

Medical Business Systems

Establishing a New Medical Practice

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www.iridiumsuite.com

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Introduction to Establishing a New Medical Practice

I recently found a blog post in my inbox titled "[A guide for new and first-time physicians participating in federal healthcare programs](#)" published by Centers for Medicare & Medicaid Services and written by Shantanu Agrawal, MD.

It pointed out that after July, new physician graduates are moving into the workforce. I would imagine that most attempt to either join an existing private medical practice or become a medical center staff member, each with well-established billing policies and procedures. In those cases, the new doctor would not have the same worries or cares about how he or she is to generate income, get patients, establish payer contracts, etc. These necessities are more or less "built-in" to the position. For those rare, ambitious types who yearn to "be their own boss" and set up shop for themselves, they may be in for a rude awakening to the complexities of creating and running the business of a new medical practice.



Chapter One: Payer Enrollment

First a medical degree, does not a legally practicing doctor make. I am not sure if there is an exact “legally required” list for starting a medical practice, but taking a look at the **CMS** provider enrollment form on the web-based “**PECOS**” (the **Provider Enrollment, Chain and Ownership System**) site should provide a very good base to start from. The first hurdle you may encounter in establishing any payer enrollment is indicated very clearly on the **PECOS** site:

“Note: If you are a Medical Provider or Supplier, you must [register for an NPI](#) before enrolling with Medicare.”

Section One: National Provider Identifier (NPI)



If this is the first time you have heard the term “NPI” or need some clarification on its importance and use, the following Q and A section and informational links should provide all you need to know.

Q: What is NPI and how is it used?

A: The **NPI** is a **Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard** and a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPI in the administrative and financial transactions adopted under HIPAA. This means all individual health care providers, health care groups, and health care facilities must apply for an NPI to be used on all its transactions with health care payers

Q: How do I apply for an NPI?

A: There are three ways to apply:

1. **Online** at the NPPES website: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>
2. **Paper Application** Form CMS-10114 at: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10114.pdf> or you may also request the form from the NPI Enumerator by calling (800) 465-3203, sending an e-mail to customerservice@npienumerator.com, or sending a letter to: NPI Enumerator, P.O. Box 6059 Fargo, ND 58108-6059

3. **Electronic File Interchange (EFI)** – You may agree to have an EFI Organization (EFIO) submit application data on your behalf (i.e., through a bulk enumeration process) if an EFIO requests permission to do so.

Q: What is the difference between an NPI and:

1. Tax ID/EIN?

A: The Tax ID/EIN is the number issued to a business for taxation purposes. Multiple NPI numbers can be linked to one Tax ID number. An example is a medical practice with 3 providers. Each provider as well as the practice entity will have an NPI for a total of 4, but there will be only one Tax ID issued by the IRS.

2. UPIN?

A: The **UPIN** (Unique Physician Identification Number) was a six-character alpha-numeric identifier used by Medicare to identify doctors in the United States as the predecessor of the NPI. They were discontinued in June, 2007 therefore they currently have no relevance in the submission of any health care transactions.

3. PIN or PTAN?

A: A **PIN** (Provider Identification Number) is a unique number issued by a specific payer, for example Medicaid or Blue Cross/Blue Shield, to identify a health care provider, group or facility. These are becoming obsolete in many cases and have been replaced by the NPI on all health care transactions. A **PTAN** (Provider Transaction Access Number) is an identification number utilized only by Medicare. The individual and group will both be issued a PTAN upon application to a Medicare contractor. While only the NPI can be submitted on claims, the PTAN is a critical number directly linked to the provider or supplier's NPI. The PTAN and NPI are both required when making inquiries to the Medicare contractor regarding claims, enrollment issues, etc.

Q: Where can I look up NPI numbers?

A: You can access the complete NPI Registry at:

<https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do>. This website allows you to search for both individual and organizational providers. The search fields consist of name, address and NPI number if already known. This is a public access website, so anyone can search for NPI numbers. They are not private or confidential

Q: What is the difference between Group NPI and Individual NPI?

A: When an individual health care provider is not a sole-practitioner, the individual NPI must be linked to the group NPI along with the other providers in the practice. When services are rendered, the payment will be issued to the group, not the individual. This is represented by specific fields on the HCFA 1500 form. Based on the **5010** standard, field 24J contains the **rendering individual provider NPI number** and field 33 contains the billing entity **group provider NPI number**.



For more information about the NPI, visit [National Provider Identifier Standard \(NPI\) | Centers for Medicare & Medicaid Services](#) on the CMS website. You may also refer to the Medicare Learning Network® (MLN) publication titled “The National Provider Identifier (NPI): What You Need to Know” located at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPIBooklet.pdf> and Chapter 10 of the “Medicare Program Integrity Manual” (Publication 100-08) located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html> on the CMS website.

Section Two: Enrollment and Contracting



Let’s say you have your basic requirements in place: NPI, medical license, malpractice insurance, tax identification number, practice location, you will now need to decide on which payers you wish to do business with and what plan types.



If you do wish to be a Medicare provider, and took the advice above about PECOS, then you should complete your Medicare enrollment “yesterday” as they say. Even though the new online format is much quicker than paper enrollment, Medicare contractors have the notorious reputation for taking quite a long time to process enrollment applications. A similarly slow and more complicated enrollment process seems to plague many state **Medicaid** agencies as well.



In regards to Commercial payers, do your research:

- o Find out which companies serve large groups in your area and consider your patient demographic type. For instance, a pediatrician would not focus on payers that offer coverage to mainly **Medicare Advantage** patients.

