

HCP MANAGEMENT CONFERENCE & EXHIBITION

Confidence in Care: Resilience, Readiness, and Results

WELCOME

Title

**Guidance From the Experts in Revenue Cycle Success in NY
Managed Care**

SPEAKERS

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Management, HHAeXchange*

AGENDA

- NY Managed Care Claims and EVV Process
- Working With Aggregators
- Payer Contracts Administration
- Authorization Management
- Eligibility
- Procedure Code Issues
- EVV and Claims Filing Tips
- KPI's and Metrics

NY COMPLIANCE

COMPLIANCE UPDATE

NY Managed Care Claims and EVV Process

New York currently doesn't have an EVV compliance threshold or hard claims edit, but the state budget indicated a **90% EVV requirement**.

NY MANAGED CARE CLAIMS AND EVV PROCESS

6 ELEMENTS OF A CURES COMPLIANT VISIT



Who

Member



Who

Caregiver



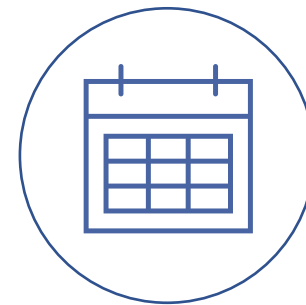
What

Type of
Service



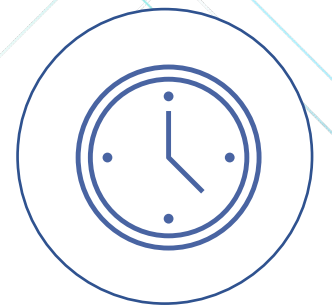
Where

Location
of Service



When

Date of
Service



When

Time of
Service

WORKING WITH PAYER AGGREGATORS

2 Types of EVV Aggregation

1. **EVV Only:** Providers must submit visits and EVV data for all EVV Mandated Services to the Aggregator
2. **EVV + Billing:** Providers must submit visits and EVV data for all EVV Mandates Services along with the billing details as required by the Aggregators Spec to bill using EVV as well.

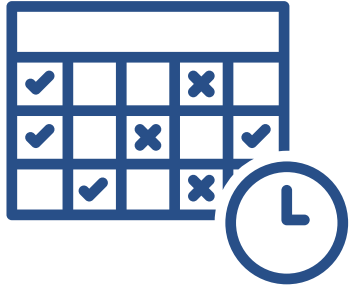
Not only do providers have to ensure visit data is sent to EMedNY for state aggregation – many Plans have also opted to work with an EVV Aggregator.

- Providers can use any EVV vendor of choice.
- Integration to the EVV aggregator for collection of EVV data and at times billing can be a plan specific requirement.

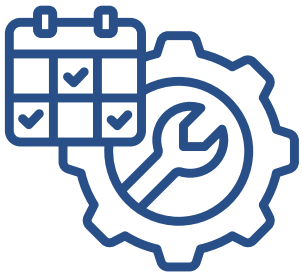


Payer	Go-live Date	DX Code Management	Provider Network EVV Compliance % (YTD)	Requires Billing through Selected Aggregator	Use the Aggregator's Communication Module
Centers Plan	Aggregation Only – Providers Choice to opt in. Not Mandated				
Fidelis	2/14/2022	Provider Managed	76%	Yes	Yes
Riverspring Health Partners	8/22/2022	Provider Managed	81%	Yes	Yes
CenterLight Healthcare (PACE)	6/9/2021	Payer Managed	55%	No	Yes
Visiting Nurse Service of New York (CHOICE)	10/15/2018	Payer Managed	65%	No	Yes
Elderplan MJHS	12/6/2020	Payer Managed	78%	No	Yes
Aetna Better Health of NY	4/26/2021	Payer Managed	79%	No	No
UHC NY		Payer Managed	78%	Yes	Yes
SWHNY-MLTC	10/1/2022	Provider Managed	66%	Yes	Yes
Molina Health NY		Provider Managed	76%	Yes	Yes
Healthfirst	8/15/2022	Payer Managed	79%	Yes	Yes
Nascentia	10/25/2020	Payer Managed	76%	No	No

Billing Workflow



Caregiver completes EVV



Provider manages visit maintenance



Step 1
Prebilling

Prepare and verify data



Step 2
Invoicing

Generate an invoice



Step 3
Billing Review

Review and finalize invoice



Step 4
eBilling

Submit invoices electronically

Prebilling



Step 1
Prebilling



Steps: Billing > Prebilling

Purpose: Prepare and verify the data before creating an invoice.

