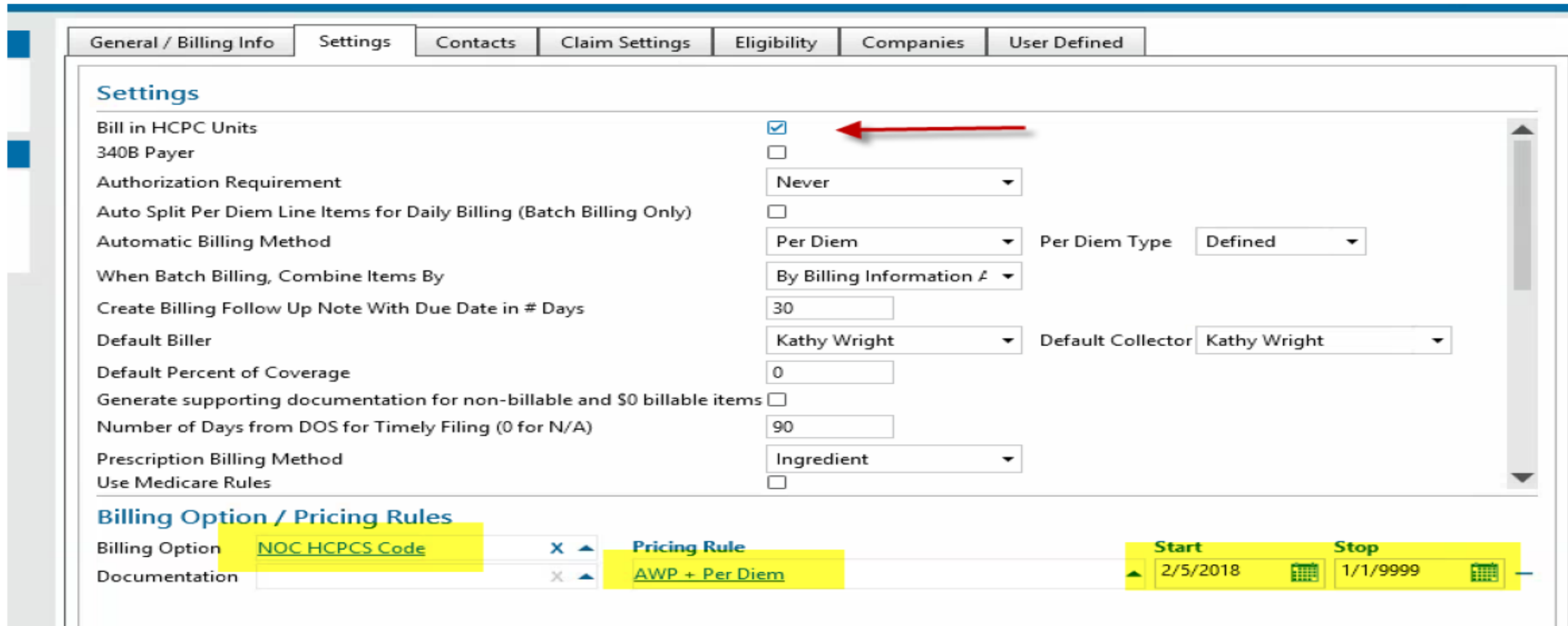
Primary Billing Address

Field	Value
Organization	AETNA
Attention	
Address	P.O. Box 981106
City, State, Zip	El Paso, TX 79998-1106
Provider # (Box 24/E9)	
Qualifier	
HPID	
OCNA	

