Back Office Best Practices

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PCC 2017 Users' Conference
Back Office Best Practices

Overview
- Take Away
- Configuration
- Pre Visit
- Claims submission
- Posting payments / responses
- Claims follow up
- Claim submission tools and reports
Back Office Best Practices

● What is the Take Away?
  - Learning the importance of the front desk and back office working together to collect money.
  - Tools to help
Back Office Best Practices

The processes used *prior to* when a patient comes in will impact the quality of your claims, increase TOS payments, and help reduce the amount of collections needed.

In short the Front End functions drive the revenue cycle.
Back Office Best Practices Configuration

- Insurance Plans
- checkout screens
- Snap Codes Table
- Billing Office Prep
Back Office Best Practices
Configuration: Insurance Table

- Proper insurance configuration
  - Pending correct procedures
  - Submitting correct procedures
  - Different copays for well vs. sick codes
  - Automatic capitation
  - Support can help you fix any of these not working properly.
Back Office Best Practices
Configuration: checkout screens

- checkout screens
  - Setup using Charge Screen Editor (csedit)
  - Can vary by visit reason, place of service, and/or provider
  - Setup form fee posting
  - Setup hospital posting
    - Hospital vs. newborn hospital
Back Office Best Practices
Configuration: Snap Codes

- SNAP Code Table
  - Use so procedures are not missed, i.e. immunizations
  - Each SNAP code can link up to 21 procedures, each capable of linking to 4 diagnoses codes each!
  - Can be placed on screens using the Charge Screen Editor (csedit) or used on the fly
Back Office Best Practices

Configuration: Billing Office Prep

- Develop a financial policy you share with parents.
- Develop guides to educate patients about insurance responsibility.
- Understand most information about patient insurance plans and share the basics with the front desk.
Back Office Best Practices
Pre Visit

- Scheduling
- Appointment Verification
- Eligibility Verification
- Eligibility Using Partner
Back Office Best Practices
Pre Visit: Scheduling

Use flags to communicate with the front office.

Take advantage of available function keys.
Back Office Best Practices
Pre Visit: Scheduling

<table>
<thead>
<tr>
<th>Name</th>
<th>Visit Reason</th>
<th>PCP</th>
<th>Provider</th>
<th>Mins</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pebbles Flintstone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Time Frame:** [ ] [ ] [ ] [ ] [ ]

**PATIENT:** Pebbles Flintstone  
DOB: 05/21/2006  
AGE: 10 years

**CUST:** Wilma Flintstone  
15 Quarry Lane  
Winooski, VT 05404

**GUAR:** Fred Flintstone  
1400 Rock Road  
Winooski, VT 05404

**H:** 802-555-0194  
PERS BAL: $37.00

**W:** 802-555-0197  
INS BAL: $128.00

**PRI:** Aetna HDHP  
CERT: 34DFJH

**SEC:** Cigna PPO $20  
CERT: 24958JD

**School:** Bedrock Central  
**Alt Name:** Rubble

**SSN:** 826-74-6104  
**Chart #:** 2755

**PAT STATUS:** Adoption, ~$ Problem  
**CUST STATUS:** CONFIDENTIAL  
**GUAR STATUS:** Billing Problem

**MISS:** 1 (01/15/16, Pebbles, Sick Call)  
**CANC:** 1 (03/10/10, Pebbles, Sick Call)

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Partner screens are now 30 lines long, so take advantage of those 5 lines!
Back Office Best Practices

Pre Visit: Scheduling

● New Patient Process
  - Who collects insurance information over the phone?
  - F4/F7 can be configured to bring you directly to eligibility and the policy program
  - Remind them to bring their insurance card and copay
Back Office Best Practices
Pre Visit: Eligibility

• Partner's elig program
  – Auto eligibility overnight
    ● For all active plans
  – Update policy information as needed through elig, especially copays!
  – Use notes for the front desk to see at checkin
Back Office Best Practices
Pre Visit: Appt Verification

Points to make during appointment verification
- Verify date, time, and visit reason
- Verify insurance plan, subscriber, start date, and end date
- Remind patient
  - to bring in their insurance card
  - payment for expected copay & outstanding balances!!!
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Back Office Best Practices
Claims Submission: Clean Claims

- Always link diagnoses to procedures
- Certified coder on staff
- Train staff on basic coding scenarios
- Use SNAP codes to reduce missed procedures
- Setup the EEF on the EHR to select the proper CPT codes for orders.
Back Office Best Practices
Claims Submission: Clean Claims

- Verifying quality claims before submitting
  - Daysheet Postings Check (dailycheck)
  - Changing insurance after charges are posted
  - Adding modifiers on the fly in oops

- Pre-authorization / Referral requirements
Back Office Best Practices

Claims Submission

Reports You Receive As Your Claim is Processed

1. **Preplugs**
   - (On-Screen Errors)
   - **Preplugs/Tagsplit**
     - Bad Claims Report
   - This report prints out when **preplugs** finishes. It warns you of basic errors and lists claims that could not be sent.

