

CareForum 2022

The WellSky® Conference

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

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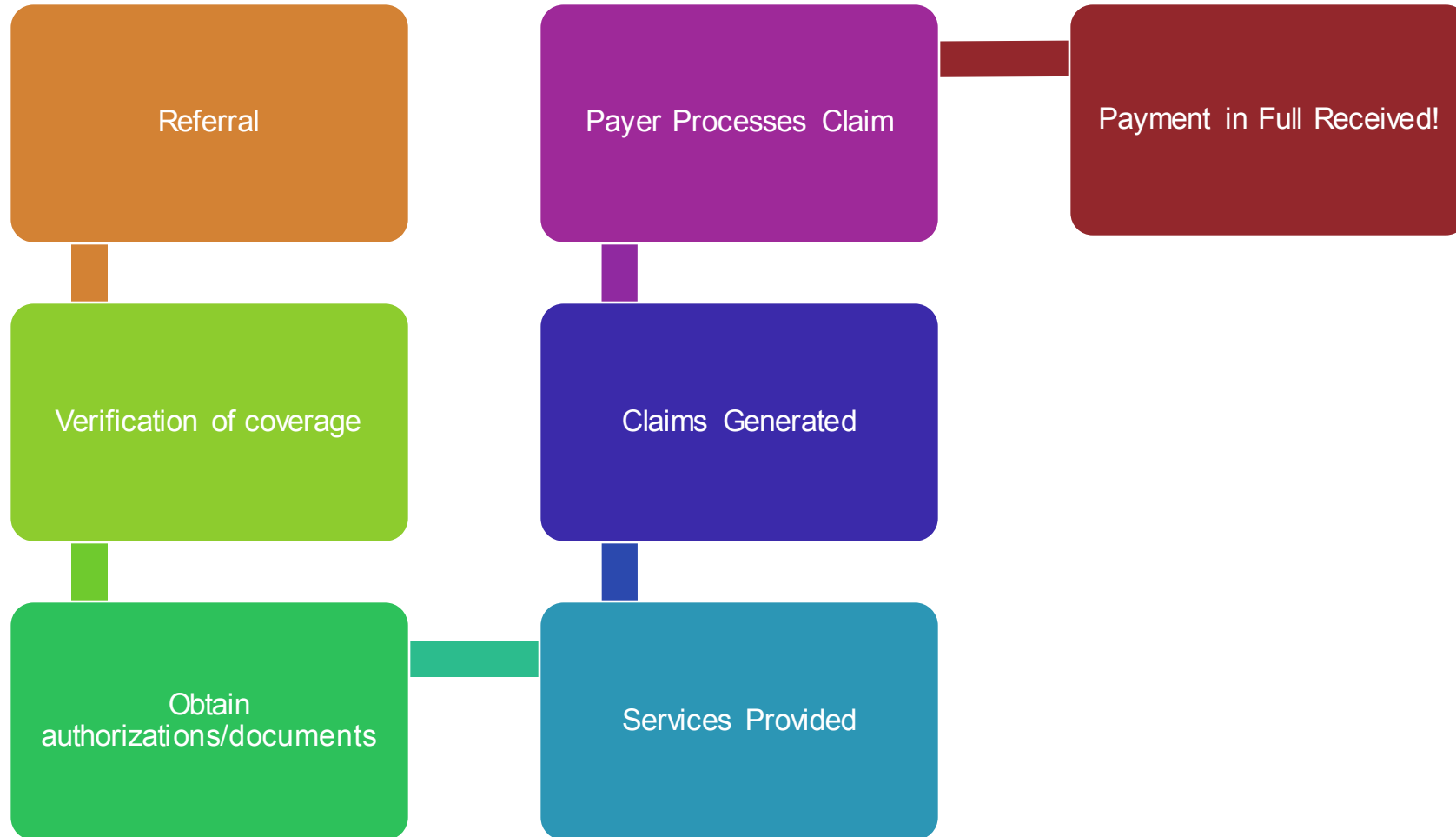
Rhonda White, Reimbursement Coordinator - Intake