Notes

Per Diems are NOC Codes
We are not contracted to supply Enteral Services

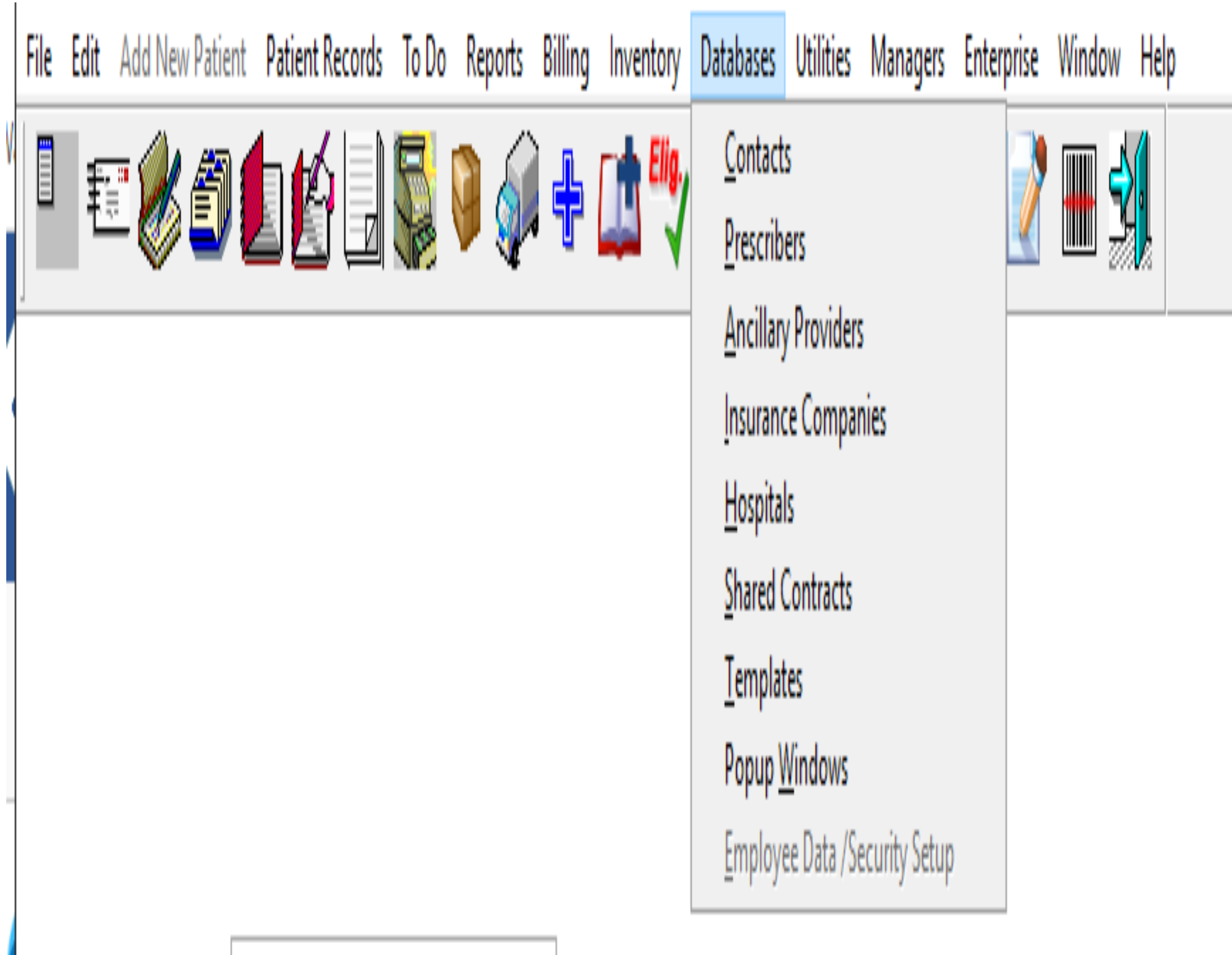
Key set up areas – CareTend – Insurance Companies



Key area set up - CPR+ - Databases

- Databases is the key area for set up in CPR+. We will review the following key areas for Revenue Cycle:

  - Prescribers
  - Insurance Companies
  - Shared Contracts
  - Popup Windows



Key area set up - CPR+ - Databases – Prescriber/Organization

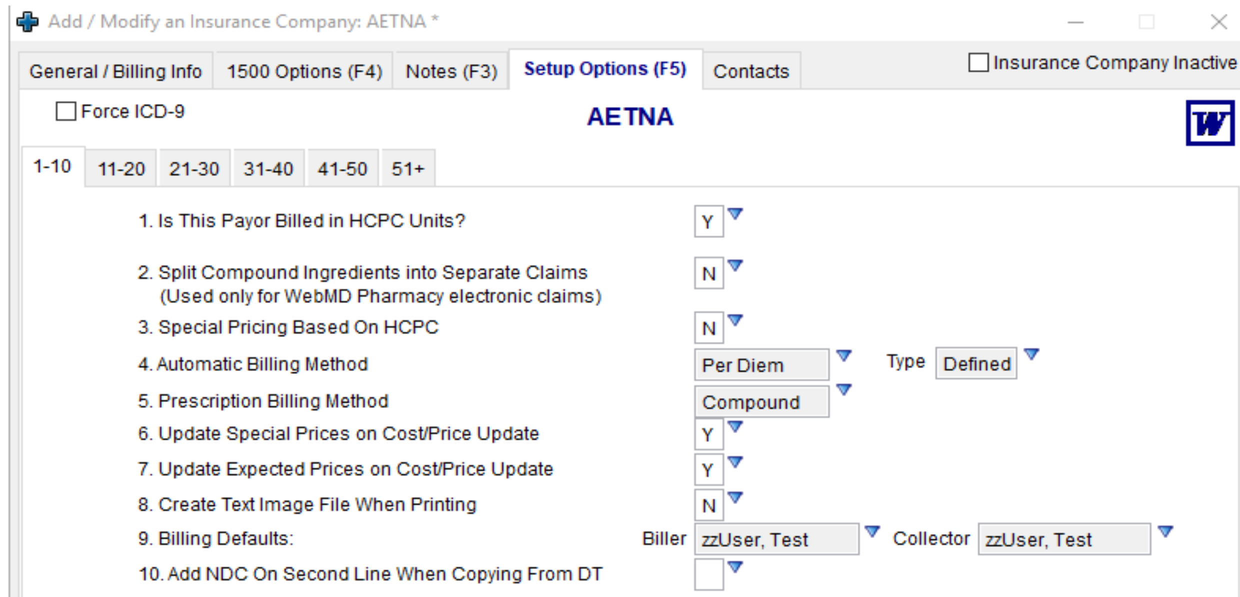
- Prescriber Name, address, phone & fax numbers
- Specialty
- Site – When operating in CPR+ multi-site mode
- PECOS Enrolled or Not
- NPI# - National Provider Identifier
- Taxonomy
- MCD Provider#
- DEA# - Drug Enforcement Agency number for controlled substances.
- License # - The prescribers state license number