2. **ECS**
   - **ECS Batch Log**
   - This report prints out when **ECS** finishes. It lists information on every claim sent out.

3. **PCC**
   - **PCC Daily Submission Summary**
     - PCC sends you this report. It lets you know that we have received your claims and sent them on to claim clearinghouses or insurance carriers.

4. **Capario, RelayHealth, Emdeon**
   - **Daily Error and Verification Reports**
     - Capario and other clearinghouses send reports when they receive your claims. These reports typically list problem claims and log claims that were sent on to the carriers.

5. **Insurance Carriers**
   - **Various Payor Response Reports**
     - Capario, PCC, and other clearinghouses collect responses from insurance carriers and send them to you in reports. The reports describe problems the insurance carriers had with your claims.
Back Office Best Practices
Claims Submission: Responses

- preptags now part of ECS
- Bad Claims Report
- Sample ECS Bad Claim Report Error

Date: 07/11/16  PCC #: 12345     Patient: Bart Simpson
Guar PCC#: 54321       Cus PCC#: 54321
Claim is for an insurance company no longer on the patient
Charge filed with: UNITED HEALTHCARE BOX 740800 $20

Date: 07/11/16  PCC #: 12345     Patient: Bart Simpson
Guar PCC#: 54321       Cus PCC#: 54321
Procedure Code: ABCDE   Diagnosis code: Z23 Amount: $ 10.00
The procedure code “ABCDE” is obsolete for the date of service.
Back Office Best Practices
Claims Submission: Responses

- Partner Claim Responses
  - ECS Batch Logs
- Clearinghouse/Intermediary Responses
  - Delivered via clearinghouse or gateway
  - Rejected claims are **not submitted** to payers
  - Accepted claims are **submitted** to payers
Back Office Best Practices
Claims Submission: Responses

- Finding Electronic Claim Responses in Partner
  - Correct Mistakes (oops)
  - EDI Reports (ecsreports)
### Back Office Best Practices

#### Claims Submission: Responses

**Electronic Claim Responses in Correct Mistakes/oops**

<table>
<thead>
<tr>
<th>DATE</th>
<th>PATIENT</th>
<th>PROCEDURE NAME</th>
<th>DIAG</th>
<th>P</th>
<th>AMOUNT</th>
<th>SUM</th>
<th>DUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/22/09</td>
<td>Pebbles</td>
<td>Well Child 5-11 yrs</td>
<td>V20.2</td>
<td>Y</td>
<td>195.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>01/26/10</td>
<td>Ins Pmt -- HUM #0000</td>
<td></td>
<td>Y</td>
<td></td>
<td>115.56</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/26/10</td>
<td>Ins Adj -- HUM #0000</td>
<td></td>
<td>Y</td>
<td></td>
<td>64.44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/15/10</td>
<td>Payor Acknowledged Claim #335370: Your claim has been processed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/15/10</td>
<td>PCC Acknowledged Claim #335370:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/15/10</td>
<td>HUMANA ECS #335370</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/15/10</td>
<td>Claim (from HUMANA) to AVAILITYHUMANA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>01/14/10</td>
<td>HUMANA claim batched by oops</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/22/09</td>
<td>TOS Cash Payment</td>
<td></td>
<td>Y</td>
<td></td>
<td>15.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use the `<F3>` See Claim Rpt/Bill function key to access the claim responses (e.g. lines 4, 5, and 6)
Back Office Best Practices
Claims Submission: ecsreports