9/13/2022

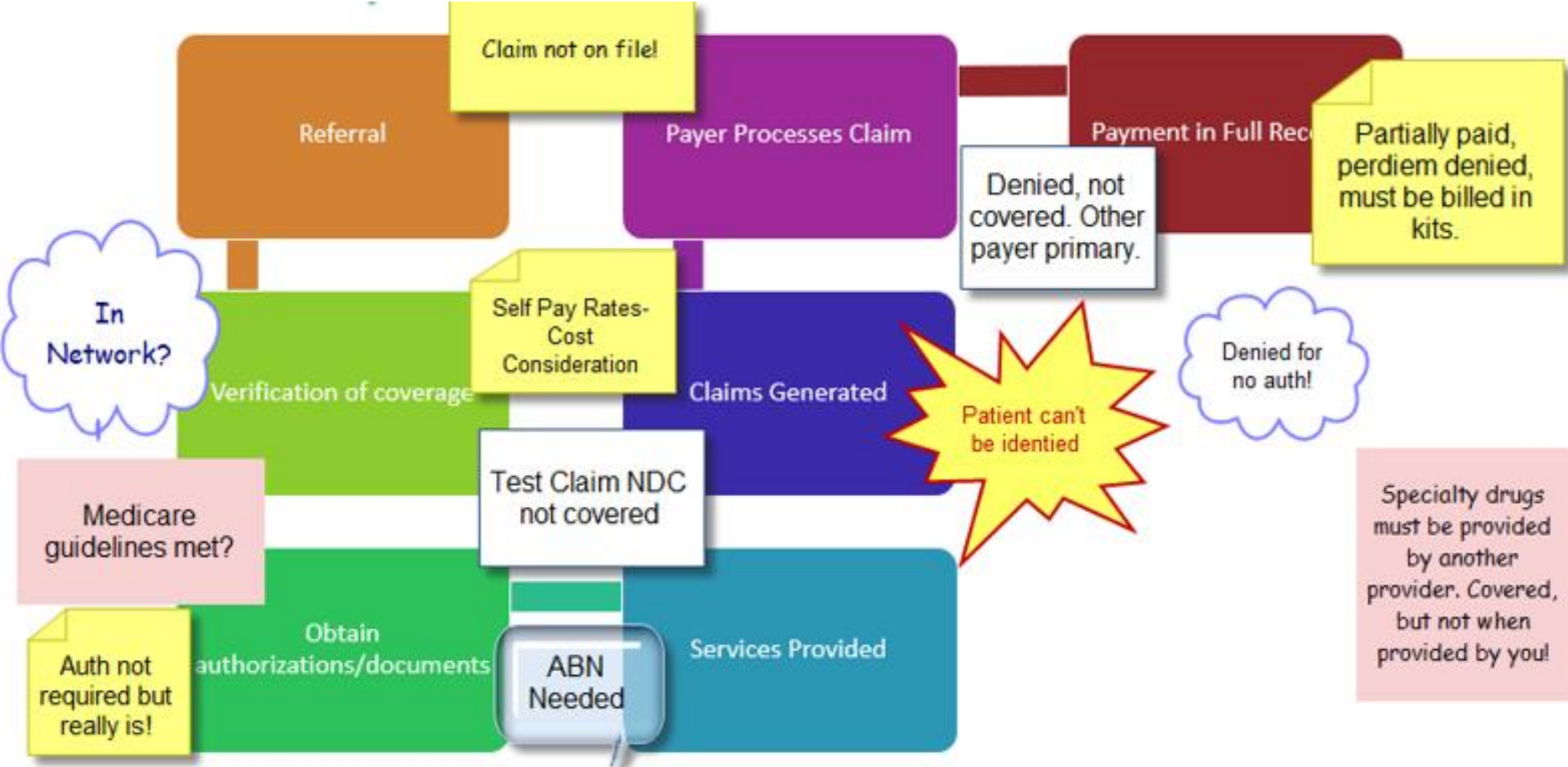
Agenda

- 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

PATIENT TEST - Patient Menu (MRN: 210115)

PATIENT TEST ⚠
TEST PATIENT

Demographic / Financial (A) | Visit Report / Assessment (H)
Orders / Medical Info (B) | Prescription File / Labels (I)
Medication Profile (C) | Delivery Tickets (J)
Physicians Orders (D) | Patient Utilities (K)
Supporting Documentation (E) | Lab Orders / Results (L)
Progress Notes (E) | **Outcomes / Discharge (M)**
Care Plans (G) | Close Patient Menu (N)

Edit Physician *

Prescriber / Organization | License Info / Notes | Contacts | Inactive

Prescriber

First / Last Name
Prof. Designation
Specialty
Site (All Sites)
Phone | - - | Ext. |
Alt Phone | - - |
Fax | - - |
E-mail
CMN Delivery: Fax

PECOS Enrolled
 Exclude from PECOS Check

Organization

Name
Address
City, State, ZIP
Contact

Cancel (Esc) | Save & Close (F2)

Edit Physician *

Prescriber / Organization | **License Info / Notes** | Contacts | Inactive

License Info

NPI | Taxonomy
UPI# | Carolina Access
MCD Provider # | HCID
DEA #
License #
MCR #
NADEAN
License Last Verified | Initials
License Next Verified | Initials

Notes

Cancel (Esc) | Save & Close (F2)

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?

