hfma oregon chapter
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Patient Accounts Problem Solving and Program Committee
Oregon HFMA Fall Conference

October 19th
2:30pm – 4:30pm (Pacific)
Oregon Garden Silverton, OR

Attendees: Evan Martin, Taylor LaNeve, Michelle Woodward, David Honzay, Ken Mitchell, Susannah Metzger, Lisa Richardson, Tracy Corwin, Sherri Nordyla, Crystal Osborne, Scott Smith, Lindsey Kalin, Carla Eagles, Andrea Fischer, Tara Toomer, Teri Howard, Took Smoot, Trevor Edwards, Brianna McDonald, Matt Navigato, Michelle Cooper, Doreen Crail, Brittany Davis, Doug Teuber, Kathryne Rouse, Tonya Siefarth, Michelle Roberts, Kiet Lam, Walt McCall, Kandi Johnson, Jeff Allen, John Esa, Bart Shea, Tyler Humphrey, Lori Kernutt, Ellie Ricker, Liana Hans, Joey Boekenoogen, Shannon Bunyard, Gavin Ford, Terrie Handy, Tammy Bickle, Jason Merck, Kelly Smith, Amanda Gordon

Time	Description	Facilitator
2:30pm	Welcome	Amanda Gordon
2:35pm	Patient Solving Questions and Answer Session	Amanda Gordon
4:00pm	Program Council Topic Session	Ken Mitchell

Patient Accounts Problem Solving :
Chair: Amanda Gordon angordon@lhs.org
Co – chair: Evan Martin evan.martin.@providence.org

Patient Accounts Programs:
Chair: Ken Mitchell Mitchken@ohsu.edu
Co- chair: Kathryne Rouse Kathryne.Rouse@providence.org

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Patient Accounts Problem Solving and Program Committee Question and Answer List
Oregon HFMA Fall Conference October 19th, 2016

1. **We are working on audit and production reporting for our staff this year, we are looking at weighing account activities and using HB Production report. Is anyone else using Epic for production and what reports are being used for billing, follow-up, self-pay and cash posting?** **(Submitted by Carla Eagles, Patient Financial Services, Salem Health)**

- Kathryn Rouse (Providence) – We use reporting for employee activities, we use report writers who put it into our success factors program and we use them for reviews etc. They are used for productivity and standards.
- Some of the problems are the series of actions that employees do does not get into the report the same. Getting a report that takes what the employee did vs. how the report kicks out can be confusing.
- Kathryn Rouse (Providence) - We have a report that we run weekly, or can do monthly – we will get you in contact with the report writer that can explain the reports and what is possible.
- (Legacy) - We use the activity reports, we use it to report meaningful activities – like when employees are looking at websites vs. working in accounts. We run reports for productivity of employees – they are not weighted – other organizations have them weighted and are not super comfortable with how they are weighted.

2. **We are adding our Source, Owing Area and Preventable fields to the RMC and opening the fields in the BDC records for denials. Does anyone have any suggestions on making this an easier process? Was anyone able to reduce denials and improve processes with the use of the reporting functions?** **(Submitted by Carla Eagles, Patient Financial Services, Salem Health)**

- Evan Martin (Providence) – Mike Jacobson (Director Rc Reimb And Recovery) would be a good contact from Providence and may be able to help. Michael.Jacobson@providence.org

3. **How are other organizations billing for charges that exceed the allowable MUE edits?**
   Are you putting charges that are over the allowable on a separate line item because the revenue is being generated but would be non-payable? OR are the charges over the allowable MUE being scrubbing off the claim?
   Are the MUE edits being treated differently by payer type? **(Submitted by Andrea Fischer, Patient Financial Services, Salem Heath)**

- (Legacy) – We split out on separate lines and do it in charge review for special MUE edits when we are aware. We don't treat them differently by payer.
- Lori Kernutt (Willamette Valley) – We put it on separate line and use a modifier
- (OHSU) – If the perimeter value of MUE is not high enough then we take it off the claim at the front end. The rest we let go through and we split them if it will make a difference on how the claim processes, and we adjust after the claim goes through. We put it on non-covered.

4. **How many hospitals require the physician offices to have an auth in place prior to scheduling referred patients for services (imaging, surgery, etc…)? (Submitted by: Janet Vos, Patient Accounts Manager, Bay Area Hospital)**

- Lori Kernutt (Willamette Valley) -We are still working on it, but it is a struggle.
- (Adventist) – It is a good idea, but the requirement part is difficult. They come back if they aren't authorized, but to make it required is different, everyone seems to be working on it.