EDI Reports - Listing All Report Types

1422 files are listed below. Times Printed

<table>
<thead>
<tr>
<th>Date</th>
<th>Report Description</th>
<th>Time</th>
<th>Printed</th>
</tr>
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<tbody>
<tr>
<td>05/20/2013</td>
<td>ECS Batch Log</td>
<td>2:33pm</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>preptags/tagsplit Bad Claims</td>
<td>2:31pm</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Post-N-Track Claim Acknowledgment Report</td>
<td>1:15pm</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>ERA/EOB Report</td>
<td>11:15am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>ERA/EOB Report</td>
<td>8:45am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Emdeon Provider Claim Status</td>
<td>4:00am</td>
<td>0</td>
</tr>
<tr>
<td>05/19/2013</td>
<td>Post-N-Track Claim Acknowledgment Report</td>
<td>1:15pm</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>ERA/EOB Report</td>
<td>11:15am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>ERA/EOB Report</td>
<td>11:15am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Availity Electronic Batch Report</td>
<td>5:45am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Availity Electronic Batch Report</td>
<td>5:45am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Emdeon File Status Report</td>
<td>4:00am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Emdeon File Summary Report</td>
<td>4:00am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Emdeon File Detail Summary Report</td>
<td>4:00am</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>PCC Daily Submission Summary</td>
<td>1:30am</td>
<td>0</td>
</tr>
</tbody>
</table>
Back Office Best Practices
Claims Submission: Mastering Claim Reports

If you missed Justin’s Mastering Claim Reports on Wednesday, make sure to download his presentation from the app.
Back Office Best Practices

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Back Office Best Practices
Payment Posting

- Autoposting of payments
  - ERA vs EFT
  - autopip
  - RARC and CARC
  - erareports
Back Office Best Practices
Payment Posting

- What's ERA?
- What's EFT?
Back Office Best Practices
Payment Posting

- ERA is not EFT
  - Most payers allow receipt of either or both
  - Some payers require both
  - Partner doesn't facilitate processing of EFT
## Back Office Best Practices

### Payment Posting

- **Sample ERA**

<table>
<thead>
<tr>
<th>Payer</th>
<th>Payee</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEVADA SUPERIOR HEALTH</td>
<td>PAULI G LAGERS MD</td>
</tr>
<tr>
<td>P.O. BOX 182223</td>
<td># 112</td>
</tr>
<tr>
<td>LAS VEGAS NV, 37427223</td>
<td>222 UNIVERSITY W BLVD</td>
</tr>
<tr>
<td></td>
<td>SILVER SPRING MO, 209011969</td>
</tr>
</tbody>
</table>

**Payment Information**

Remittance Information Only

Check 871450137

Amount: $132.64

**Adjustment Reason Key**

45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).

<table>
<thead>
<tr>
<th>Date CPT</th>
<th>Charge</th>
<th>Deduct</th>
<th>Copay / CoInsur</th>
<th>Personal</th>
<th>Total</th>
<th>Per Due</th>
<th>Contractual</th>
<th>Other</th>
<th>Adjust</th>
<th>Other</th>
<th>Adjust</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>121807 93392</td>
<td>148.00</td>
<td>-10.00</td>
<td>0.00</td>
<td>0.00</td>
<td>10.00</td>
<td>-47.35 45</td>
<td>0.00</td>
<td>96.65</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>121807 90855</td>
<td>30.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>-15.77 45</td>
<td>0.00</td>
<td>15.97</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>121807 36616</td>
<td>35.00</td>
<td>-10.00</td>
<td>0.00</td>
<td>0.00</td>
<td>10.00</td>
<td>-90.36 45</td>
<td>0.00</td>
<td>21.79</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>121807 90465</td>
<td>233.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td>132.64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Back Office Best Practices
Payment Posting

- ERAs now contain the four Business Scenarios
  - Additional information required, missing/invalid/incomplete claim
  - Additional information required, missing/invalid/incomplete documentation
  - Billed service not covered by health plan
  - Benefit for billed service not separately payable
Back Office Best Practices
Payment Posting

How does ERA benefit you?

- Standardization of presentation format/layout
- ERA is generally delivered more quickly than a paper/mailed EOB
- ERA is required for automatic payment posting
Back Office Best Practices
Payment Posting: autopip

- **autopip** is Partner's automatic insurance payment posting program
  - Why are you not using this program?
  - Why are you not using it for all available insurance companies?