Specialty Drugs not covered

Bills in Per Diem S codes unless it is for the Medicare 20%

Auth needed on TPN

Enteral PO not covered

Specific notes can be added directly into the insurance company for quick reference.

Buttons: Copy Data (F12), Pricing (F6), Electronic Setup (F8), Delete Company (F9), Save & Close (F2)

Documents such as payer specific contracts or job aides can be scanned into the payer..

Section	Field	Value
General	Organization	AETNA
	Payor Type	PRIVATE
	Identifier	AETNA
	Address	P.O. BOX 981107
	City, State, Zip	EL PASO TX 79998-1107
	Phone	888-632-3862
	Optional Org. Name	
Primary Billing Address	Organization	AETNA
	Attn	
	Address	P.O. BOX 981107
	City, State, Zip	EL PASO TX 79998-1107
	Provider Number	0007068150
	WebMD Medical #	60054
	Requires Invoice Type	ELECTRONIC MEDICAL
	OCNA	06457A001

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

Subject: Insurance Verification

Note: INSURANCE VERIFICATION

Medicare Coverage:
Medicare PART D Coverage:

Verified Insurance with: Phone # Ref #
Insurance:
In or Out of Network:
What network does the plan bill under:
Effective Date:

Buttons: Help (F1), Delete (F9), Save & Close (F2)

Insurance Verification - Patient

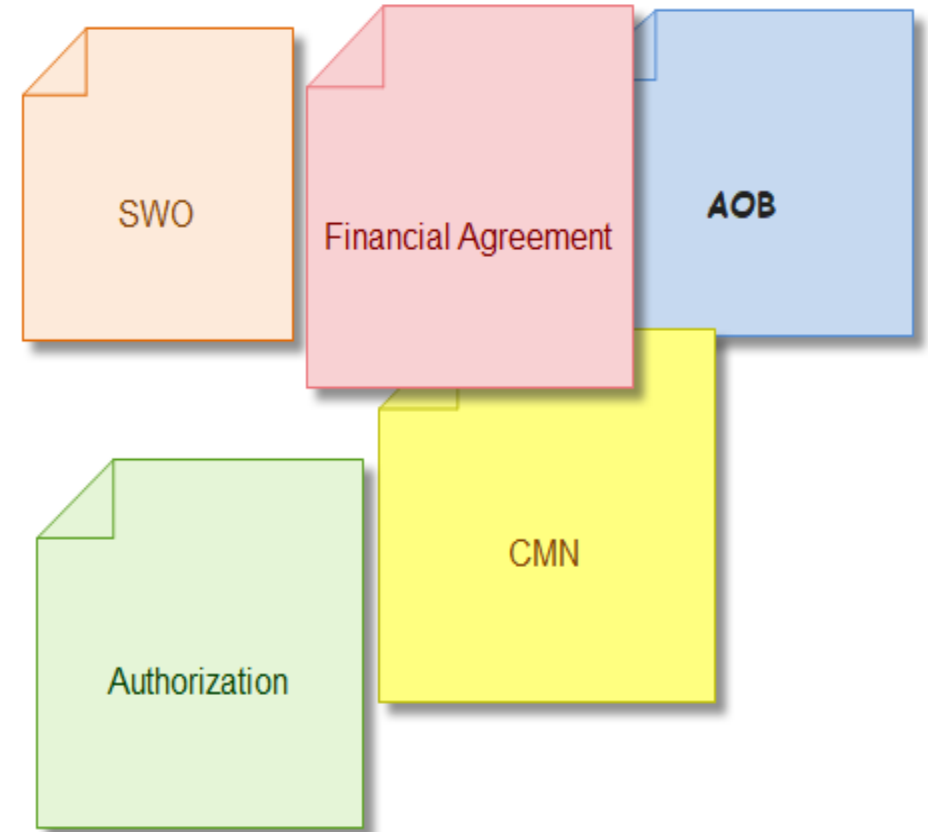
Policy Owner:	xxxx	Policy Effective Date:	7/13/2020	Insurance Contract:	
Policy Number:		Policy Expiration Date:		Phone Number:	
Group Number:		Policy ID#:		Plan Number:	
		Policy Sub:		Plan Name:	

Buttons: Print, Cancel, Save & Close

Verification Date	Current Date	Insurance	Plan	Insurance	Out of Pocket
7/13/2020	7/13/2020	xxxx	xxxx	xxxx	xxxx
Medicare Supplemental	Yes	Out of Pocket Maximum	Yes	Part of Self-Pay	Yes
Major Medical	Yes	Coverage Under Drug Plan for Rx	Yes	Out of Pocket of Self	Yes
Coverage after Self	Yes	Coverage for Self Therapy	Yes	Self Pay to Date	Yes
Max Allowable Charge	Yes	Medical Necessity	Yes	Pre-Cost Required	Yes

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.