5. **Inpatient Self-Administered Drug workflows and the patient experience. Billing Medicare part D out of Medicare system – how are you managing patient experience while working with patient Administered Drugs. (Submitted by Matt Navigato, Director Enterprise Revenue Cycle, OHSU)**

- Lori Kernutt (Willamette Valley) – We are no longer billing for them, determined it is not worth it – we will be writing them off. It is a better patient experience to write them off – we are automating. Writing off across the board. Medicare no longer requiring so we stopped billing.
- Kathryn Rouse (Providence) we are the same – it is a huge patient dis-satisfier. Providence has made the decision to not bill. We are writing it off before billed.
- Matt Navigato (OHSU) - Is there a reason we aren't creating a process to bill for them? Can we bill the part D?
- Lori Kernutt (Willamette Valley) – can we bill part D as HB? I don't think we can?
- Michelle Roberts (Salem health) – Inpatient does not apply – only outpatient Observation. It is confusing for everyone. We created education piece to patients on what they owe and how they can get reimbursed and the patient complaints were through the roof and now we're having payer problems with the PI remark code. Insurance is telling patients that hospitals don't have to bill so patient dissatisfaction is high.
- Lori Kernutt (Willamette Valley) - There are more observations now than there used to be.
- Matt Navigato (OHSU) – what actually qualifies for SAD's
- Kathryn Rouse (Providence) – We created a specific code for the SAD's.
- Evan Martin (Providence) – We will get the build for Matt (OHSU) to show how we no longer charge.
- Kiet Lam (Triage) – yes it is outpatient side only.

6. **At OHSU, we have traditionally always held that when HB sends out a bill, a resident can't be the attending on the UB. The resident could have ordered the service (let's say x-rays and labs) but never be the attending. The attending always had to be a physician. We have recently received information that that stance may not be entirely warranted. The information is that Medicare doesn't prohibit the resident on the UB---that we may have confused the difference between PRO FEES and the technical side. That if the resident is licensed and has a valid NPI, they can be the attending on the UB for ancillary services. (Submitted by Matt Navigato, Director Enterprise Revenue Cycle, OHSU)**

- Evan Martin (Providence) – No, not from the charge perspective. It populates whoever is the overseeing physician for it. In the SER record it identifies as the resident and whoever the hospitalist is the one populating.
- Matt Navigato (OHSU) – We enroll all residents as full docs. And we enroll with Medicare
- Evan Martin (Providence) – At Providence we split between the UB and payer sometimes. Regardless we will bill the same way.

7. **Good Faith Estimates check-in, and then discuss additional process improvement initiatives (i.e. patient statement improvements, health literate service/billing descriptions, statement formatting improvement (clear & concise & easy to understand). (Submitted by: Terrie Handy, VP of Revenue Cycle Operations, Legacy Health)**

- Good faith estimates – everyone meeting the tier 1 estimates. Offering the info that there could be other providers etc. Please be sure to audit that for qualify assurance. We should anticipate a secret shopper in 2017. There was a release in May from secret shoppers. Only 3 or 4 nailed it, some were doing very well – and others had mentions but no clear communication.

8. **Single Statement billing (HB, PB, including third party bills) etc.? Also… partnering with our payers for friendly billing initiatives. (Submitted by: Terrie Handy, VP of Revenue Cycle Operations, Legacy Health)**

- (Legacy) - SBO – how is it?
    - OHSU and Providence use it, both working well.
- (Legacy) - Are you looking at binging in other services? Have you brought in other providers?
    - Matt Navigato (OHSU) - We don't because we use rich text through Epic and there is no way to do it, otherwise we would be.
    - Kathryn Rouse (Providence) – We met with simply – Providence is exploring partnering with a vendor in 2017. We do outsource our statements. Ideally we would want to set it up in Epic, but we cannot do that yet. Simply and IG health do it better at this point.
- (Salem Health)– Have you seen how changes in my chart is?
    - Kathryn Rouse (Providence) – We have it uploaded to my chart so they can log in and it will be an image in the chart.