- o Research provider complaints against payers regarding inappropriate claim denials, underpayments, etc. You will have to weigh the level of frustration “problem” payers can cause against the potential monetary benefits.
- o Meet with Provider Relations representatives from new payers. Getting in on the provider panel early can be a great chance to get exposure to patients without a lot of competition from other providers.
- o You may even want to investigate the possibility of participating in **ACO** options. Some commercial insurers are supporting ACO development for their own members in response to the intentions of the **Affordable Care Act** that ACOs will eventually be available to everyone. Multispecialty medical groups, physician-hospital organizations (**PHOs**), integrated delivery systems (**IDSs**), and independent practice associations (**IPAs**) are likely candidates to become the ACOs of the future.



For general information on ACOs go to: [cms.gov/aco](https://www.cms.gov/aco) and [HealthCare.gov ACO Fact Sheet](https://www.healthcare.gov/aco-fact-sheet)



Chapter Two: Medical Office Clerical Workflow



Medical school prepared you to be a doctor, but probably not an office administrator. Even though you will need to hire someone to act in that capacity, in order to select properly and understand your own practice, you need to become intimately familiar with the clerical workflow of a medical office.

We all know that successful claims reimbursement is increasingly challenging with payers becoming more detail-oriented in their focus to ensure that every aspect of the claim filing process is completed exactly as the payers require.

Follow this step by step guide to help you tightly organize your office clerical procedures and ultimately be financially successful. By outlining these processes, we hope to help you guarantee your proper **claims reimbursement** and improve your cash flow by putting steps in place to achieve maximum reimbursement the first time each claim is filed.

Section One: New Patient Check List

When scheduling a patient for their first visit to your practice, front office staff should advise them of what they need to bring to help ensure a smooth registration process and to assist you physician in making that first visit as thorough as possible.

Provide this list to staff as a guide:

- o Picture identification and current insurance card(s)

➡ Once provided with this information, you need to verify insurance coverage and benefits. This is the optimum time to collect copayments from the patient.

- o Contact information for emergency contact and/or healthcare surrogate

➡ Make sure the patient indicates the name(s) of any authorized persons on your HIPAA notification form.

- o Contact information for all current healthcare providers

➡ Please have the patient add to the HIPAA form, the names of any physicians they would like your physician to communicate with or share their medical records.

- o Copies of any applicable medical records and recent diagnostic testing results

➡ If you are handed records that are the patient's only copy, make your own copy and return the "originals" to the patient. They may need them for another provider. X-rays or radiology "films" stored on computer discs, should be logged in the patient's record if they are left behind after the visit.

- o Complete list of current medications, both prescription and over the counter.

➡ Adding the pharmacy name and phone/fax number into the patient chart facilitates issuing any required prescriptions.

Section Two: Verify Patient Insurance Coverage

For successful claims processing and payment, it all starts with the proper verification of each patient's insurance coverage and benefits.

Instruct clerical staff to follow the guide below to ensure all the necessary information to create a complete and accurate patient benefit profile is obtained.



Basic information needed before contacting the insurance company:

- o First and last name of patient and the subscriber (if other than the patient)
- o Patient's date of birth
- o Policy number as shown on the insurance card

➡ (The insurance card is one piece of essential information your patient should bring on their first visit.)

- o Diagnosis or chief complaint
- o CPT codes for anticipated procedures



Ask these questions to build your patient benefit profile:

- o What are the effective dates of the current policy?
- o Are there any pre-existing conditions limitations?

- o What are the benefits for the anticipated service?
- o Does a deductible apply or only a copayment?
- o If there is a deductible, how much is the deductible and how much is met?
- o After the deductible, what is the co-insurance amount?
- o How much is the copayment?
- o What is the annual out of pocket maximum and how much is met?
- o Do the deductible and copayments apply toward meeting the out of pocket maximum?
- o Does this policy require any type of authorization of the anticipated service(s)? If yes, make sure to obtain the proper contact information for that internal department or outside agency.
- o Is there an annual, lifetime or per illness/diagnosis maximum benefit? If so, how much has been met?



If some of the above terms seem confusing, refer to the table below for helpful explanations.

Q:	A:
Pre-existing Condition	Most often occurs with a lapse of insurance coverage. The new insurer can refuse to cover a condition that was diagnosed before the effective date of the policy.
Deductible	Amount the subscriber is responsible to pay before insurance will pay their portion.
Copayment	A flat rate assigned to specific procedures that the subscriber is required to pay. Most commonly to office visits and outpatient diagnostic procedures.
Coinsurance	The percentage of the charge that is the subscriber's responsibility. Refers to benefits like "80/20", the insurance pays 80%, the patient pays 20%.
Out of pocket Maximum	This is the total patient's out of pocket financial responsibility designated by the payer. Once the subscriber has met this amount, services then become covered at 100% by the payer.
Benefit Maximum	This is the monetary payment limit set on the subscriber's policy. Once this maximum is reached the payer has no more financial liability and the subscriber must pay for the rendered services.



Iridium Suite medical billing software from **Medical Business Systems** has an integrated insurance **Real Time Eligibility** function that can do most of this work for you and your staff. See how Iridium Suite can help you “work smarter not harder”.

Section Three: Obtain Proper Authorizations

During the insurance verification process, staff may become aware that one or more of the services you will be either providing or ordering for your patient require an authorization.

For obtaining authorizations, use the following suggestions to create your office process.

- o Gather all pertinent patient information: name, date of birth, insurance policy number and contact information for the **authorizing entity**.