- autopip works in conjunction with pip
  - Yes, you'll still need to post some payments the old fashioned way
Back Office Best Practices
Payment Posting: autopip

Learning to use autopip

- autopip and the autoposting process is documented at
  http://learn.pcc.com/
- Our video tutorial is highly recommended!
Back Office Best Practices
Payment Posting: autopip

- Partner auto posting in a nutshell
  - autopip posts the claim payments it can
  - Claim payments which are not auto posted are directed to the Manual Post Report
  - Print the Manual Post Report and post those payments with pip, i.e. the old fashioned way
Back Office Best Practices
Payment Posting: autopip

- Use a different default payment / adjustment type than pip to make auto postings easier to see in Partner programs
  - Payment Types table
  - ced option
Back Office Best Practices
Payment Posting: autopip

- Which payments and adjustments must be manually posted?
  - Those for which the charge amount, CPT, and/or copay doesn't match Partner's data
  - Those which don't relate directly to charges with unpaid insurance balances
  - Denials
Back Office Best Practices
Payment Posting: autopip

- Which payments and adjustments must be manually posted?
  - Depending on your Partner configuration
    - Adjustment codes which are not predefined as acceptable for auto-posting
    - Payments which do not match the corresponding Partner allowable value
Back Office Best Practices
Payment Posting: autopip

- Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) Values
  - HIPAA standardized the coding payers use to identify adjustment reasons
  - All payers must use the standard code values in electronic remittance advice
  - Partner's formatted ERA translates the codes to the corresponding text descriptions
Back Office Best Practices
Payment Posting

- Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) Values
  - RARC Values
  - CARC Values
Back Office Best Practices
Payment Posting: erareports

- erareports provides access to archived ERA data separated by check, like autopip
- All ERA – auto posted, manually posted, and unposted – is presented, separated by payment date, payor, check number, and check amount
- Search and print functions are provided
How do I get started with auto posting?

1. Contact your CA! They will help you determine which of your payers have ERAs available and help you with any needed paperwork.

Back Office Best Practices
Payment Posting: pip

- Posting insurance payments manually, aka pip
  - Payment/Adjustment types to track denials
  - CARC fields can be configured to appear
  - Insurance Allowables / Fee Schedules
Back Office Best Practices
Payment Posting: pip

Allowable values, schedule and config option

CARC Values
Back Office Best Practices

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Back Office Best Practices
Insurance Follow Up

- Unpaid claims
- Denial management
- Appeals process
- Partner claims submission tools and reports
Back Office Best Practices

Insurance Follow Up: oops

- oops vs. oopsp vs. oops -k
  - oops: prompts for account name / PCC #
  - oopsp: prompts for patient name / PCC #
  - oops -k: prompts for patient name / PCC#, but only shows that patient's charges instead of the entire family
Back Office Best Practices

Insurance Follow Up: oops

- oops
- Correct insurance <F4>
- Correct diagnoses <F5>
- Correct billing provider <F5>
- Batch corrected claims <F2>
- Unlink/Relink payments <F6>
Back Office Best Practices
Insurance Follow Up: oops

- oops
  - Recent Changes
    - Updating policies in oops
    - See the CPT code on the first screen
    - Visit based notes
Recent Changes in oops

- Generate Claim, Insurance and Visit Status possible by Claim ID or transaction date.
- Original Claim Amount
- Business Scenarios, in the ERA report
Back Office Best Practices
Insurance Follow Up Tools

● maketags
● insaging
● inscoar – interactive mode
● srs Billing & Collection reports
● ecsreports
● allowedit
● cfs
Back Office Best Practices

Insurance F/U Tools: maketags

- ONLY for special circumstances

RESUBMIT CLAIMS

Age of Charges:
- 45 or more days old
- from 45 to 90 days old
X for dates from 05/21/12 through 05/20/13

Charges to Resubmit:
X Only Unpaid, Pending Charges
- Only Unpaid Charges, Pending or Personal
- All Charges, Paid or Unpaid, Pending or Personal

Which Insurance Plans:
X Many Plans
- Just One Plan: 

All Providers: Yes

NOTE: the above criteria will be ignored when using F5 (SRS).