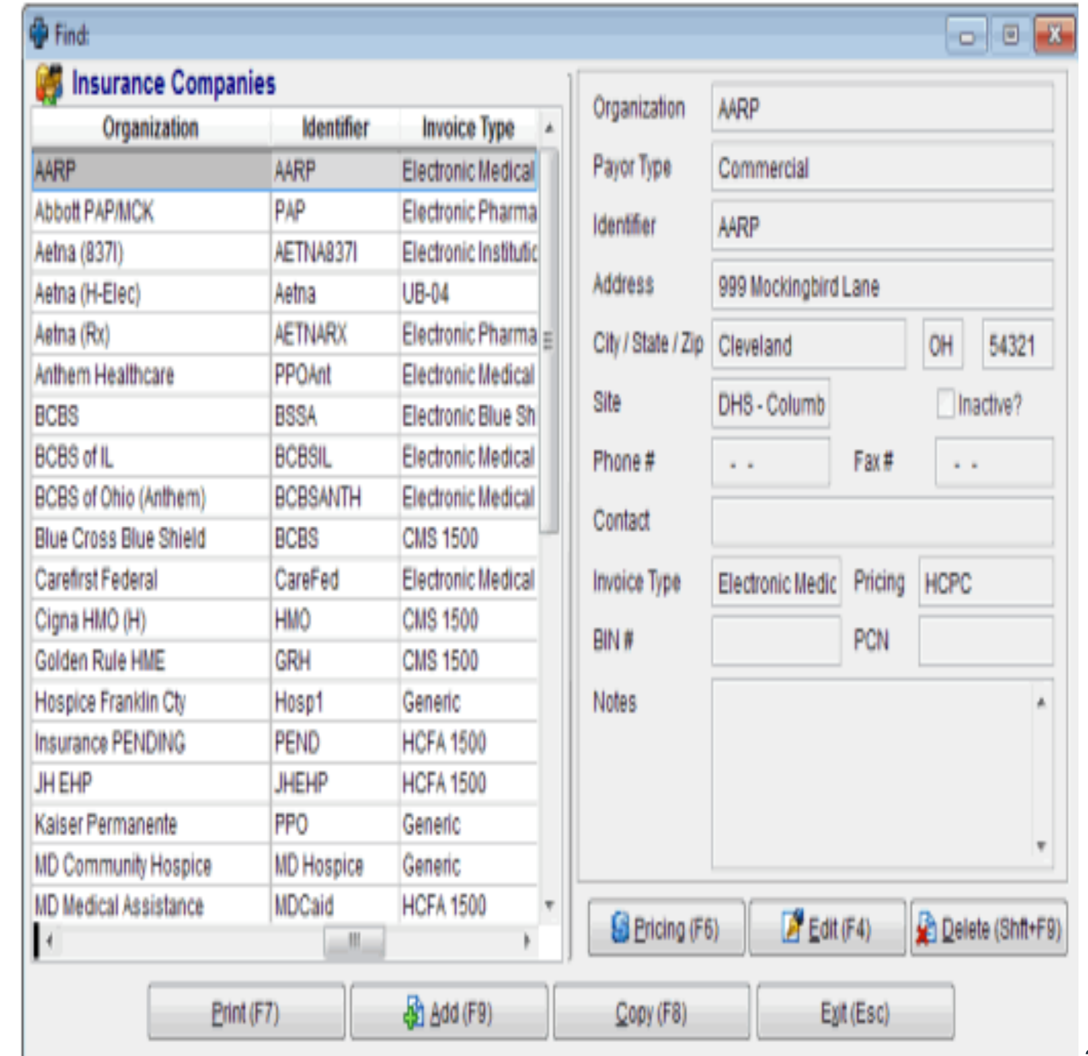
Edit Physician
Prescriber / Organization | License Info / Notes | Contacts
Inactive
Prescriber
First / Last Name: Benjamin | Adams
Prof. Designation: MD
Specialty: Oncology
Site: DHS - Columbus
Phone: 666-333-1212 Ext.
Alt Phone
Fax
E-mail: patcha@medworld.com
CMN Delivery: Fax
Allow Web Access?
PECOS Enrolled
Exclude from PECOS Check
Organization
Name: Adams Hematology / Oncology
Address: 89890 Hawfield Terrace
City, State, ZIP: Columbus | OH | 43229
Contact: Jamie Farr
Sales Code
RR MCR#
Cancel (Esc) | Save & Close (F2)