➡ The **authorizing entity** can be the insurance company, but more and more frequently payers are contracting out to third party organizations to perform this function.

- o Obtain the following data: accurate diagnosis including the ICD9 or 10 code, copies of related medical records, the history and physical report from your physician, and the procedure(s) ordered with the appropriate CPT code(s).

➡ Because you will need accurate medical data on your patient and in some cases actual office notes to provide to the authorizing entity, your hands may be tied in regards to the speed in which the authorization can be obtained. For this reason, it is always helpful when possible to schedule the services enough into the future as to allow for processing time.

- o Begin the authorization process by following the guidelines indicated by the authorizing entity to complete the authorization request. This can vary from phoned in requests, to online or faxed submissions. Make sure to complete any forms as accurately and completely as possible.

➡ It is helpful to compile a file on authorization processes for each authorizing entity encountered. This allows staff to have the information readily available again and again.

- o Now you wait. With online submissions, an authorization may be generated within seconds or minutes. Other authorizing entities may take 24-48 business hours as their standard turn around. On occasion it may be a week or more between the request and the response.

➡ If your office fails to get a response in the time specified by the entity, staff should not wait idly by. Follow up by telephone or email should be initiated. It may be discovered the request was incomplete and this provides the opportunity to furnish the additional needed information.

Unfortunately, sometimes it is just floundering around on someone's desk and it has to be brought to their attention.

- o Once you have received your authorization make sure to pass it on to the appropriate party: the billing staff in your office for an in office procedure, the hospital or outpatient facility, or the diagnostic center.

Section Four: Collecting Your Charges and Filing Claims

By properly registering the patient and verifying their benefits, the groundwork has been laid for correct claims reimbursement.

➡ You now need to establish a reliable process for collecting charge data and filing claims. One of the best ways to accomplish this is to utilize your Practice Schedule. Billing staff will want to verify they have received a charge slip or "superbill" for each patient that has been marked as seen on the schedule.



Integrating multiple systems can enhance your work environment and improve efficiency. A **billing and coding software** that is able to directly import charge data from your **EHR** will eliminate the need for manual charge entry from "superbills".



Iridium Suite **medical billing software** now comes with the [Connectivity Clearinghouse](#) enabling connections to multiple EHR systems. You can connect to your EHR as often as your office work flow dictates. With accurate and complete data entry in your EHR, you are able to bring in all the necessary information to bill and file your patient claims. The Connectivity Clearinghouse can use multiple protocols such as: LLP, HTTPS, and SFTP. It can also be extended to use multiple data formats such as: multiple versions of HL7, any well-formed XML and delimited text. The versatility of the Connectivity Clearinghouse in Iridium Suite **medical billing software** provides the foundation to integrate with your existing Electronic Health Record, saving your practice time and money.

➡ To prevent denials and receive proper reimbursement, be aware of any services or procedures you provide that may conflict with others or be bundled together according to [NCCI \(National Correct Coding Initiative\) edits](#).



[Iridium Suite](#) features a built-in **claim scrubber** that has many capabilities, so a biller can be confident that coding violations will be caught before the claim is generated.

➡ Stay informed of your commercial payers' Medical Policies and government payers Coverage Guideline.



For more detailed guidelines on payer's policies please see Chapter Two, Subsection Four on page 16 of this document.

➡ Now that you have entered your "clean claims", it is time to get them off to the payer. Filing your claims can be done:



via paper on the standard HCFA-1500 claim form, or sent electronically.



Sending claims electronically utilizes **Electronic data interchange (EDI)**. EDI is the structured transmission of data between organizations by electronic means. Claims are batched in the **medical billing software**, and then transmitted in an electronic format directly to the payer or to a clearinghouse.



Iridium Suite utilizes EDI to improve your claims processing in the following ways:

- Ability to track the [Electronic Claims](#) from receipt by the clearinghouse to the acknowledgement and acceptance by the payer.
- Electronic claims are pre-screened for certain errors with notices being sent back to the medical practice within days for quick correction and resubmittal.
- Due to their formatting, electronic claims are much more quickly processed by the payer, reducing the wait for reimbursement in some cases from weeks to days.

Section Five: Payment Posting

Once your charges have made it out the door, payer responses can be received in as little as 5 days for electronic claims transactions and 3 weeks for paper claims. An electronic response is commonly referred to as an **Electronic Remittance Advice (ERA)** and a paper one is usually referred to as **Explanation of Benefits (EOB)**. The corresponding payments can also be received electronically via **Electronic Funds Transfer (EFT)** or by paper check.



[Iridium Suite Practice Management software](#) imports the ERA and often can adjudicate the payments automatically in the indicated patient's account.

- ➡ Information regarding denials is attached to the designated services with complete details allowing medical office staff to research and choose the best action in order to resolve the denial with the payer.

Subsection One: Understanding a Remittance Advice - Terminology

Whether or not your medical billing software has the ability to automatically post your ERA's, billing staff will need to have a full understanding of the terminology used on any format of payer remittance. The "Amount Paid" column is usually the most self-explanatory; it is the details that accompany the non-payment amounts that are much trickier to navigate.

This table contains a sample of a remittance advice based upon the standard Medicare Remittance Notice format.