- **Review Visits** – ensure caregiver times are accurate
- **Verify Service Authorizations** – review authorization hours/units are allocated appropriately

Note: *Manually confirmed visits will not be in compliance.*

Prebilling



Caregiver Compliance does NOT prevent visits from being invoiced



Any visits in Prebilling are NOT eligible to be invoiced until issues are corrected

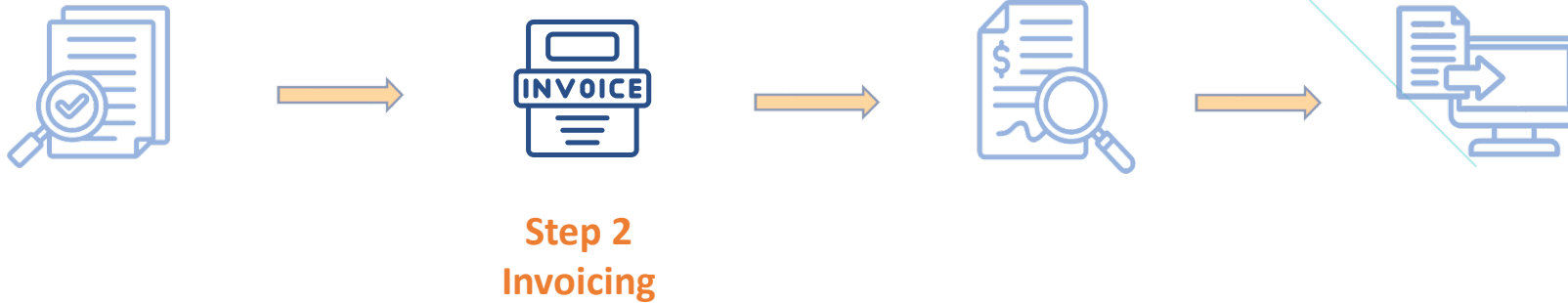
Most Common Prebilling Problems:

- **Incomplete Confirmation** – A visit does not have a clock in and/or clock out
- **Unbalanced** – A caregiver's clock in was outside of the tolerance range of the scheduled visit
- **Not Authorized** – A caregiver has gone over his/her authorized hours or there is no authorization available to cover the visit

Check out the HHAeXchange Knowledge Base for step-by-step videos on how to resolve Prebilling problems

<https://knowledge.hhaexchange.com/enterprise/Content/Training/Getting-Started-T.htm>

Invoicing



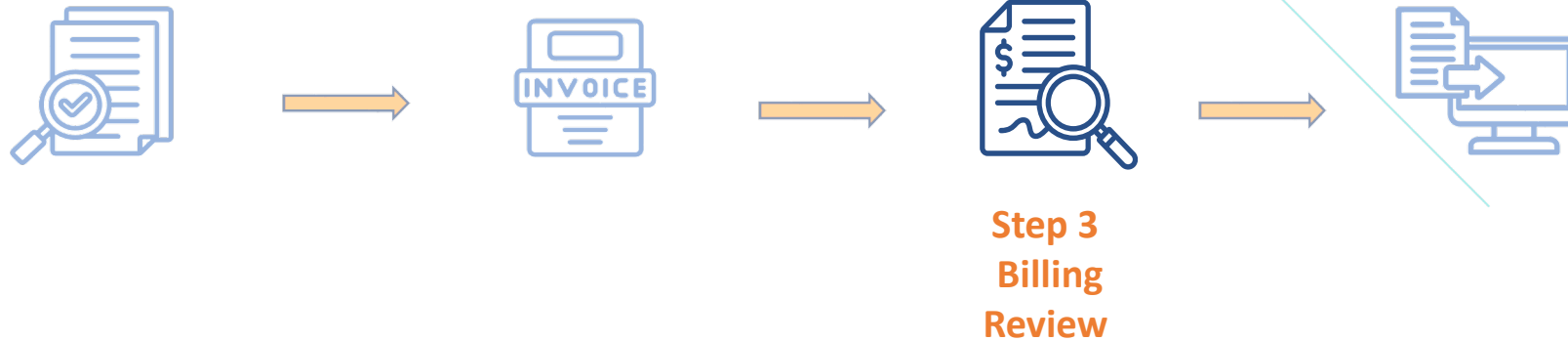
Steps: Billing > New Invoice (Internal)

Purpose: Generate invoices based on verified data and service authorizations

- **Create Invoice:** Select the appropriate time period and services to create an invoice
- **Verify Invoice Details:** Review the invoice for accuracy, including billing codes, and amounts

Note: *Ensure billing rates are entered under your Contract/
Service Codes*

Billing Review



Steps: Billing > Billing Review

Purpose: Review and finalize invoices before they are sent out

- **Correct:** Correct any errors that appear in the Problems column and make any necessary adjustments
- **Finalize:** Confirm that all approved invoices are finalized to continue to the last step

Note: Ensure diagnosis codes are entered in patient's profile.