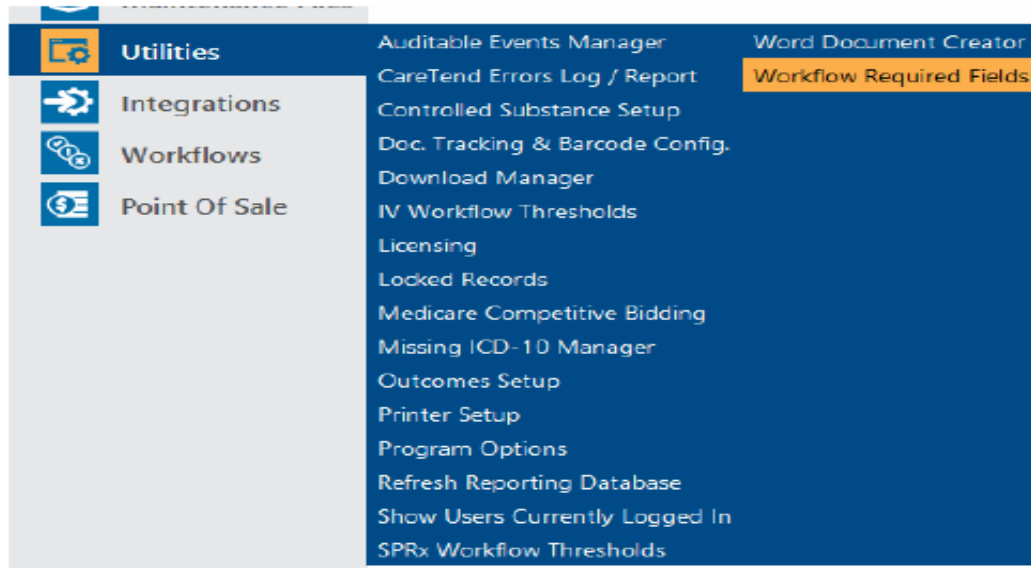
- AR Staff

- 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.



A screenshot of the 'Workflow Required Fields' configuration window. The window has a blue title bar and a search bar at the top. Below the search bar is a table with three columns: Entity, Description, and Active. The table contains 20 rows of configuration items for the 'Patient' entity. Each row has a checkbox in the 'Active' column. The 'Active' column is currently unchecked for most items, but checked for 'Primary Address must be set', 'Primary Address City must contain a value', 'Primary Address State must contain a value', 'Primary Address Postal Code must contain a value', 'Patient Allergies must be checked', 'Current Prescriber must be set', 'Patient Height must be set', and 'Patient Weight must be set'.

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

Key set up areas – CareTend - Demographics

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

The screenshot displays the 'Demographics' tab of a patient record form. The form is organized into several sections:

- Personal Information:** Fields for First Name, Last Name, Address, Zip, Time Zone, City, ST, County, Home Phone, Mobile Phone, Work Phone, Email, Gender, Date of Birth, Age, Date of Death, SSN, Referral Date, and Referral Source. Required fields are highlighted in red.
- Medical Information:** Fields for Patient Status (Pending), Company, Start of Care, Primary RN, Biller, Sales Rep, Site of Service, Marital Status, Drivers License#, ST, and Preferred Method of Contact.
- Administrative/Insurance:** Fields for Team, Service Area, Ins Coordinator, Collector, Category, Code Status, Language (English), and External MRN.
- Checkboxes:** Advance Directives, Track SHP Patient, and Track Catheters.
- Contacts Table:** A table with columns for Name, Home, Work, Cell, Relationship, Contact Type, and Primary.

At the bottom of the form, there are checkboxes for 'Information Complete' and 'Enrolled in Engagement Module', and buttons for 'Print', 'Cancel', and '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 [Close]

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			↔ - +

→ Edit, Delete, or add policy

[Close]

Anna Smith - Demographics (MRN: 200422)

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		

Patient Policies Sequence [Close]

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

Left sidebar menu items: 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, Synaxis, Trends/PTM Activity, View Authorizations, Check Eligibility, Copy Assistance, Insurance Verification, **Patient Verification**, **Resequence Policies**, View Eligibility History

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

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.)