PALMETTO GBA 23711 LA PASADENA, CA 911850001 8669313903 TECHNICAL DEPARTMENT CONTACT: PALMETTO GBA; TELEPHONE8669313903; TELEPHONE8669313901; FACSIMILE8034623912;											MEDICARE REMITTANCE NOTICE
DEMO PRACTICE PO BOX 5396702 BLDG 13 RENO, NV 89521 281-305-1717											PROVIDER #: PAGE #: Page 1 of 2 DATE: 05/08/2013 CHECK/EFT 881991388
REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME AGUILAR, TERENCE E				HIC 620506338B		ACCT 150903795E		ICN 1802215290		ASG Y	MOA MA01
	04/23/2013	11	1	77014	26	130.00	42.83	0.00	8.57	CO-45 87.17	33.57
										CO-223 0.69	
	04/23/2013	11	1	77290	26	638.40	78.69	0.00	15.74	CO-45 559.71	61.69
										CO-223 1.26	
PT RESP	24.31			CLAIM TOTALS		768.40	121.52	0.00	24.31	648.83	95.26
ADJ TO TOTALS:	PREV PD			INTEREST		0.00	LATE FILING CHARGE		0.00	NET	97.21

Since most payers have their own formats and terminology, the table below is also provided to "crosswalk" other terms to the ones found on the sample.

Medicare Terms	Definitions	Terms Used by Other Payers
Remittance Notice	Title given to the report issued by the payer summarizing the processing details of the claim.	Explanation of Benefits, Explanation of Payment, Remittance Advice, Statement of Payments
Billed/Billed Amt	Represents the fee charged for the services.	Charge Amount, Charges, Requested Amount, Submitted Expenses.
Allowed/Allowed Amt	Equals the amount of the fee that is allowed per the contracted rate with the payer.	Eligible Expense or Amount, Approved, Covered Charges.

Deductible/Deductible Amt	Indicates if any of the allowed fee was applied to outstanding deductible on the patient's policy.	Annual Deductible.
Coins/Coins Amt	Indicates the amount of the allowed fee that the patient must pay per their policy terms.	Customer or Patient Liability. Out of Pocket Amount (OOP). Commercial payers may also indicate Copayment on a service which is a flat rate charged independent of the fee.
Grp/RC-Amt/Total RC Amt	Grp stands for Group and RC stands for Reason Code. These are codes that abbreviate the basis for any amounts not paid by the payer. See section below for further details on Group Reason Codes.	Adjustment Grp and Reason Code, Not Covered Reason, Payment Codes.
Prov Pd/Prov Pd Amt	This is the amount of money paid for the claim.	Amount Paid, Payment, Benefits Paid, Pay Amount, Net \$, Total Benefit, Policy Pays.
HIC	The health insurance identification number for the patient.	Subscriber ID, Member Number, Policy Number.
ICN	This is the Internal Control Number assigned to the claim once processed by the payer. This is used for their internal tracking.	Claim Number, Payer Claim Control Number.
Pt Resp	This is the amount of money the patient can be billed for the services on the claim.	Customer or Patient Liability. Out of Pocket Amount (OOP). This will typically be the summary of Deductible, Coinsurance and Copayment amounts applied to the services.
Prov Adj(Prev Pd,Interest,Late Filing Charge)	When the payer has additional adjustments to apply to the provider's portion of the payment, this area is used. It may increase the base payment as in the case of interest paid. It would decrease the base payment if a portion of the service had been previously paid on another ICN.	Penalty, Recoupment.
Remark Codes	These codes are used to provide additional explanation for an adjustment already described by an Adjustment Group/Reason Code. See section below for further details Remark Codes.	Abbreviations of REM or RMK.



Subsection Two: Understanding a Remittance Advice – Adjustment and Remark Codes



The explanations for non-payment amounts are indicated by using a combination of the **Claim Adjustment Group Code** (two alpha characters) and a **Claim Adjustment Reason Code (CARC)** that can be numeric or alpha-numeric, ranging from 1 to W5. Claim Adjustment Reason Codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.



For a complete list of Claim Adjustment Reason Codes, visit Washington Publishing Company's website by [clicking here](#).

These are the 5 **Claim Adjustment Group Codes**:

Code	Description	Indicated Action
CO	Contractual Obligation	This represents amount of the fee that must be written off as uncollectable based on provider's agreement with the payer. It will most commonly indicate the amount billed over the allowed payer fee schedule amount. As a contracted provider, contractual obligation amounts cannot be passed on to the patient.
CR	Corrections and Reversal	This code is mainly utilized to indicate a service has been reprocessed by the payer. It would apply if a denial was overturned indicating additional payments were sent. It can also be used when the payer overturns an original payment, making the provider aware of an overpayment on the service.
OA	Other Adjustment	You can relate this to a "miscellaneous" category. The Reason Code that is attached will be the key to understanding the impact and proper processing of this adjustment. It will be typically seen on a secondary payer EOB to show the amount paid by the primary carrier and how it affected the payment issued.
PI	Payer Initiated Reductions	A payer may use this code to explain monies withheld from the claim payment. If a provider has an outstanding refund due the payer, they can withhold payments on new services.
PR	Patient Responsibility	Of all the codes, this is probably the most logical. Any amounts to be passed on the patient, or in some cases a secondary payer, will have this indicator. It would apply to Deductible, Copayment and Coinsurance .

Examples of EOB Claim Adjustments are:

Grp/RC	Indicated Action
CO-45	Indicates claim amount that must be written off based on payer contracted fee schedule.
CO-97	Indicates the benefit for this service is included in the payment/allowance for another service or procedure that has already been adjudicated.
OA-23	Indicates the impact of prior payer(s) adjudication including payments and/or adjustments.
PR-1	Indicates amount applied to patient deductible.