Edit Physician *
Prescriber / Organization | License Info / Notes | Contacts
Inactive
License Info
NPI: 12313131313
UPIN: 12131
MCD Provider #
DEA #
License #
Taxonomy
Carolina Access
HCID
MCR #: MCR#
License Last Verified: 01/01/2006 Initials: TC
License Next Verified: 01/01/2007 Initials
Notes
Enter a note here.
Cancel (Esc) | Save & Close (F2)

Key area set up - CPR+ - Databases – Insurance Companies

- Basic Information
  - Payer Address
  - Phone/Fax Numbers
  - EMC Payer ID/BIN#
  - Contract Information





Key area set up - CPR+ - Databases – Shared Contracts

Contract Name: Test

A Price Matrix does not exist for this Contract

Update Special Prices on Cost/Price Update? Y

Update Expected Prices on Cost/Price Update? N

Please Select a Type

Select the Type of Matrix to Create

- (•) By Price Code
- ( ) By HCPC
- ( ) By Medicare Fees

Cancel (Esc) | Save & Close (F2)

Price Matrix Formulation

Price Codes

Code	Category / Name	Formula (Special)	Multiplier (Special)	Formula (Expected)	Multiplier (Expected)	$	Auth
01	Drugs	List Price	1.0000	List Price	1.0000	Y	
02	Supplies	List Price	1.0000	List Price	1.0000	Y	
03	Rentals	List Price	1.0000	List Price	1.0000	Y	
04	Per Diems	List Price	1.0000	List Price	1.0000	Y	
05	Enterals	List Price	1.0000	List Price	1.0000	Y	
06	Compounded Drugs	List Price	1.0000	List Price	1.0000	Y	
07	DME	List Price	1.0000	List Price	1.0000	Y	
08	Consultation	List Price	1.0000	List Price	1.0000	Y	
09	Nursing Visits	List Price	1.0000	List Price	1.0000	Y	
10	Misc.	List Price	1.0000	List Price	1.0000	Y	
11	Dispense/Mix Fee	List Price	1.0000	List Price	1.0000	Y	
12	TPN	List Price	1.0000	List Price	1.0000	Y	
13	Drugs	List Price	1.0000	List Price	1.0000	Y	

Key area set up – CPR+ - Popup Windows

- Popup Windows allow you to set predefined areas for use in patient care. Some used for Revenue Cycle are:
  - Adjustment Type – Defines the reason for the adjustment so that reporting can be done on the specific denial reason.
  - Billing Note Subjects – examples include:
    - Corrected claim sent – Patient Call – Denial – Adjustment Requested
  - Billing Note Templates – Defines specific areas needed to be noted on the billing note.
  - Delivery Ticket Status Code – Used to status tickets as well as invoices. Examples:
    - Appealed Invoice – Adjustment Requested – ESD (End Service Date Hold)