The screenshot displays the 'Adjustment Codes' section of the CareTend Lookup Editor. On the left, a sidebar lists various lookup categories, with 'Adjustment Codes' selected. The main area shows a search bar and a table of adjustment codes. The table has columns for 'Freq. Code', 'Description', and 'Active'. Several rows are highlighted in yellow, including 'COLL Referred to Collections', 'OPL Overpayment Liability', and 'PT EXP Patient Expired (BD)'. Other visible codes include P5, P6, P7, P8, P9, CADJ, REF, SM BAL, SEQ, ASC-CT Self, BILLING ERR, and PTF.

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

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

The screenshot displays the 'Lookup Editor' window in CareTend. On the left, a sidebar lists various lookup categories, with 'Billing Review Status' selected. The main area shows a search bar and a list of lookup items. A pop-up window titled 'Billing Review Status' is overlaid on the bottom right, showing a table with columns for 'Value', 'Description', and 'Active'. The table contains four rows: BQ (Billing Questions), II (Insurance Issue), Auth (Pending Authorization), and RXQ (Pharmacy Question). Each row has a checked checkbox and a minus sign in the 'Active' column. A red arrow points to the minus sign in the 'Auth' row.

Value	Description	Active
BQ	Billing Questions	<input checked="" type="checkbox"/> -
II	Insurance Issue	<input checked="" type="checkbox"/> -
Auth	Pending Authorization	<input checked="" type="checkbox"/> -
RXQ	Pharmacy Question	<input checked="" type="checkbox"/> +

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.)

The screenshot displays the 'Lookup Editor' interface in CareTend. The left sidebar contains navigation icons and labels: Favorites, Open Windows, Dashboard, Recent, Patient Records, Things To-Do, Billing / Financial, Inventory, Reports / BI, Maintenance Files (highlighted), and Utilities. The main content area is titled 'Lookup Editor' and features a search bar with the text 'Search for'. Below the search bar, there are radio buttons for 'Starts With' and 'Contains'. A list of lookup items is displayed, with 'Claim Hold Status' selected and highlighted in blue. To the right of the main content area, a detailed view of the 'Claim Hold Status' is shown, listing various status codes with checkboxes and expand/collapse icons. The status codes listed are: QA, DWO and DIF, DWO, DIF, Pending Initial, and Fix. A red arrow points downwards from the 'Fix' status code.

QA	<input checked="" type="checkbox"/>	-
DWO and DIF	<input checked="" type="checkbox"/>	-
DWO	<input checked="" type="checkbox"/>	-
DIF	<input checked="" type="checkbox"/>	-
Pending Initial	<input checked="" type="checkbox"/>	-
Fix	<input checked="" type="checkbox"/>	+

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						
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						
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

Settings

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

Settings

Bill in HCPC Units	<input checked="" type="checkbox"/>	
340B Payer	<input type="checkbox"/>	
Authorization Requirement	Never	
Auto Split Per Diem Line Items for Daily Billing (Batch Billing Only)	<input type="checkbox"/>	
Automatic Billing Method	Per Diem	Per Diem Type: Defined
When Batch Billing, Combine Items By	By Billing Information ^	
Create Billing Follow Up Note With Due Date in # Days	30	
Default Biller	Kathy Wright	Default Collector: Kathy Wright
Default Percent of Coverage	0	
Generate supporting documentation for non-billable and \$0 billable items	<input type="checkbox"/>	
Number of Days from DOS for Timely Filing (0 for N/A)	90	
Prescription Billing Method	Ingredient	
Use Medicare Rules	<input type="checkbox"/>	