When the payment for a service requires extra detailed information, the remittance with contain a **Remittance Advice Remark Code (RARC)**. It may correspond to either a standard message found in the RARC List or will reference a payer specific message that will be shown on the EOB.



For a complete list of RARCs, visit Washington Publishing Company's website by [clicking here](#).

Some examples of remark codes and their use can be found in the table below:

Remark Code	Expected Use
M2	Would be applied to a denied or bundled service to indicate the service was not paid separately when the patient is an inpatient.
M25	Gives further details as to why a service would have been paid at a lower than expected contractual rate based on the information furnished does not substantiate the need for this level of service.
M25	If a service requiring documentation was denied, it would indicate there was a missing operative note/report.
MA18	Used for Medicare payers to show the claim information was sent electronically to a secondary payer.
MA40	Explanation for denied inpatient service that was missing or contained an incomplete/invalid admission date.



As explained above, on the standard Medicare Remittance, the column heading **Grp/RC-Amt** shows the combined alpha-numeric adjustment code for the service billed. You may have also observed directly to the right of the code, a number as shown here: CO-45 87.17. This represents the **Disallowed Amount** for the service line. Other payers may indicate the same by using other terms, such as: Non-allowed Amount, Not Covered, Discount, Ineligible, or Policy Does Not Cover.

Subsection Three: Posting the Payment (or Denial)



When billing staff is familiar with the terminology, the remittance can be posted:

- As the service date and procedure are matched, the appropriate indicated amounts for payments, contractual write off amounts, and patient responsibility are entered.
- The patient responsibilities, such as co-pays, co-insurance and deductibles, are allocated to the next responsible financial party; this may be the patient or another insurance company.

- o Once data has been entered for the service line, the remaining balance should be \$0 for the payer you are processing, unless it was a denial. (See section below on denials). Any allowed amount, but not paid, would now be showing as the responsibility of another party, either patient or an additional payer.

Subsection Four: Researching a Medical Necessity Denial



A **DENIAL** is typically identified by a \$0 allowed amount. Billing staff should never assume without verification that a \$0 allowed amount has been processed correctly by the payer. This requires a careful review of the adjustment code against **payer payment policies**, [NCCI edits](#), your billing records for the account and the patient's medical record. Only when you are convinced the service has been denied appropriately should you accept this write-off amount.



Payer payment policies refer to the guidelines set forth by the payer in regards to what is considered to be a covered benefit. These are typically developed based upon the standard of accepted medical care for a particular diagnosis.

- o Medicare utilizes National Coverage Determinations (NCDs) for its nationwide policies and Local Coverage Determinations (LCDs) are determined by the Fiscal Intermediary that processes claims at the state level. Each Fiscal Intermediary (FI) has the authority to produce their own LCD, based on NCDs. As new procedures are developed, the FI will then set out to create an LCD. The FI will also review existing LCDs to see if changes are necessary based on treatment advances, statistical data, industry standards, etc.



How would an LCD create a denial for a service? If the criteria set forth in the LCD are not met, you will get a very swift denial. If your billing staff is familiar with the parameters of the LCD, you may be able to avoid the denial or at least have the exact medical documentation needed that addresses the specific potential cause for denial. Most LCDs do contain the "Medically Necessary" clause. If your documentation can prove that the case is an "exception" to the rule and the procedure is medically necessary, you will likely be successful in your appeal. (See Subsection Six below for [Appealing a Medicare Denial](#)).



The websites for all FIs include a search for LCDs. You can quickly and easily enter a CPT or HCPC code to get the most recent version of the LCD.

- o Commercial payers may use the terms medical policies or clinical guidelines and are used in the same fashion as the LCD. The Carrier's websites typically allow you to search for their website by procedure name and/or CPT/HCPC code. Most Medicare replacement plans offered by Commercial

payers have to follow the medical coverage policy issued by the state's Medicare Fiscal Intermediary. Non-Medicare plans can choose to follow the same policies or they may have their own set of coverage rules. True Medicare Supplement policies must follow the Medicare coverage guidelines. For example: if Medicare pays, they pay.

➡ It is extremely helpful for billing staff to know this information and keep it close for quick reference. This enables them to notify the physician as soon as possible if an ordered procedure is not covered by a patient's insurance plan. This gives the physician and patient the opportunity to discuss other possible treatment options that are covered. If it is determined that the non-covered procedure is the only option, the Insurer can be contacted immediately for a possible pre-service review of medical necessity and coverage. This is much more efficient than a post-service appeal and is usually favorable.



By knowing the Coverage Guidelines, the patient can have the best treatment without bearing the cost of a non-covered procedure and the provider receives full reimbursement in a timely manner.

Subsection Five: Other Common Denial Reasons

1. 18 - Duplicate claim/service.

Manual keying of services lends itself to duplicate entry of those services. A configurable [Claim Scrubber](#) as found in **Iridium Suite** will check each service entered and alert the user immediately if the same service is already on record.

2. 16 - Claim/service lacks information which is needed for adjudication.

Some payers have specific claim rules that require “non-standard” 5010 format information be included on their claims. An example is the rendering provider’s Taxonomy code in addition to the standard **NPI**. **Iridium Suite** allows the user to include this specialized data on the claims to those individual payers as needed.

3. 97 - Payment is included in the allowance for another service/procedure.

Government payers, such as Medicare, as well as the larger Commercial payers have adopted the NCCI standard for “bundled” services. The Iridium Suite [Claim Scrubber](#) comes standard with all current NCCI edits built in. The Scrubber alerts the user when entering two or more procedures that are considered inclusive of each other.