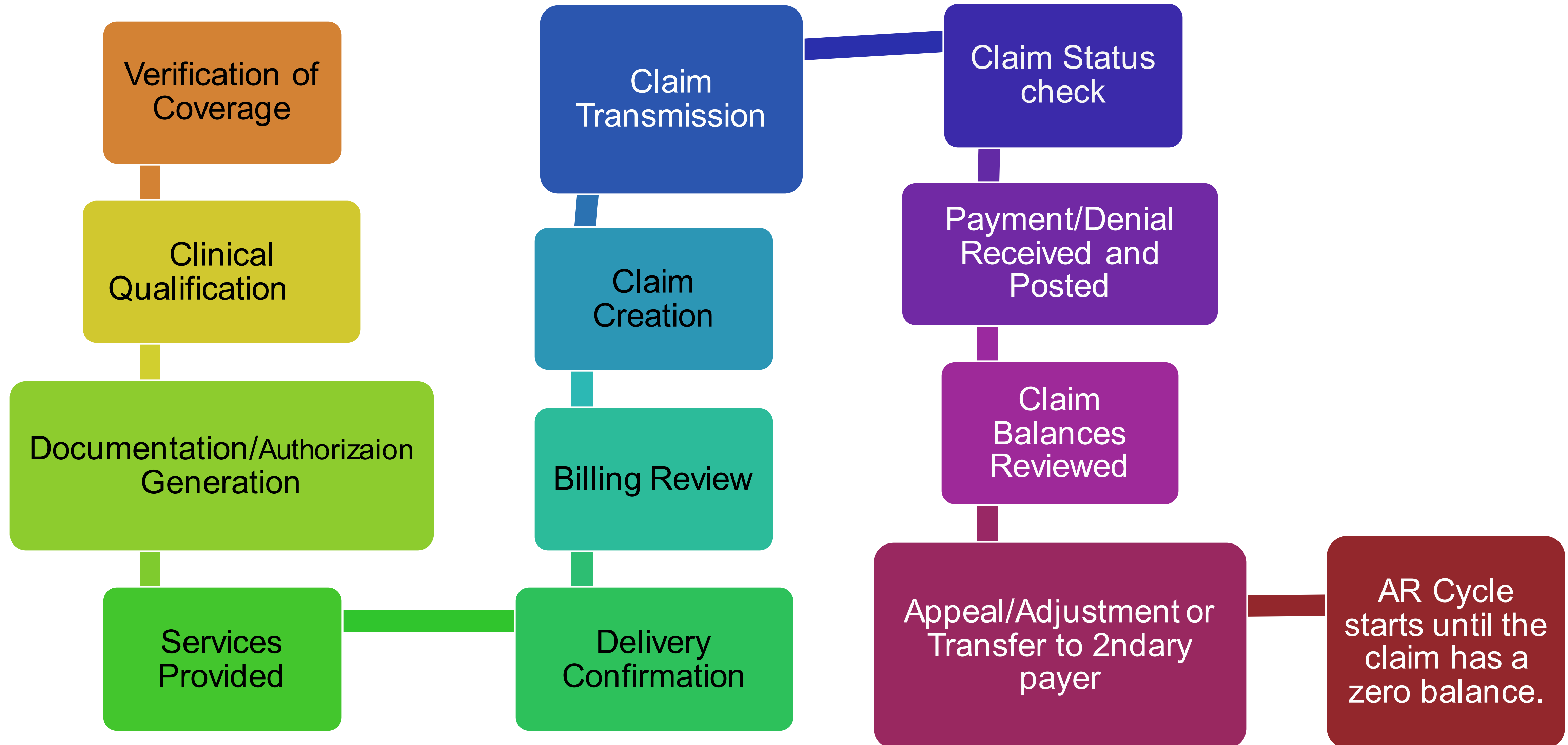
Denials – The importance of logging them

- Understanding why logging denials is importance:
  - ***You cannot track and monitor what you cannot see!***
- Not all denials are bad:
  - Most home infusion therapies are not covered by Medicare and a secondary insurance is needed for coverage. That secondary insurance is not going to pay unless you show them proof that the primary insurance has denied for not being a covered service.

Denials – The importance of logging them

- Identify trends and learn from them:
  - We miss key learnings by not logging denials. We can run reports by denial reason, by payer and by service to pick up on any key payer, contract, regulation or billing requirement changes.
- Work denials within timely filing limits:
  - After logging the reason for the denial in your system, it's time to determine what you need to resubmit the claim within the timely filing guidelines. Working backward from the timely filing limit is a great way to make sure you have enough time to capture missing information, gather physician signatures, etc., so you can resubmit by the deadline. A best practice for managing denials is to work them within seven days or less.

Revenue cycle process flow



Reporting

- Reporting is a critical part of ensuring your success. It allows you to view all the activity or in some cases, lack of activity that is done. There are many reports in CareTend BI that offer a deep dive into your financials. Below are some of these reports:

  - Adjustments with reasons by payer/service
  - AR Aged by payer
  - Billing Notes with unacknowledged follow up
  - Denials by patient/invoice
  - Partial Payments by patient/invoice
  - Aged Cash Receipts

Questions???

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Thank you.

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