Include entire visits: No
Back Office Best Practices
Insurance Follow Up Tools: insaging

- Use to find insurance companies not paying timely

<table>
<thead>
<tr>
<th>Insurance Company Aging Report – All Providers 05/21/13</th>
<th>Current</th>
<th>30-59</th>
<th>60-89</th>
<th>90-119</th>
<th>120+</th>
<th>Total</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Personal</td>
<td>5,676</td>
<td>6,348</td>
<td>3,426</td>
<td>1,746</td>
<td>63,973</td>
<td>81,172</td>
<td>52</td>
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<td>Medicaid</td>
<td>0</td>
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<td>0</td>
<td>46</td>
<td>46</td>
<td>0</td>
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<tr>
<td>Aetna USHC HMO</td>
<td>1,426</td>
<td>180</td>
<td>265</td>
<td>0</td>
<td>0</td>
<td>1,871</td>
<td>1</td>
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<tr>
<td>Aetna MC &amp; Elect</td>
<td>1,259</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>1,259</td>
<td>1</td>
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<tr>
<td>Aetna Open</td>
<td>2,099</td>
<td>441</td>
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<td>2,540</td>
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<td>BCBS</td>
<td>2,521</td>
<td>30</td>
<td>619</td>
<td>38</td>
<td>122</td>
<td>3,331</td>
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</tr>
<tr>
<td>Capital Blue Cross</td>
<td>10,638</td>
<td>4,950</td>
<td>99</td>
<td>0</td>
<td>588</td>
<td>16,275</td>
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<td>Health America</td>
<td>4,873</td>
<td>621</td>
<td>165</td>
<td>0</td>
<td>15</td>
<td>5,674</td>
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<td>Keystone HealthPlan</td>
<td>2,028</td>
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<td>185</td>
<td>40</td>
<td>261</td>
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<tr>
<td>HealthyKids HMO</td>
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<td>13,290</td>
<td>2,310</td>
<td>346</td>
<td>460</td>
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<td>17,320</td>
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<tr>
<td>Cigna</td>
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<td>393</td>
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<tr>
<td>Highmark Blue Shield</td>
<td>16,922</td>
<td>1,141</td>
<td>0</td>
<td>72</td>
<td>60</td>
<td>18,195</td>
<td>12</td>
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<tr>
<td>Retired Insurance Plans</td>
<td>1,267</td>
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<td>105</td>
<td>143</td>
<td>169</td>
<td>2,727</td>
<td>2</td>
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<tr>
<td>Total</td>
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<td>17,702</td>
<td>5,417</td>
<td>2,499</td>
<td>66,480</td>
<td>154,865</td>
<td></td>
</tr>
</tbody>
</table>

Percentage: 41% 11% 3% 2% 43%
Back Office Best Practices
Insurance Follow Up Tools

- inscoar generates a list of outstanding claims
  - Interactive gives you access to everything!
    - fame (notes) / notjane
    - refund
    - pam / pip
    - oops
    - checkout
    - visit notes
Back Office Best Practices
Insurance Follow Up Tools

INSCOAR INTERACTIVE SCREEN
Use the PgUp and PgDn keys to scroll through this information.

ACCOUNTS WITH BALANCES PENDING Aetna HDHP ()

Flintstone, Fred (#1980)
Flintstone, Dino (#3335) (03/29/12) (34DFJH)
01/16/2016 0 0V Expanded Focus 99213 372.30 D $ 79.00
Visit Notes:
06/16/16 Here is my very important note tracking what I have d insurance company about their lack of payment.

Billing History:
12/11/14 Aetna HDHP claim batched
01/17/15 Aetna HDHP claim batched by oops
03/21/16 Aetna HDHP HCFA #69 $ 79.00
05/02/16 Aetna HDHP HCFA #105 $ 79.00
## Back Office Best Practices

