Billing Managed Care and Private Insurance Payers...Successfully!
January 22, 2013
Questions & Answers

Following are answers to the questions that were asked in our webinar. We hope that this information proves valuable to you and your staff.

1. Initially, we were told HMOs do not require face to face documentation and I keep thinking that if these HMOs are managed plans that they will follow Medicare guidelines. Are you aware of what the requirement is on the face to face documentation and HMO’s?

   It varies by payer. We suggest that you document the reason for care as well as the reason patient is homebound.

2. What is an indemnity plan?

   An indemnity plan allows a member to choose any doctor or hospital that they wish when seeking health care services. They are considered fee-for-service plans.

3. Can you make money contracting with PPOs or is it just spending time chasing payments and dealing with co-pays and deductible payments? Is it even worth it?

   Absolutely! You need to learn how to make money doing these plans if you want to stay in homecare, as they are becoming more and more common.

4. We have had a few patients on hospice that also have HMOs. We have had to discharge hospice patients due to ineligibility so my understanding is that they revert from Medicare as the primary payer (hospice) to whatever managed care company they had prior to hospice admission. The problem I’m running into is once discharged from hospice, they go on home health services, I bill the HMO and they deny saying it’s the responsibility of Medicare, even though the patient is no longer on hospice. Advice?

   We suggest you ask the payer if the patient needs to re-enroll with their plan. You may be able to bill Medicare until the patient chooses to go back to the HMO.

5. For out-of-network care, we get an authorization and document that is transmitted on the claim. So if we have that authorization will we get paid?

   Yes, you should be paid if you do the correct services and number of visits. Remember though... payers often quote “an authorization is not a guarantee of payment!”
6. **What is your suggestion for how often to "drop" and follow up?**

   Our billing services department prefers to drop claims one time a month for patients. We follow up as soon as two weeks unless a payer specifically states we have to wait 30 days. Blue Cross Blue Shield does this on some plans. The sooner you can follow up the better.

7. **We have sent bills to commercial payer via certified mail and were told that the signature only says that they received a box from us and does not prove what was in the box. How can you respond to this?**

   This is why we stress electronic submission. If you are unable to submit electronically, you should try to list on the delivery what is enclosed and on your paperwork. This is a typical avoidance to pay excuse.

8. **We have requested to join a managed care network and have been told they have enough providers in the area. I am not sure that’s true, as there are only two home health agencies in our area. So what can we do?**

   If you have exceptional results in re-hospitalization rates or any specialized clinical programs, try to get the information to your local contract managers. In addition, get your local referral sources on your side by asking for you to join.

9. **Could you provide some verbiage as to what specifically should be asked when calling to request updated contracts? I have made multiple phone calls to our payers and have yet to receive an updated contract and in fact have gotten responses that would be equal to a blank stare if I were talking with the person face to face.**

   Ask for a copy of the latest contract with the current year (give the year fee schedule and codes for services). If they don’t know what that means, go up the ladder in the payer organization by speaking to a contract or provider relations manager.

10. **What should you do if you filed correctly but they didn’t pay by mistake and now it’s been over six months? Where do we go?**

    You should try to escalate the issue to a higher level Support representative or ask for a Supervisor. Many payers have different tiers of Support.
11. Is it important to file a claim monthly with commercial billing or at the end of each cert period?

If it is an episodic payer, you do just as you do with Medicare. For other PPO or HMO pay-per-service claims we suggest you bill monthly or bi-weekly as your cash flow demands.

12. What kind of certifications should I look for when hiring billers for my agency?

You should look for a biller with experience in home care billing if at all possible. Commercial payer experience is helpful, as is knowledge of the DDE system. Get people that are bright and like to problem solve. Commercial billers need to have a “collector’s mentality.”

13. If Medicare MCO is paying according to the Medicare Fee Schedule, why do they authorize by number of visits instead of paying by HHRG code?

The plans can choose to be paid whichever way they decide. Likely, they are carrying over the fee-for-service mentality to the episodic payment arena.

14. How can I find out which Managed Care plans are in our service areas?

You can determine this information a number of ways including searching on the internet or by asking physician offices and hospital discharge planners. Find out which ones are worth dealing with and have a volume of business locally. Don’t try to do contract with every insurance company. Pick a couple of good ones and learn how to deal with them. Then expand.