4. 29 - The time limit for filing has expired.

Payers each have their own time filing limits guidelines for claim submission. It can be as short as 60 days, or the current Medicare limit is 12 months. The sooner you submit your claims, the quicker you will receive your payment and eliminate the risk of untimely filing denials. With the [Connectivity Clearinghouse](#) within **Iridium Suite**, you can import patient demographic and service data directly into the billing software from your **EHR/EMR**. Your patient and charge entry process can be almost completely automated allowing for close to “real time” claims submission for your services.

5. 140 - Patient/Insured health identification number and name do not match.

By utilizing the [Real Time Eligibility](#) function in **Iridium Suite**, you can virtually eliminate denials like the one above or similarly “subscriber not eligible at time of service.” You will be able to successfully submit charges to the correct active payer with the proper identification number and receive your proper **claims reimbursement** on the first submission.

6. 197 - Payment adjusted for absence of precertification/authorization.

A **medical billing software** with the ability to indicate payers requiring authorization as well as track a multiple service/visit authorization as it is assigned to the performed procedures is crucial in assisting office staff with this issue. **Iridium Suite** provides a specific area in the patient insurance information section to indicate authorization requirements and to record the authorization details. Before a claim can be submitted, it is scrubbed for authorization requirements and will warn the user if the authorization is missing. You are unable to submit the claim without the appropriate authorization.



By utilizing an advanced **Medical Practice Management Billing Software** like [Iridium Suite](#) from **Medical Business Systems**, you can avoid many of these types of denials.

Subsection Six: Appealing a Medicare Denial

If you have received a claim denial from your Medicare contractor you do have the right to submit an appeal.



Based on the Reason Codes provided on the ERA, a **Clerical Reopening** may be indicated instead of an appeal. Minor errors or omissions on some **Part B claims** can be corrected for reprocessing using the **clerical reopening** process.



There are two ways to initiate this process:

- o Telephone reopening requests via the [interactive voice response \(IVR\)](#) allows providers/customers to request telephone re-openings on certain claims. For the IVR reopening request help sheet, [click here](#) .
- o For reopening requests in writing, use the [clerical reopening](#) .



Common clerical errors consist of: Mathematical or computational mistakes, Transposed procedure or diagnostic codes, Inaccurate data entry, Misapplication of a fee schedule, Computer errors, Denial of claims as duplicates which party believes incorrectly identified as duplicate, Incorrect data items such as provider number, modifier, date of service.

First level of appeal: Redetermination

A redetermination is an examination of a claim by fiscal intermediary (FI), carrier, or MAC personnel who are different from the personnel who made the initial claim determination. The appellant (the individual filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A redetermination must be requested in writing. A minimum monetary threshold is not required to request a redetermination.

Second level of appeal: Reconsideration

A party to the redetermination may request a reconsideration if dissatisfied with the redetermination decision. A qualified independent contractor (QIC) will conduct the reconsideration. The QIC reconsideration process allows for an independent review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

Third level of appeal: Hearing by an administrative law judge (ALJ)

If at least \$140 remains in controversy following the qualified independent contractor's (QIC's) decision, a party to the reconsideration may request an administrative law judge (ALJ) hearing within 60 days of receipt of the reconsideration decision. Appellants must send notice of the ALJ hearing request to all

parties to the QIC for reconsideration. ALJ hearings are conducted by the Office of Medicare Hearings and Appeals (OMHA).

➡ By [clicking here](#)  you will find information on the OMHA website.

Fourth level of appeal: Review by the Medicare Appeals Council

If a party to an ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Medicare Appeals Council. There are no requirements regarding the amount of money in controversy. The request for Medicare Appeals Council review must be submitted in writing within 60 days of receipt of the ALJ's decision, and must specify the issues and findings that are being contested.

➡ By [clicking here](#)  you will find information on the Medicare Operations Division/Medicare Appeals Council.

Fifth level of appeal: Judicial review

If \$1,400 or more is still in controversy following the Medicare Appeals Council's decision, a party may request judicial review before a Federal District Court judge. The appellant must request a Federal District Court hearing within 60 days of receipt of the Medicare Appeals Council's decision. The Medicare Appeals Council's decision will contain information about the procedures for requesting judicial review.



Additional resources

Within the CMS websites you will find information related to the five levels in the Part A and Part B appeals process.

- [CMS Appeals Web resources](#) 
- [CMS Appeals process flowchart](#) 

CMS resource materials available for download

- [MLN - The Medicare Appeals Process Brochure](#) 

CMS Internet-only manuals: Publication 100-04

- [Chapter 29](#)  – Appeals of Claims Decisions
- [Chapter 34](#)  – Reopening and Revision of Claim Determinations and Decisions

Section Six: Aggressively Work your Accounts Receivables

If you followed the advice given in the previous steps, you have properly identified the patient benefits, obtained the necessary authorizations, and carefully produced clean claims. Each one of those steps is an integral part of keeping a “young” Accounts Receivables (ARs) balance. They ensure the quickest turn-around time for your claim payments which keeps your cash flow smooth and predictable.



You may wonder why I use the reference “young” when speaking of ARs. One of the most common ways to evaluate your practice cash flow situation is by analyzing the open balances by their aging. The aging is most often broken down into “buckets” of 30 day increments: 0-30 days, 31-60 days, 61-90 days, 91-120 days, 121-150 days and 151 days and over. As the aging increases, the balances should decrease with the highest amounts, hopefully, always in the 0-60 days’ categories.