### Insurance Follow Up Tools

- **Billing & Collections**
  - **Gross Collection Ratio Report**

### Gross Collection Ratio Report

<table>
<thead>
<tr>
<th>Insurance Group at Time of Service</th>
<th>Charge Amount</th>
<th>Amount Collected (all pmts + all adj)</th>
<th>Percent Collected (all pmts + all adj)</th>
<th>Amount Deposited (all pmts)</th>
<th>Percent Deposited (all pmts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal/No Insurance</td>
<td>$10,459.27</td>
<td>$10,459.27</td>
<td>100.00%</td>
<td>$7,535.28</td>
<td>72.04%</td>
</tr>
<tr>
<td>Aetna USHC HMO</td>
<td>$16,768.02</td>
<td>$16,768.02</td>
<td>100.00%</td>
<td>$5,433.00</td>
<td>32.40%</td>
</tr>
<tr>
<td>Aetna MC &amp; Elect</td>
<td>$7,068.30</td>
<td>$7,068.30</td>
<td>100.00%</td>
<td>$5,325.80</td>
<td>75.35%</td>
</tr>
<tr>
<td>BCBS</td>
<td>$30,049.30</td>
<td>$30,049.30</td>
<td>100.00%</td>
<td>$24,710.89</td>
<td>82.23%</td>
</tr>
<tr>
<td>Health America</td>
<td>$47,321.44</td>
<td>$47,321.44</td>
<td>100.00%</td>
<td>$29,077.26</td>
<td>61.45%</td>
</tr>
<tr>
<td>Aetna Open</td>
<td>$11,228.00</td>
<td>$11,228.00</td>
<td>100.00%</td>
<td>$6,699.30</td>
<td>59.67%</td>
</tr>
<tr>
<td>Keystone HealthPlan</td>
<td>$35,695.00</td>
<td>$35,695.00</td>
<td>100.00%</td>
<td>$8,695.28</td>
<td>24.36%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>$149,265.09</td>
<td>$149,265.09</td>
<td>100.00%</td>
<td>$97,110.55</td>
<td>65.06%</td>
</tr>
<tr>
<td>HealthyKids HMO</td>
<td>$24,060.00</td>
<td>$24,060.00</td>
<td>100.00%</td>
<td>$18,452.33</td>
<td>76.69%</td>
</tr>
<tr>
<td>Cigna</td>
<td>$9,115.22</td>
<td>$9,115.22</td>
<td>100.00%</td>
<td>$7,279.12</td>
<td>79.86%</td>
</tr>
<tr>
<td>Capital Blue Cross</td>
<td>$113,431.24</td>
<td>$113,431.24</td>
<td>100.00%</td>
<td>$91,355.80</td>
<td>80.54%</td>
</tr>
<tr>
<td>Highmark Blue Shield</td>
<td>$97,533.57</td>
<td>$97,533.57</td>
<td>100.00%</td>
<td>$78,892.47</td>
<td>80.89%</td>
</tr>
<tr>
<td>Retired Insurance Plans</td>
<td>$51,980.60</td>
<td>$51,980.60</td>
<td>100.00%</td>
<td>$42,161.28</td>
<td>81.11%</td>
</tr>
</tbody>
</table>

**Total**

|                      | $603,975.05   | $603,975.05                          | 100.00%                                | $422,728.36                 | 69.99%                      |

Criteria for this report run: Transaction Date Range: 07/12/11 - 07/11/12

Charge Amount Due selection, Range is between $0.00 and $0.00.
## Back Office Best Practices

**Insurance Follow Up Tools**

- Billing & Collections
  - Claim Error Report

### Claim Error Report (pre-tags/Proxymed/Emdeon Claims)

**Responsible Party Group: Private Insurance**

<table>
<thead>
<tr>
<th>Acct</th>
<th>Acct Last Name</th>
<th>Acct First Name</th>
<th>Pat</th>
<th>Pat First Name</th>
<th>Date of Current Billing Status</th>
<th>Current Billed Message</th>
<th>Transaction Date</th>
<th>Charge Amount</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>477</td>
<td>Gordon</td>
<td>Neeru</td>
<td>733</td>
<td>Jason</td>
<td>07/05/12</td>
<td>Claim (from Private Insurance) to Error</td>
<td>06/29/12</td>
<td>$56.00</td>
<td>$46.00</td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$56.00</td>
<td>$46.00</td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$56.00</td>
<td>$46.00</td>
</tr>
</tbody>
</table>

**Responsible Party Group: HealthyKids HMO**

<table>
<thead>
<tr>
<th>Acct</th>
<th>Acct Last Name</th>
<th>Acct First Name</th>
<th>Pat</th>
<th>Pat First Name</th>
<th>Date of Current Billing Status</th>
<th>Current Billed Message</th>
<th>Transaction Date</th>
<th>Charge Amount</th>
<th>Amount Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>428</td>
<td>Keller</td>
<td>Alan</td>
<td>2429</td>
<td>Thomas</td>
<td>07/05/12</td>
<td>Claim (from HealthyKids HMO) to Error</td>
<td>01/28/12</td>
<td>$15.00</td>
<td>$15.00</td>
</tr>
<tr>
<td>931</td>
<td>Wells</td>
<td>Jack</td>
<td>1173</td>
<td>Anna</td>
<td>07/05/12</td>
<td>Claim (from HealthyKids HMO) to Error</td>
<td>06/24/12</td>
<td>$56.00</td>
<td>$46.00</td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$71.00</td>
<td>$61.00</td>
</tr>
<tr>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$71.00</td>
<td>$61.00</td>
</tr>
</tbody>
</table>
Back Office Best Practices
Insurance Follow Up Tools