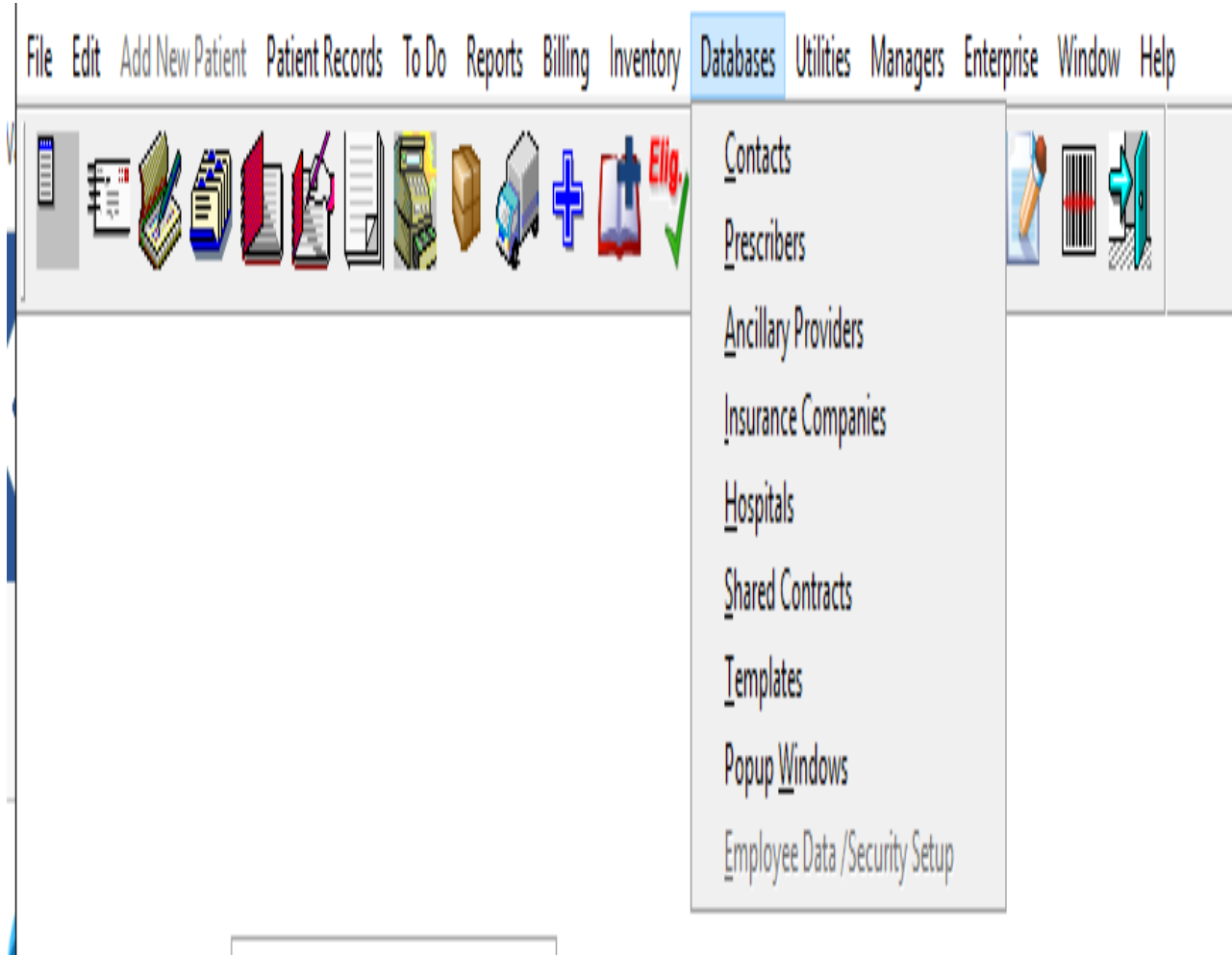
Billing Option / Pricing Rules

Billing Option		Pricing Rule	Start	Stop
	NOC_HCPCS Code		2/5/2018	1/1/9999
Documentation		AWP + Per Diem		

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

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 123131313 Taxonomy

UPIN 12131

MCD Provider # Carolina Access

DEA #

License # 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

✚ Add / Modify an Insurance Company: AETNA *

General / Billing Info 1500 Options (F4) Notes (F3) **Setup Options (F5)** Contacts Insurance Company Inactive

Force ICD-9 **AETNA** 

1-10 11-20 21-30 31-40 41-50 51+

1. Is This Payor Billed in HCPC Units? ▼

2. Split Compound Ingredients into Separate Claims
(Used only for WebMD Pharmacy electronic claims) ▼

3. Special Pricing Based On HCPC ▼

4. Automatic Billing Method ▼ Type ▼

5. Prescription Billing Method ▼


6. Update Special Prices on Cost/Price Update ▼

7. Update Expected Prices on Cost/Price Update ▼

8. Create Text Image File When Printing ▼

9. Billing Defaults: Biller ▼ Collector ▼

10. Add NDC On Second Line When Copying From DT ▼

Find:  **Insurance Companies**

Organization	Identifier	Invoice Type
AARP	AARP	Electronic Medical
Abbott PAMCK	PAP	Electronic Pharma
Aetna (B37I)	AETNAB37I	Electronic Instituc
Aetna (H-Elec)	Aetna	UB-04
Aetna (Rx)	AETNARX	Electronic Pharma
Anthem Healthcare	PPOAnt	Electronic Medical
BCBS	BSSA	Electronic Blue Sh
BCBS of IL	BCBSIL	Electronic Medical
BCBS of Ohio (Anthem)	BCBSANTH	Electronic Medical
Blue Cross Blue Shield	BCBS	CMS 1500
Carefirst Federal	CareFed	Electronic Medical
Cigna HMO (H)	HMO	CMS 1500
Golden Rule HME	GRH	CMS 1500
Hospice Franklin Cty	Hosp1	Generic
Insurance PENDING	PEND	HCFA 1500
JH EHP	JHEHP	HCFA 1500
Kaiser Permanente	PPO	Generic
MD Community Hospice	MD Hospice	Generic
MD Medical Assistance	MDCaid	HCFA 1500