➡ An optimum strategy for keeping your ARs the most current involves three main tasks:

1. Reviewing all rejected/denied claims as soon as received. In the case of electronic transactions, claims that contain bad data are pre-screened at the claims clearinghouse and are often seen back in your **practice management** software within 24 hours for quick correction and resubmittal. Electronic claims that pass on to the payer can be processed within just a few days by receiving an ERA right into your **medical billing system**.



[Iridium Suite Practice Management software](#) optimizes the advantages of electronic claims responses and remittances with unique warning system. The user will see visual alerts when claims have been rejected or an ERA contains a denial. These tools assist office staff to be continually aware of situations that negatively affect your Accounts Receivables.

2. Regular monitoring of all claims dated over 61 days for activity by office staff or payer. Whether you have just had no payer response or you are waiting on a reply to some type of re-submittal, the aging Accounts Receivables must be evaluated for proper activity. For instance, a claim sent with records for appeal should prompt a call to the payer at least every 4 to 6 weeks for a status update.
3. The most delicate of these three necessities is working patient balances. A physician’s reputation in both the community and with their peers can be influenced by their approach to patient invoicing. Below are some simple strategies to ensure your patient’s trust and understanding of the components of their financial responsibilities.
 - o When patients walk into a “free-standing” physician’s office, they expect a bill from the provider they “see” for the service rendered. When being provided medical services in an outpatient facility, as a hospital outpatient, or inpatient, things can be a lot less clear. Medical services can be performed by “unseen” professionals: anesthesiologists,

radiologists, pathologists, etc. There is typically a facility charge in addition to the professional charge. Patients do not always put this together, and it is important when scheduling the services to give a detailed explanation of who will be billing for the services rendered. This helps to keep your patient from being surprised when the bills start coming in and prevents those dreaded accusatory phone calls.

- o We are all human and can make mistakes. These mistakes can go both ways by billing services that did not occur or by missing some that did. Even our EHR software with automated charge capture capability, since used by fallible humans, can contain honest errors. Internally audit all charges before they are submitted to the payer for accuracy and proper medical documentation. You will never have to “defend” your claims to the insurance company and will be completely confident if any questions arise from the patient about “if” the services were truly provided.
- o Utilize **medical billing software**, such as [Iridium Suite](#), that produces a clear and concise reconciliation of each service provided in an itemized fashion. Send invoices on a regular schedule, ideally once a month, which allows patients the chance to match up services to their insurance explanation of benefits and if necessary make monthly payments on large balances they cannot pay in full.
- o A typical healthy person utilizes very little of their insurance benefits and has little experience deciphering a medical bill, so they may require additional assistance from your staff. Ensure you have someone available who has full access to the details of the account and a thorough understanding of the services rendered so that any questions from your patient can be answered promptly, correctly and with patience and compassion. Your ideal contact person should be able to turn the complicated terminology and processes of billing into a something an everyday person can understand. This is the drawback to utilizing an “outsourced” type call center, those persons are typically ill-equipped to answer anything more than the most general of inquiries.



[Iridium Suite Practice Management software](#) is designed for paperless AR follow up with an entire module in the software dedicated to sorting and prioritizing your ARs the way you like to see them. Specific payers or issues can be divided up and assigned to individual office staff allowing for tracking of progress and positive resolutions.

Chapter Three: Making your Work Count for EHR and PQRS Incentives

Providers of Part B services on the **MPFS** can **increase reimbursement** and **avoid future penalties** by taking advantage of Medicare incentives for **EHR** and **PQRS** reporting. Below you will find guidance on both of these programs to help improve your bottom line.



To qualify for Medicare PQRS incentive payments, EPs must sufficiently report on the applicable quality information measures. In the PQRS 2013 program, there are several hundred measures.



To help navigate through this complex process, you can access the “Getting Started” page of the CMS PQRS website by [clicking here](#).



Advanced Practice management software like [Iridium Suite](#), has an integrated PQRS claim scrubber.

The practice can configure the **medical billing system** to automatically request that the physician sets up **PQRS** measures for each patient. The claim scrubber also recognizes which billing codes are potential **PQRS** denominators and automatically suggests the **PQRS** numerator codes that should be added to the claim. The biller simply accepts these suggestions and the claim scrubber automatically adds the proper **PQRS** charge codes to the claim.



To qualify for the Medicare EHR incentive payments eligible professionals (EPs) must utilize certified meaningful use EHR technology. Proof of meaningful use can only be demonstrated by reporting clinical quality measures (CQMs) as well as the meaningful use measures.



Providers wishing to purchase certified EHR software can access a list of options on the CMS site by [clicking here](#).



In 2013, EPs may satisfy the meaningful use objective to report CQMs to CMS by reporting them through:

- o Medicare and Medicaid EHR Incentive Programs’ web-based Registration and Attestation System

EPs who choose to report CQMs through the CMS Attestation system must still report information on individual quality measures or measure groups using one of the four reporting options in order to also participate in PQRS.

- o Participation in the PQRS-Medicare EHR Incentive Pilot, which utilizes the 2013 PQRS EHR Measure Specifications.

EPs who participate in the pilot may submit their meaningful use objectives through the CMS Attestation system, and then complete a single submission of CQMs to receive credit for both programs.



EPs who successfully participate in PQRS and EHR can receive an incentive in 2013 and avoid the 2015 payment adjustment for both programs.



Participating in both the PQRS and EHR programs in 2014 and beyond is being simplified by CMS with the alignment of several of key components.