Billing Review



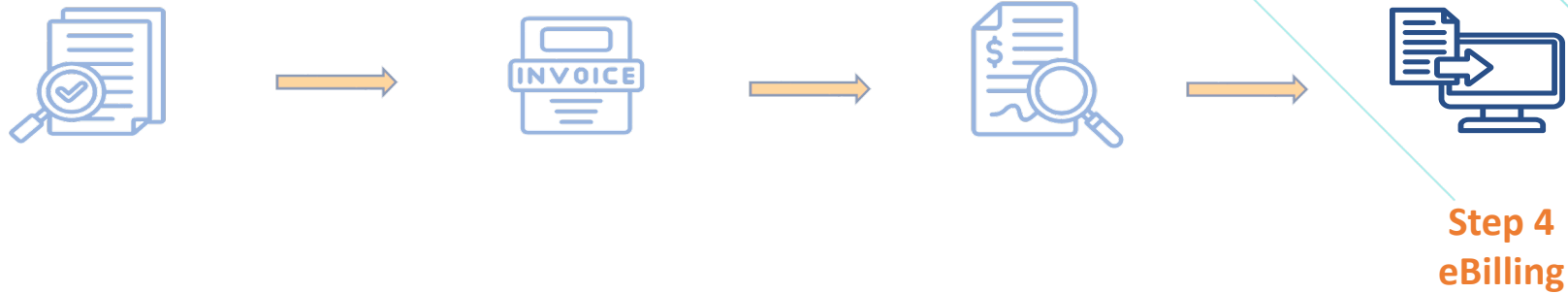
Any visits in Billing Review are NOT eligible to be electronically submitted until issues are corrected

Most Common Billing Review Problems:

- **Missing Diagnosis Code**– The billing diagnosis code is not available
- **Pending Billing of Additional Shifts on Same Day** – Only one visit has been invoiced on a day with multiple visits
- **Visit on Same Day/Service Code must be billed on same Invoice**– Multiple visits on the same day were not invoiced together during Invoicing step

Check out the HHAeXchange Knowledge Base for step-by-step videos on how to resolve Billing Review problems <https://knowledge.hhaexchange.com/enterprise/Content/Training/Getting-Started-T.htm>

Electronic Billing



Steps: Billing > Electronic Billing > E-Submission Batches

Purpose: Submit invoices electronically, manage resubmissions, and send corrected claims if needed

- **Select:** Choose the visits ready for electronic submission
- **Submit:** For linked contracts, send claims electronically to the respective payer(s) via an overnight process

Claim Status Report

Steps: Report > Billing > Claim Status Report

Purpose: View all electronic claims and their corresponding acceptance or rejection status

- Review:** See which claims were accepted or rejected by the payer
- Correct:** Correct any claims that were rejected and resubmit as necessary
- Analyze:** Track any patterns and report on how many claims were submitted during a specific time period



The Claim Status will only update for linked contracts and visits that completed the E-billing step

PAYER CONTRACTS ADMINISTRATION

CONTRACTS SUMMARY (CHARGEMASTER)

	Dates				Terms			Contract Rates			
	<u>Executed Copy</u>			<u>Ever-</u>	<u>Timely</u>	<u>Timely</u>	<u>Timely</u>	<u>Code ==></u>	<u>T1019 - HHA Hourly</u>		
	<u>Received</u>	<u>Inception</u>	<u>Expiration</u>	<u>Green</u>	<u>Filing</u>	<u>Appeal</u>	<u>Payment</u>	<u>Desc ==></u>	<u>Contract</u>	<u>Billed</u>	<u>Paid</u>
Payer 1											
Payer 2											
Payer 3											
Payer 4											
Payer 5											