9. **What other systems are doing as far as collecting SSN & with patients less willing to give SSN have they seen an impact in collections –since bad debt would not report on their CBI and propensity to pay cannot be run without SSN. (Submitted by: Teresa Spalding, VP of Revenue Cycle, Providence)**

- (Legacy) - Asking identity and EMPI team how we can match records in the future for folks that do not give you their social. Folks don't want to give in a clinical setting when we do verbal verification
- Lori Kernutt (Willamette valley) - we have a lot of issues with last names – having multiples is causing supplicate records etc.
- With Medicare cards changing in 2019, we will not have social security numbers anymore so we won't have a way to check it.
- Evan Martin (Providence) – We will follow up with Eva sterns from providence, she may have some other information to share.
- (Samaritan health) – We are looking into biometric - hand ID instead. A couple of companies provide services.
- Evan Martin (Providence) – We may have biometrics looking at it currently. We will explore more.

10. **Request for 278/Electronic Notification to payer update (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**
    i. **For those submitting electronic 278 to payers….which payers are in place, any lessons learned, and**
    ii. **Is anyone submitting non-278 yet electronic notification (i.e. Regence-Availity) etc.??**
    iii. **Have others turned on electronic faxing as well (or other savvy technology?)**

- (Legacy) Is everyone using a 278?
  - Lori (Willamette Valley) – Yes.
- (Legacy) – We are hoping to have it turned on in December, we are looking at turning on as many 278's as we can. Looking to go direct.
- Lori (Willamette valley) – Denials went down 90% by turning it on.

11. **3D Mammo update (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**
    i. As more payers are covering 3D services, how are providers handling the billing process?

- (Legacy) - If you include managed care, we are at about 60% coverage of 3D. Come April 1, we are making sure we have that billing turned on.
- Lori (Willamette Valley) - Cigna has turned it on now. We charge for those who pay and we do not bill patients at all.

12. **Need Payer update re: any issues with Oct 1st (2016) ICD-10 claims. (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health) ADD TO NEXT SESSION.**

- Too soon, no issue yet.
- Two week lag time currently.

13. **For those who manage Coding/CDI areas……what is the typical best practice for coding (vs cdi) physician responses, etc.? (Submitted by: Terrie Handy, VP Revenue Cycle Operations, Legacy Health)**

- ADD TO NEXT SESSION

14. **How are you handling billing Medicaid Secondary Claims? Are you able to update your CEV fields within EPIC, or is your team manually keying claims in MMIS? (Submitted by Amanda Gordon, Dir Pt Access Telecom HIM, Legacy Health)**

- ADD TO NEXT SESSION

15. **Are you receiving letters for non-contracted payers by any law firms? The firms state they represent the patient (form letter), and offer an amount much lower than Medicare rates for reimbursement? (Submitted by Amanda Gordon, Dir Pt Access Telecom HIM, Legacy Health)**

- Lori (Willamette Valley) - We do not respond and shred them – we continue to bill the normally and send to collections if they do not pay.
- Matt N. (OHSU) – same scenario – patient doesn't even know attorney wants to represent them, we ignore the letters and continue to bill the patient as normal.
- (Providence) – We ignore the letters and follow up with the patients – we continue to bill as normal.
- Lori (Willamette Valley) – We don't do it because it would set a precedence for everyone.

16. **For patients with Medicaid seeking a tubal – are you collecting # up front or writing it off to Medicaid?**

- Lori (Willamette Valley) - if it is a part of the delivery, we write it off. If they come in just asking for that without a delivery, then we charge them directly – otherwise we write them off.
- (Adventist) – we do not charge at all, no payment

17. **Shannon - Patient comes in and hits medical necessity checker for failing medical necessity and they sign the ABN that they will pay for the service – do you apply the self-pay discount?**
- Matt N. (OHSU) - Yes we do give discount but we WILL NOT bill insurance because it will go into denial and get messy.
- Lori K. (Willamette Valley) - We let the physician know also
- Are you 501 compliant if you are not applying the self-pay discount to that charge?
- Kathryn (Providence) – if they have insurance and it is denied and not medically necessary – we do not apply discount unless it is Medicaid necessity services. It does drive complaints into our compliance center. We have customer support liaisons to look at each and see if we can get discounts for each one. We could put it into self-pay and Epic would auto do it. They have to be medically necessary in order for us to apply discount. For us we are doing a lot of genomics which is arguable whether it is necessary. (which is another issue)

18. **Lori (Willamette Valley) - VA denials – We bill them and be sure the service is connected, and we call and they say we aren't. What is the turnaround for the VA claims?**
- Lori (Willamette Valley) we usually get timely filing denials for them.
- (Adventist) - They respond and deny and say because of X litigation we are not going to pay. VA is saying they will pay after litigation they will pay... so do we wait?
    - Lori (Willamette Valley) - Patients come in inpatient and they say VA is connected and then a case manager says don't even bother, bill them Medicaid because VA won't pay anyway.
- Kiet Lam (Triage) - Can you bill Medicare for a traditional payment and then bill the VA?
- Shannon (Adventist) - Will get the system for doing this
    - Shannon (Adventist) No we are just billing as Medicare prime. If Medicare shows VA as primary in the msp record, we would have to bill as conditional and would use value code42 which would tell them VA was prime and leave the $$ amount 0.00 as payment from them.
- Charles Celnik (department of veteran affairs – he is local)