15. When filing a claim, do payers require dates of service for supplies?

In our experience, the services just have to be associated with a date that falls within the billing from and through that you’re billing for. Please note, if the payer is episodic be sure the service line date for supplies is not prior to your true first billable visit.

16. Are there requirements for providers as to timely payments or response to claims? Also, if they do not respond in a reasonable time, what can we do about it?

Yes, information regarding timely filing deadlines should be spelled out in your contract. If you have no contract and you are handling an individual client, ask for that information upon intake.
17. Are there companies that can help us to initiate HMO contracts? What would be the best avenue to start building our HMO contracts?

Get out to local network meetings and find out which companies people are using. Your ALFs, doctor’s offices and hospital discharge planners will know. Then get the facts on them. Start with one or two and learn the ins and outs of billing. Then go for more payers.

18. What are your thoughts on Workers’ Comp patients?

Many times what believe to be a Workers’ Comp patient may be a patient that simply needs to have their CWF (Common Working File) updated. We often run into claim rejections when billing Medicare for the patient showing they have Workers’ Comp but after research it’s a matter of Medicare’s CWF having inaccurate data.

19. Do you have any suggestions on what the next step is in this scenario? We called BCBS of TX for authorization, got a Pre Authorization Reference number, but when we billed they said that there is no authorization and they will not honor the reference number. We have appealed, patient has appealed and the patient’s work HR has appealed...to no avail.

Pre Authorization Reference numbers will not work. You can bill the patient if you have appropriate paperwork in place to do so. Or take it as an expensive lesson. Sorry. They got you!!

20. What is the average cost to expect when using a billing service?

Billing service costs vary based on vendor, census, etc. HEALTHCAREfirst’s billing service pricing starts at $550 for up to 25 unduplicated patient census. If you are interested in learning more about our billing service, please call 800.841.6095 or visit our website, www.healthcarefirst.com.

21. How do we bill a patient who was Medicare, then went to Medicare Advantage or vice versa? Do we need a new OASIS or a whole new SOC packet with consent and all the paperwork?

That depends. Where you are at in the episode is important. If you find out mid-episode it gets a little tricky sometimes as to when to switch billing. If you are doing the same paperwork that MCR requires it is easy to go back and forth. Always do face-to-face forms so you’ll have if them if you need them. Remember to always check eligibility.
22. Is there a central learning place like a website/forum to learn and get tips and tricks on some real nuances of commercial billing and keep pace with the constant changes that are going on?

Unfortunately, we don’t know of any central learning location. We do encourage you to subscribe to our blog, as we post late breaking news, billing topics, regulatory updates, etc. regularly. We also host webinars such as this one covering a wide variety of topics that can affect your agency’s business practices.

23. When requesting an authorization for SN visits, do we only request for SN or do these plans recognize any other types of G codes for services like Medicare does?

This will depend on your contract and payment schedule. They aren’t all the same.

24. What is EDI?

EDI (Electronic Data Interchange) the broad field of work that relates to electronic transactions to/from any payer for the purpose of billing. This can include eligibility, prior authorization, claim submission and remittance retrieval.

25. What is the best way to gather information on what each insurance company requires?

To be sure you are gathering the appropriate information, read the language of each contract carefully. Look for whether they are episodic or per service payers, timely filing deadlines and service codes. If are not a contracted provider, get as much information as possible up front.

26. Could you provide some verbiage to assist an agency on getting deductible/OOP payments up front? I’m told it is required to bill the payer prior to billing the patient their portion and there are arguments about violating contracts if we request upfront payment.

If there are co-payments and deductibles, it is acceptable to bill up front. Any payer who denies that would not be one I would contract with. You need a contract with the payer for responsibility in case the insurance denies coverage.

27. You said if you are not in-network you can ask for authorization, but is an authorization a guarantee of payment?

An authorization is NEVER a guarantee of payment, but failing to get one when required is a sure easy out for the insurance not to pay you.
28. Is there any talk or rumors that insurances will work toward a more universal system for billing and information such as through a one location portal?

There is probably little likelihood that there will be just one location for everyone, but the use of portals is increasing and will continue to do so. MCAD especially has gravitated in this direction with their MCOs.

29. How would you respond? We billed electronically on Managed Medicaid through a third party vendor and when I verified, they indicated they never received the electronic claim. Then upon contacting the third party vendor, the EDI department says there was no response from the payer. As a result the 3rd party vendor placed it on the “rejected” list as “no response from the payer.”