ELIGIBILITY

ELIGIBILITY TIPS

- Large dollar risk for billing incorrect payer or ineligible client
 - Up to 6 weeks billing at risk
- Obtain Medicaid ID# prior to admission
- Check Medicaid and Payer Eligibility 1st and 15th of each month – not earlier
- Payer switches – need auth from new payer (may be retro)
- An auth is not a guarantee of payment – eligibility is critical



ELIGIBILITY COMPLEXITIES

Know the rules for New York:

- Newly eligible consumers
 - 90-day choice period / those not making choice are assigned to a plan
- Plan changes allowed during annual enrollment only except for special circumstances
- Continuity of care (90 days)
- Loss/regaining eligibility
- Additional documentation requirements for long term care qualification
- Federal funding reductions?
- Newly dual-eligible – re-determination, coverage gap, payer assignment changes – continuity of care rules apply



AUTHORIZATIONS

AUTHORIZATIONS AND CASE SET UP

- Second largest denial category (after Eligibility)
- Procedure codes, Modifiers, Member ID #, Units – count/type
- Watch for incorrect or missing info
- Units type and total units calculations
- Discrepancies vs contract
- Set up case correctly – eg procedure code/modifier and unit type per auth/contract/reality
- Monitor reauths – expiring, hospitalization returns
- Monitor system reports – expiring, expired auths
- Gaps from old expiration
- Service level changes – appropriate?
- Correct procedure codes, missing modifiers
- Make sure Dx code on bill matches auth
- When in Doubt? – Call the payer

BILLING CODES AND MODIFIERS

CODES AND MODIFIERS

- Contract, auth, service, and claim must match
- Auth shows non-contracted code? You're out of network or worse
- What's a modifier?
 - Defined by the payer eg:
 - Weekend services
 - Multiple beneficiaries on service in household



CLAIMS FILING AND FOLLOW-UP

CLAIMS NOT BILLED



Unconfirmed Time In Your System

EVV discrepancies and paper timesheets

Monitor and resolve unverified time

- Report by coordinator



Held Billing – caused by system edits – your system and aggregator

Split shifts

Authorizations – end date

Procedure code/auth match

Monitor held billing edit reports

Release prior to timely filing deadline

EDI TIPS



Verify claims counts / total dollars after every file



Check your rejections after every file



Check all payer portals for your files every week



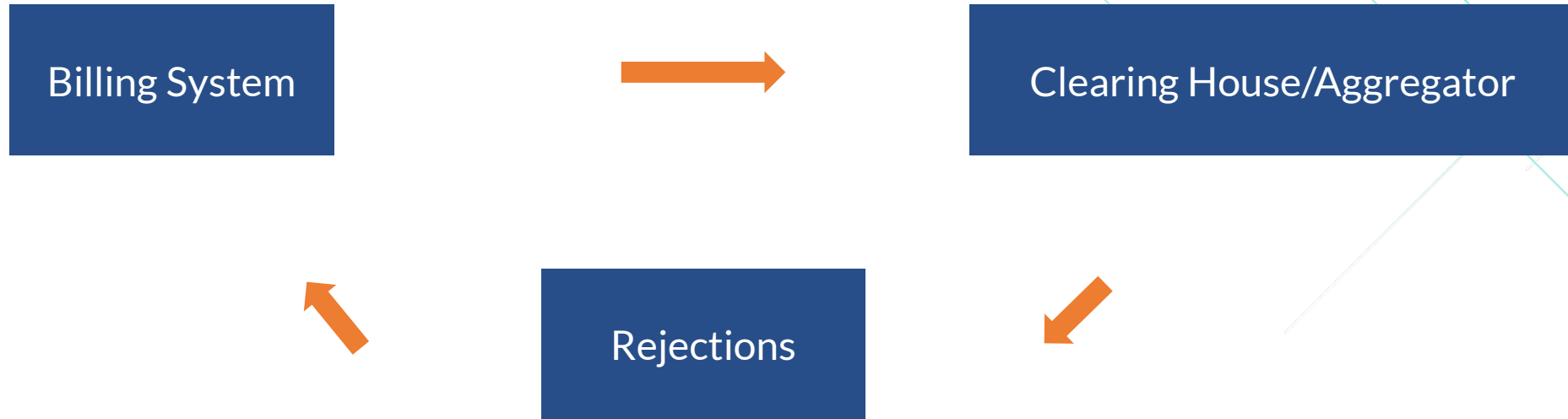
Check for, and post your payments every week

Set up auto-posting (ERA)