- Allowables
  - allowedit
  - srs
    - Allowable Overpayments Report
    - Allowable Underpayments Report
- Learn more about this at learn.pcc.com
### Back Office Best Practices

**Insurance Follow Up Tools: cfs**

#### The Special Accounts Editor

<table>
<thead>
<tr>
<th>Account Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>(o) Overdue</td>
<td>(10) Physician Coverage</td>
</tr>
<tr>
<td>(b) Budget</td>
<td>(11) Coordination of Benefits</td>
</tr>
<tr>
<td>(u) Budget Overdue</td>
<td>(12) CONFIDENTIALITY</td>
</tr>
<tr>
<td>(h) Bills Held</td>
<td>(13) Missed Appt Fee</td>
</tr>
<tr>
<td>(m) Medicaid</td>
<td>(14) Archived</td>
</tr>
<tr>
<td>(d) Delinquent Medicaid</td>
<td>(15) Form Fee</td>
</tr>
<tr>
<td>(l) Late insurance payments</td>
<td>(16) New Patient</td>
</tr>
<tr>
<td>(c) Credits</td>
<td>(17) <strong>Billing Problem</strong></td>
</tr>
<tr>
<td>(n) Billing Notes</td>
<td>(18) New Pt Records</td>
</tr>
<tr>
<td>(1) Inactive</td>
<td>(19) Financial Policy</td>
</tr>
<tr>
<td>(2) Dismissed</td>
<td>(20) Records</td>
</tr>
<tr>
<td>(3) Employee</td>
<td>(21) <strong>Copay Due</strong></td>
</tr>
<tr>
<td>(4) Transferred Out</td>
<td>(22) 2013 Transferred</td>
</tr>
<tr>
<td>(5) <strong>Collection</strong></td>
<td>(23) 2013 Copy Card</td>
</tr>
<tr>
<td>(6) Cash Only</td>
<td></td>
</tr>
<tr>
<td>(7) <strong>Payment Plan</strong></td>
<td></td>
</tr>
<tr>
<td>(8) PC(insurance)</td>
<td></td>
</tr>
<tr>
<td>(9) Copy Card</td>
<td></td>
</tr>
</tbody>
</table>

Check accounts with specific flags used for follow up your office may have created.

**Note:** The red box highlights specific accounts that are relevant for follow-up. The `Billing Problem` and `Copay Due` are particularly important for tracking and managing patient payments.
Back Office Best Practices
Insurance Follow Up Tools

How often to run?

- insaging: Monthly
- inscoar: Weekly
- Gross Collection Ratio: Monthly
- Claim Error Report: Weekly
- cfs: It depends on the status flag
Back Office Best Practices

Insurance Follow Up

- Challenges
- Unpaid claims
- Denial management
- Appeals process
- Partner claims submission tools and reports
Back Office Best Practices
Insurance Follow Up

- Challenges:
  - Variety of plans covering your families
  - Coding requirements
  - Ever-changing payer 'rules'
  - Claims submission address changes
Back Office Best Practices
Insurance Follow Up

● Division of work load
  - By carrier
  - By task
    ● Claims submission
    ● Payment posting
    ● Follow up on denials
    ● Follow up on unpaid claims
Insurance Follow Up: Unpaid Claims

Follow up schedule for contacting the carrier

- Call if no acknowledgment of receipt of claims
  - 10 days for paper
  - 3 days for electronic
- Use inscoar
Back Office Best Practices
Insurance Follow Up: Denial Management

- Create denial/appeals procedure
- Automate appeal form letters
- Reminder system for follow up
  - tickle
  - Account flags
Back Office Best Practices