Here are the changes affecting PQRS and EHR in 2014:

- o PQRS and EHR programs will align on the same set of eCQMs (64 total) and the same electronic specifications
- o All Medicare-EPs beyond their first year of demonstrating meaningful use will be required to electronically report their CQM data to CMS for the EHR program
- o Submitting data electronically using 2014 certified EHR technology will meet the standards for both EHR and PQRS programs
- o Participating EPs will have the option to submit patient-level data (via QRDA I) or aggregate data (via QRDA III) using the same reporting mechanism for electronic reporting for both programs.

Chapter Four: Watching the Vital Signs of Your Practice

Everything may not be like in the movies “If you build it, they will come.” But, most often, when it comes to a new medical practice, it does happen. A Medical Practice is a business and must be treated as such. You must not forget to check the health of your practice just like to check the health of your patients. Below we will look at these Vital Signs, pulse, blood pressure and temperature, to help you assess the financial well-being of your medical practice.

Section One: The Pulse

Subsection One: Evaluate Practice Growth

How many new patients are you seeing each month?

Once you have been established a few months, you will be able to analyze the trends month over month, to calculate your current growth rate and estimate the potential need for increased staffing and other infrastructure changes. If close monitoring of your patient numbers shows a progressive decline or steep increase, it can give you the opportunity to research the reason why. One reason could lie in the next section referrals.

Subsection Two: Monitor Referral Base

Who is referring those patients to you?

With the almighty internet, physicians have been able to reach out much more easily and cost effectively to a wider range of patients. While many people with basic medical needs may feel comfortable doctor-shopping online, there are many who have complicated issues. These referrals generally come from colleagues and satisfied patients. Know which providers in your area are referring patients to your office and always keep the lines of communication open in regards to those mutual patients. A happy, well-taken-care-of patient is the best advertising. Many times less than stellar office staff can scare away patients who “love” their doctor, and those unpleasant episodes can make their way back to the referring colleague. Watch for trends that would show a reduction in referrals from a particular source and take the time to reach out personally.

Section Two: The Blood Pressure

Subsection One: Tracking Services Provided

Are the numbers of services you bill increasing, decreasing, or staying the same?

Depending on your type of medical practice, you could expect to see one or two procedure codes billed per patient visit or for some specialties like Radiation Oncology, you may bill 10 procedure codes per visit. In either case, reviewing reports that show month-to-month statistics can allow you to recognize anomalies in your billing patterns. Sharp declines in a certain procedure may indicate forgotten or missed coding opportunities and therefore missed revenue. Many payers have time filing limits from the date of service. They can range from 60 days to one year. A regular review for missed charges will enable to meet those filing limits and collect on all of your rendered services. If your report showed an unexpected procedure or an unusually high number of a certain procedure was billed, you will be able to audit the medical record(s) for appropriate documentation. If billing errors are discovered, you can get ahead of an insurance audit by quickly refunding any payments received for these non-provided services. Keeping yourself in the good graces of your payers is always important.

Subsection Two: Analyzing Insurance Reimbursement

Is your claim reimbursement in line with your contracted fees?

This type of analysis is invaluable to any medical practice. Once you have signed on that dotted line with the payer, you are wise to ensure that you are receiving the proper reimbursement based on the agreed upon contractual rates. In the daily whirlwind of activity in the medical office, office staff seldom has the time to comb over the detail of every paid line item. A monthly report that compares the payments received to the payer's fee schedule will indicate payments that are below (as well as above) the payers contracted fees. Payments that are below should immediately prompt a call the Provider Relations Department. For payments above the contracted fees, research has to be done on the accuracy of the fee schedule you are using, for instance, perhaps the payer has updated its schedule and you have not. This type of report could also make you aware of overpayments. If those are pre-emptively refunded to the payer, it will show your practice to be following proper procedures in the eyes of the payer.

Section Three: The Temperature

Subsection One: Evaluate the Aging of your Accounts

What is the aging breakdown of your accounts receivable?

A basic Accounts Receivable report typically includes monies due in aging “buckets”: Less than 30 days, 31-60 days, 61-90 days, 91-120 days, 121-150 days, and over 151 days.

Ideally you want to see the largest percentage of receivables in the less than 30 days bucket with balances diminishing as you progress through the older buckets. The older the receivables get, the more difficult it is to collect from the payer. It can also snowball into an increasing amount of information to go through if not addressed in a timely fashion. It can become so overwhelming, office staff may not know where to start.

Subsection Two: Verify Collections Activity

Do you have adequate procedures to ensure quick collection of monies due?

Your receivables in the 31-60 days category, when analyzed by payer, can indicate if most of the money is based on secondary payer balances. Due to the nature of processing turnaround time, it is not unusual to see secondary payer balances in this bucket and to some extent in 61-90 days also. If you notice a large amount of primary payer monies landing in the 31-60 days bucket, checking the claim status with the payer is advised. It could indicate the claim was not received by the payer and resubmittal is necessary in order to avoid those timely filing issues. If you wait until they hit 61-90 days or more, it could be too late. Claim denials should also be addressed frequently; if not daily as received by the payer, but at least monthly during the accounts receivable analysis. Payers also have timely filing limits for appeals that are usually only 60 -180 days after the date of the EOB. The quicker the appeal is sent, the quicker you may receive your reimbursement.



Now that you are aware of the medical practice vital signs, adhere to the same recommendations you give to your patients. Follow through with regular check-ups to maintain your practice health. A **medical practice management software** like [Iridium Suite](#) has built in report scheduling to assist you in keeping that close eye on the pulse, blood pressure and temperature of your medical practice.