Identify, record and WORK denials every week

REJECTED CLAIMS



- Rejections should be worked immediately
- Some common rejections reasons:
 - Member Number invalid/not found
 - Subscriber/Member ID not found
 - Patient Eligibility Not Found with Entity
 - Subscriber and Subscriber ID not found

PAYER SYSTEM DENIED CLAIMS



- Denied Claims

- *Work your denials on a regular basis - start on receipt of eob*
- *Analyze your denials by payer and denial reason and look for trends*
- *Make process changes to avoid future denials*

- Examples of denials:

- Authorization not on File
- Number of Units Exceeds Limit
- Procedure/Service Not Authorized
- Client's authorization was terminated
- Client's authorization date range changed
- Duplicate Claim
- No EVV or EVV mis-match

BILLING AND RESUBMISSION TIPS

Resubmissions

- Resubmit entire claim, not just corrected DOS: Otherwise payer may recoup entire claim and only pay the corrected line
- MLTC payers typically require a “6” or “7” in the bill-type field or claim will be denied as duplicate
- Above is typical, but always refer to provider/aggregator manuals
- EVV re-match



AR AGING REPORTS

- Post your payments!
- The Aging Report will help you see which claims remain outstanding.
- If you missed working rejections or denials, these claims will be caught on your Aging Report. However, if applicable, your pre-billing held claims may not appear on the Aging Report since they have not yet been submitted for billing.
- This report is a tool for you to use to follow-up on all open balanced claims.

KPI'S AND METRICS

PERCENT COLLECTED OF NET REVENUE

Example Agency						
Billed vs Applied Dollars By Month						
Month	Billed	Adjustments	Net Billed	Deposits	Difference	Deposits % Net Billed
22-Jan	\$194,239	(\$508)	\$193,731	\$75,041	\$118,690	38.7%
22-Feb	\$189,312	(\$12,419)	\$176,893	\$150,063	\$26,830	84.8%
22-Mar	\$208,453	(\$5,094)	\$203,359	\$112,363	\$90,996	55.3%
22-Apr	\$199,312	(\$10,319)	\$188,993	\$211,363	(\$22,370)	111.8%
22-May	\$201,326	(\$440)	\$200,886	\$200,295	\$591	99.7%
22-Jun	\$209,127	(\$1,384)	\$207,743	\$56,286	\$151,457	27.1%
22-Jul	\$179,279	(\$15,332)	\$163,947	\$69,892	\$94,055	42.6%
22-Aug	\$182,872	(\$27,808)	\$155,064	\$285,566	(\$130,502)	184.2%
22-Sep	\$222,602	(\$12,030)	\$210,572	\$151,727	\$58,845	72.1%
22-Oct	\$210,041	(\$21,049)	\$188,992	\$209,972	(\$20,980)	111.1%
22-Nov	\$199,613	(\$2,427)	\$197,186	\$184,092	\$13,094	93.4%
22-Dec	\$224,520	(\$12,782)	\$211,738	\$295,643	(\$83,905)	139.6%
23-Jan	\$216,926	(\$2,207)	\$214,719	\$152,369	\$62,350	71.0%
Totals	\$2,637,622	(\$123,799)	\$2,513,823	\$2,154,672	\$359,151	85.7%
		-4.70%				

DAYS SALES OUTSTANDING (DSO)

- ▶ AKA – Average Daily Billing in Accounts Receivable
- ▶ Measures the speed at which a company collects its cash
- ▶ Lower DSO = quicker collections
- ▶ Higher DSO = slower collections
- ▶ Formula:
 - **Accounts Receivable / Average Billing Per Day**
- ▶ Allows “apples to apples” comparisons across payers and providers
- ▶ Ask your revenue cycle department:
- ▶ If our contract says clean claims are paid in 30 days, why isn't our DSO 30 days?

DAYS SALES OUTSTANDING (DSO)

Example DSO Computation:

- Formula (all after contractual adjustments):

Accounts Receivable

Average Daily Billing (Annual Billing / 360)



- Computation:

100,000

(1,000,000 / 360)



DSO = 36 days

DAYS TO BILL

- ▶ Definition – Timeline DOS vs Bill date
- ▶ Impactors:
 - ▶ Unconfirmed visits
 - ▶ Held billing
- ▶ Watch for:
 - ▶ Timely submission to payers
 - ▶ Clearinghouse/aggregator rejections

QUESTIONS?

Thank You!

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Session Survey