If this happens, you should probably take a second look at your third party vendor. HEALTHCAREfirst’s billing services team uses Zirmed and they are very accurate and efficient and are immediately notified if there is a problem.

30. How do you suggest I deal with insurance companies who say they can’t tell me what copays or deductibles are due, they can only tell patient?

If you are doing business with a payer they should tell you. If they can’t or won’t tell you, you shouldn’t do business with them. You have the right to be paid.

31. What do you mean by “Employer Group?”

Employer Groups are companies that contract with payers to cover their employees. They can set benefits specific to their employees such as co pays and deductibles as well as benefits provided.

32. What if a claim was sent almost a year ago and when we followed up they said that they didn’t receive the claim? Will they still pay us? Filing was on time.

Not unless you can prove it. If you sent it electronically, you can present that information and hope that they will change their minds.
33. My agency was just admitted into a managed care network. They say we will get a percentage of "allowable" but they won't say what the "allowable" is. Do you have any idea?

It usually depends upon the plan. Some pay 76% on HMOs, 86% on PPOs and another % on indemnity. They should give you the exact schedule with your contract. If they don’t give it to you ask again. I know agencies are getting copies so you know how to book your net AR.

34. How do you suggest we handle out-of-network payers who send the checks and EOBs directly to the patient instead of to our agency?

Contact your patient and be sure they know the check will be going to them and you will be owed the amount and need a copy of the EOB.

35. How soon will we be reimbursed for Medicaid room and board patients?

Every state is different. Now with the shifting of the payer mix to managed plans even different plans under the same state’s Medicaid may have differing adjudication timeframes. With that being said, for the straightforward Medicaid’s we have seen weekly reimbursement schedules.

36. What do you see as far as medical supplies with insurance companies? I’m having issues with a payer paying on an ostomy pouch. They are paying all the other ostomy supplies, but this one they keep trying to say is included in the visit and is a routine supply.

If they are paying episodically they could include some or all supplies under the payment. That is what you need to clarify with your contract manager at the plan.

37. Just received a referral. Patient has $2,500 deductible of which only $200 has been met. What if patient does not have the $2,300 to pay up front?

If you really want to take the patient, all you can do is set up a payment plan and hope to be paid.

38. When you talk about authorization, is this for EVERY patient you take from a particular payer even if you have a contract with them? Or is it just for payers with whom you have no contract?

Even some contracted payers require authorizations. Check your contract and talk to the plan manager.
39. For electronic submission, are most of the companies set up Web-based or do they use the old fashion dial up modems? I know we have a modem for one company.

Most payers only accept electronic claim submissions from clearinghouses that they have agreements with or know will send them “scrubbed” claim files. You would want to either contract with a billing service company for these types of claims, or contract with a clearinghouse such as Zirmed.

40. If we collect a deductible payment up front, how does the patient’s insurance company know that they have met their deductible?

The first bills to hit get applied to the deductible. If the patient has other bills hit before yours and they go to the deductible you may get paid more than you thought and you would owe money back to the patient.

41. If a patient has a secondary payer, and leaves their coverage area, do they return to Medicare?

This will depend on if the area to which they move has an MCO available and they elect to join that MCO. If not, then yes they would return to Medicare.

42. Some insurance companies are saying they are no longer accepting more providers, but yet often those providers that are active refuse a patient. Do companies ever take "emergent" applications so the patients get the care needed?

Most usually approve a non-network provider on an individual basis in this situation.

43. How do these managed care changes affect the Hospice side of Medicaid billing?

Since Hospice is on a per-diem model we haven’t seen many changes on the primary care billing. We have had some states move to different plans for the room & board billing though. Luckily they don’t typically make it harder or change billing codes, etc. It’s just that you need to know where to send the claims since it could be more than one claim center.

44. If filing claims electronically, how do you know if they need documentation?

Your contract should specify what needs to be sent and a process is developed to send documentation.
45. What is the best way to complete preauthorization and manage this process to limit non-authorized care?

Train your intake staff and on-call clinicians as to what to ask. Software that interfaces with scheduling helps limit exposure to non-approved services and number of visits. HEALTHCAREfirst offers comprehensive agency management software for both home health and hospice. Visit our website, www.healthcarefirst.com for more information.

46. How often should I ask for a new contract and new rates?

You should request a new contract no less than annually.