19. **Joey Boekenoogen (Western) CFPB.org any new rulings and impact to medical billing.**

- Lori (Willamette Valley) - Third party vendor – if you have a mini Miranda on it, it freaks people out
- Major Banks and collections agencies – consumer satisfaction etc. is their goal. Credit reporting is now coming out for top issues etc.

NEXT SESSION OPTIONAL TOPICS

- Does anyone know the new Noridian people that we can get to come to the February session for HFMA. Ken Mitchell will reach out and ask.
- Medicare refresher of rules and regulatory changes. Would like to get some information on who to contact for what area/types of questions.
- What are other options on social the security number issue – what are vendors or others doing about this issues – even collections? What are collectors doing when a social security number is not provided?
- 501R – a lot of auditing happening here for a lot of organizations. What is the best way to PVCA? Facilities present on how they are handling 501R? Does someone have a good PVCA plan? Internal auditing person for OHSU could possibly come in present.
- Topic at ABN's at OHSU
- Medical tourism, international patient packages. Help with concierge services, because some of these special procedures - how are others handling it? – How is Swedish handling it?
- Best practice for global bundle, CGR will still be pay for service. Hit a contract for bundle global payment? Ambulatory surgery center is hitting some of it.
- Billing and management for wound care. (hyperbaric)
- Payer panel
- Vents Sessions 3 (30 min) of 4 (20 min) with QA
- Self-pay discount process 35% and programing EPIC – things above line of service- best practice.
- Telemedicine – virtual visits, how do you bill? So many avenues to be able to use it. Oregon health care association. Kiet has a good contact.
- 276 and 277 claim status – who is managing it well in epic. (legacy)? How you have it set up etc. the time to put your labor on it. Digital labor- 90 minute session.

FYI:

20. **Update from Nordian:** Noridian's Provider Outreach and Education Department would like to provide the Oregon HFMA Chapter with our latest news and updates. Noridian appreciates your support and assistance communicating the following items to your members. Currently, our top trending items are:

* **Medicare Access & CHIP Reauthorization Act (MACRA):** This **proposed** CMS Initiative for future Quality Reporting repeals the sustainable growth rate (SGR) formula and changes the way eligible providers are rewarded for value over volume. MACRA establishes the **Quality Payment Program (QPP)**, which is set to begin January 1, 2017. MACRA streamlines the current multiple reporting programs (Value Modifier {VM}, EHR-Meaningful Use {Electronic Health Records-MU} and PQRS or Physicians Quality Reporting System that will sunset the end of 2018. For more information on this proposed program, read http://go.cms.gov/QualityPaymentProgram.

* **Social Security Number Removal Initiative (SSNRI):** MARCA requires the removal of Social Security Numbers (SSNs) and the use of Medicare Beneficiary Identifiers (MBI). Beginning April 2018, new Medicare cards will be sent to beneficiaries with an expected completion of transition by December 31, 2019. The MBIs will become Protected Health Information (PHI). This change will affect providers and vendors that bill Medicare. Learn how and when to use the MBIs, at https://www.cms.gov/Medicare/SSNRI/Providers/Providers.html.
* **ICD-10 Flexibility Phase Ending 10/1/16:** CMS will not extend ICD-10 flexibilities as of October 1, 2016. Providers are required to code accurately and reflect the clinical documentation, as per the required coding guidelines. Page 8 of the CMS resource, "*Clarifying Questions and Answers Related to the July 6, 2015, CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities*" has valuable information.
* **CERT A/B MAC Outreach and Education Task Force - Resources:** The Task Force is a joint collaboration of all A/B MACs to communicate national issues. The goal is to reduce improper payments to the Medicare program. Review the recent educational resources on common billing errors.
    - JEA: CERT A/B MAC Outreach & Education Task Force
      JFA: CERT A/B MAC Outreach & Education Task Force
- **Influenza Vaccine Allowables Now Available for 2016 – 2017 Season:** Please see the influenza season (August 1, 2016 to July 31, 2017) allowables listed in Change Request (CR) 9758 and ASP pricing at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html.