Organization: AARP
Payor Type: Commercial
Identifier: AARP
Address: 999 Mockingbird Lane
City / State / Zip: Cleveland OH 54321
Site: DHS - Columb Inactive?
Phone #: . . Fax #: . .
Contact:
Invoice Type:
BIN #:
Notes:

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

Contract Name

A Price Matrix does not exist for this Contract

Update Special Prices on Cost/Price Update?

Update Expected Prices on Cost/Price Update?

Please Select a Type

Select the Type of Matrix to Create

By Price Code

By HCPC

By Medicare Fees

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)

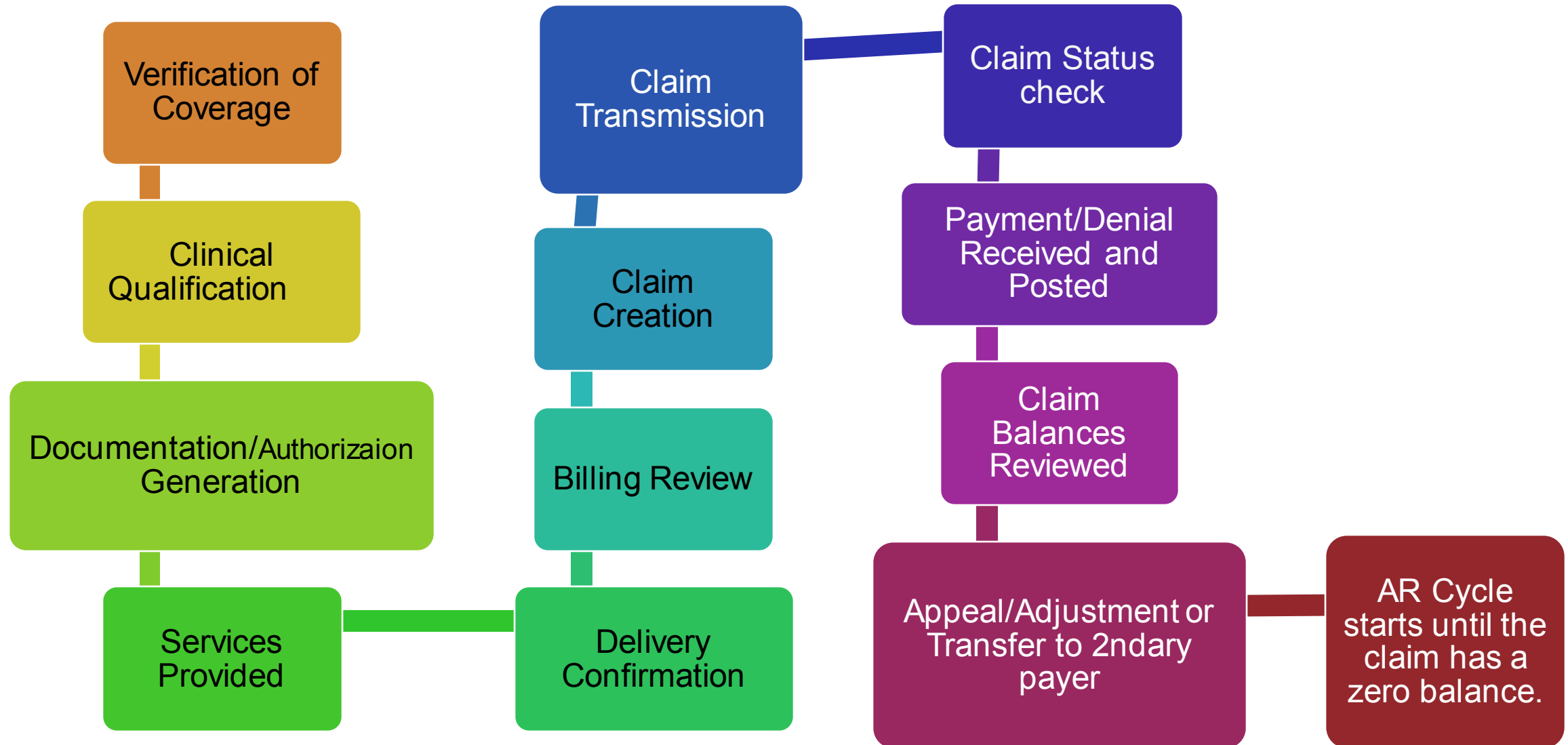
Denials – The importance of logging them