Insurance Follow Up: Denial Management

- CARC Reports in srs
  - CARC Summary Report
  - CARC Insurance Detail Report
<table>
<thead>
<tr>
<th>CARC Code</th>
<th>Count</th>
<th>CARC Amount</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45</td>
<td>14635</td>
<td>$670,290.43</td>
<td>Charge exceeds fee schedule/maximum allowable or contracted/legis</td>
</tr>
<tr>
<td>181</td>
<td>2284</td>
<td>$83,136.00</td>
<td>Procedure code was invalid on the date of service.</td>
</tr>
<tr>
<td>1</td>
<td>5979</td>
<td>$49,345.53</td>
<td>Deductible Amount</td>
</tr>
<tr>
<td>3</td>
<td>4828</td>
<td>$30,123.00</td>
<td>Co-payment Amount</td>
</tr>
<tr>
<td>204</td>
<td>896</td>
<td>$29,345.00</td>
<td>This service/equipment/drug is not covered under the patient's cu</td>
</tr>
<tr>
<td>2</td>
<td>1735</td>
<td>$2,345.72</td>
<td>Coinsurance Amount</td>
</tr>
<tr>
<td>197</td>
<td>21</td>
<td>$1,523.00</td>
<td>Precertification/authorization/notification absent.</td>
</tr>
<tr>
<td>27</td>
<td>196</td>
<td>$1,245.00</td>
<td>Expenses incurred after coverage terminated.</td>
</tr>
<tr>
<td>33</td>
<td>2</td>
<td>$258.00</td>
<td>Insured has no dependent coverage.</td>
</tr>
<tr>
<td>182</td>
<td>5</td>
<td>$129.00</td>
<td>Procedure modifier was invalid on the date of service.</td>
</tr>
<tr>
<td>B20</td>
<td>3</td>
<td>$0.00</td>
<td>Procedure/service was partially or fully furnished by another pro</td>
</tr>
<tr>
<td>B16</td>
<td>1</td>
<td>$0.00</td>
<td>'New Patient' qualifications were not met.</td>
</tr>
<tr>
<td>B10</td>
<td>1</td>
<td>$0.00</td>
<td>Allowed amount has been reduced because a component of the basic</td>
</tr>
<tr>
<td>98</td>
<td>1</td>
<td>$0.00</td>
<td>The hospital must file the Medicare claim for this inpatient non-</td>
</tr>
<tr>
<td>97</td>
<td>1894</td>
<td>$0.00</td>
<td>The benefit for this service is included in the payment/allowance</td>
</tr>
<tr>
<td>96</td>
<td>510</td>
<td>$0.00</td>
<td>Non-covered charge(s).</td>
</tr>
<tr>
<td>94</td>
<td>1</td>
<td>$0.00</td>
<td>Processed in Excess of charges.</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>$0.00</td>
<td>The diagnosis is inconsistent with the patient's age.</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>$0.00</td>
<td>The procedure code is inconsistent with the provider type/special</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>$0.00</td>
<td>The procedure/revenue code is inconsistent with the patient's gen</td>
</tr>
</tbody>
</table>
Back Office Best Practices
Insurance Follow Up: Appeals

- Know you payer contacts
  - Claims services representative
  - Provider services representative
  - Claims supervisor
  - Appeals coordinator
  - Medical review manager
  - Medical Director
Back Office Best Practices
Insurance Follow Up: Appeals

● Sample phone call with carrier
  − Have necessary data in front of you
  ● inscoar: interactive mode
  − Know the history of the claim
  − Ask for a time estimate for response
Back Office Best Practices
Insurance Follow Up: Appeals

- Sample phone call with carrier
  - Make detailed notes in the Family Editor (fame) or Correct Mistakes (oops)
  - Track start/end time
  - Names, titles, phone number and extension
  - Check numbers and dates
  - Claim id numbers
  - Reference numbers
Back Office Best Practices
Insurance Follow Up: Appeals

- Use Partner to track claims in appeals
  - Add “Appeals” as an insurance group
  - Add “2. Appeals” as an insurance company
  - Pend claims in appeals to this insurance company using oops
    - Select “Some Other Insurance”, then “2. Appeals”
  - Use inscoar to keep an eye on them
Back Office Best Practices Review

- Configuration
  - Insurance Configuration
  - Charge Screen Configuration
  - SNAP codes
- Billing Office Prep
- Posting Charges
Back Office Best Practices Review

• Pre Visit
  - Scheduling
  - Appointment Verification
  - Eligibility Verification
Back Office Best Practices Review

- Insurance Collections
  - Claims submission
  - Posting payments / responses
  - Claims follow up
  - Claim submission tools and reports
Back Office Best Practices
learn.pcc.com

- Start with our Billing and Practice Management page.
Back Office Best Practices

Questions?

- Join myself and Jim Frei at the Collection Roundtable for more discussion next! Or go to Insurance Education 101 for Patients.