- Understanding why logging denials is important:
 - ***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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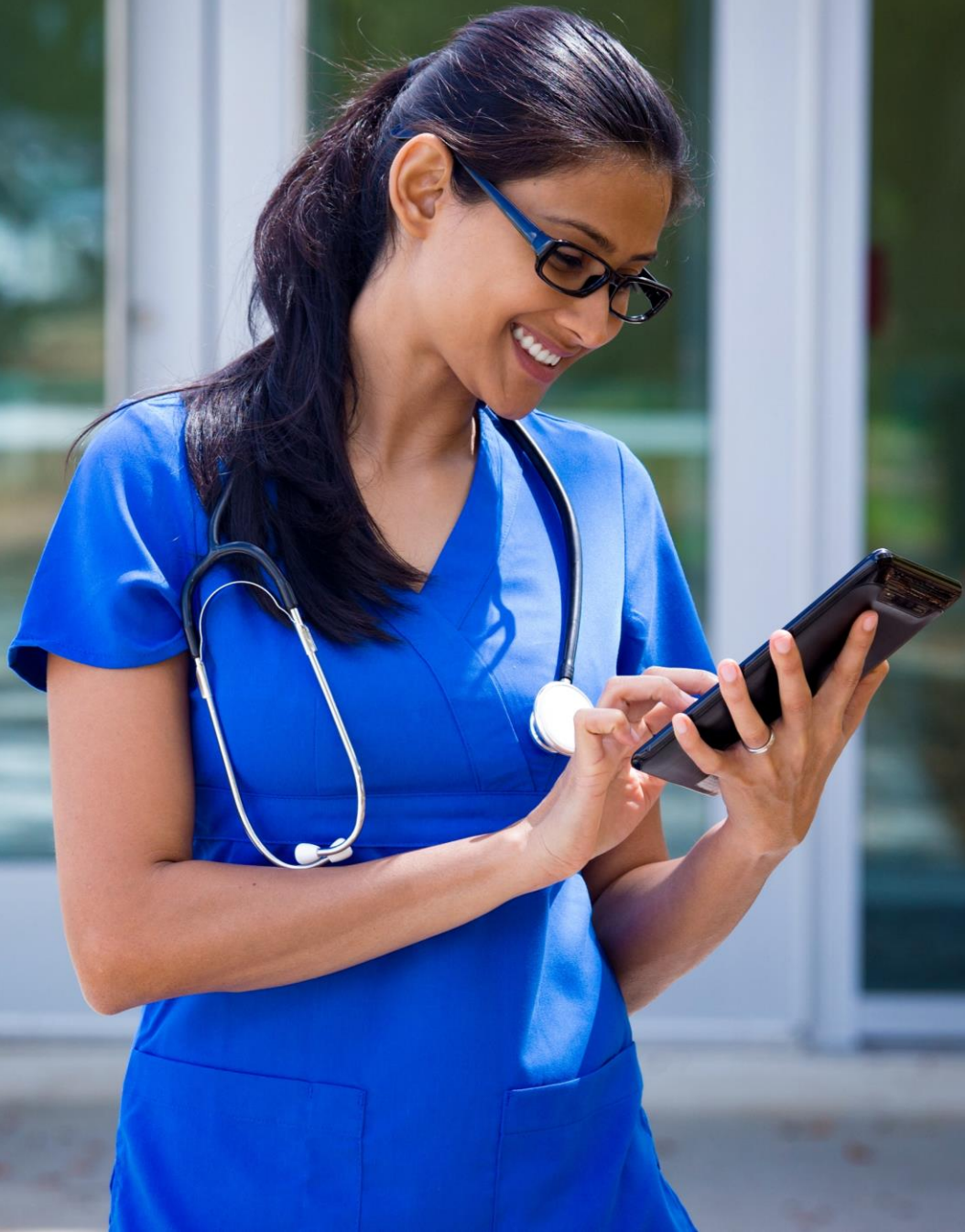
Thank you.

Contact us:

Diane Poole

Vice President of Revenue Cycle Services

Diane.Poole@WellSky.com



Learn more about WellSky Revenue Cycle Services

Delivering timely, compliant, and
accurate billing for home infusion



Request a consultation today!

