PedsOne
Pediatric Business Specialists

UC 2024

7 Pitfalls of Billing and How to Avoid Them

Presented by Heidi Chamberlin, PedsOne Senior Billing Specialist

The 7 Pitfalls

- **Not Utilizing Your Front Desk**
- **Absence of Effective Policies and Procedures**
- **Inattentiveness on Credentialing & Incident-To**
- **Inadequate A/R Management**
- **Lost Revenue**
- **Lack of Accountability**
- **Failure to Know Your Payers**
- **Time for Questions**

Pitfall #1:
Not Utilizing Your Front Desk

Utilizing Your Front Desk

- Teach your front desk staff how to catch issues through the use of flags or alerts
- Train the front desk how to properly read and enter insurance info.
- Help your front desk feel comfortable asking for money-co-pays or balances.
- Have your staff check for needed forms/signatures every Jan 1st such as financial policy, privacy notices, etc.
- Help staff understand the DOB rule for entering 2 insurances for one child.

Utilizing Your Front Desk

1. Make sure the patient's most current insurance card is scanned in - both front AND back- and on every child individually in the family- not just one.

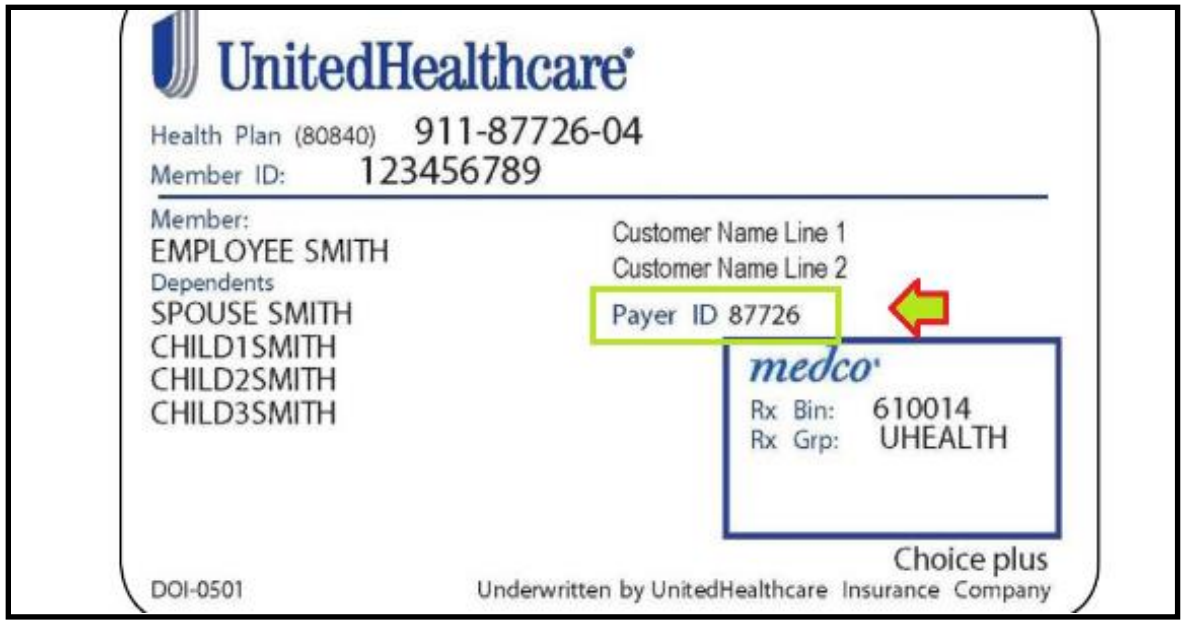
1. Eligibility is one of the biggest denial reasons! Ensure your staff knows how to run and verify eligibility.

1. Correct start and term dates are essential!

1. Entering the subscriber's DOB is another essential step to ensure correct billing.

1. Knowing if your office is “in-network” is the family's responsibility- have your front desk work with them to verify this. NPIs are public.

1. Ensure that patient suffixes are correct for each individual child if applicable.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Member ID: 123456789
Member:
EMPLOYEE SMITH
Dependents
SPOUSE SMITH
CHILD1SMITH
CHILD2SMITH
CHILD3SMITH
Customer Name Line 1
Customer Name Line 2
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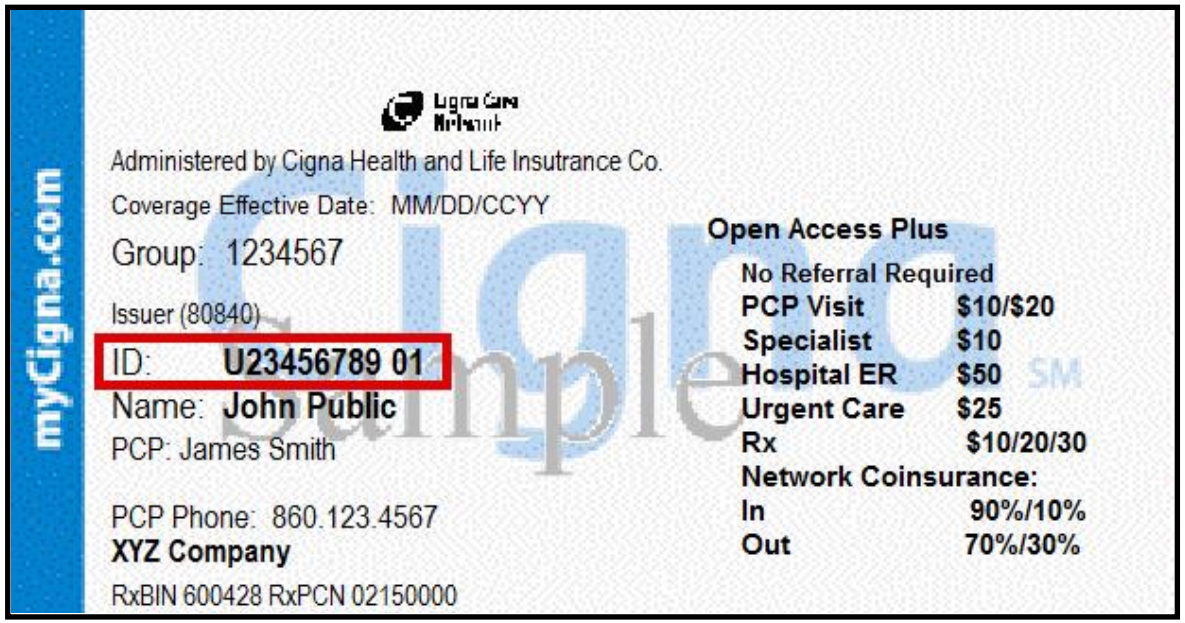
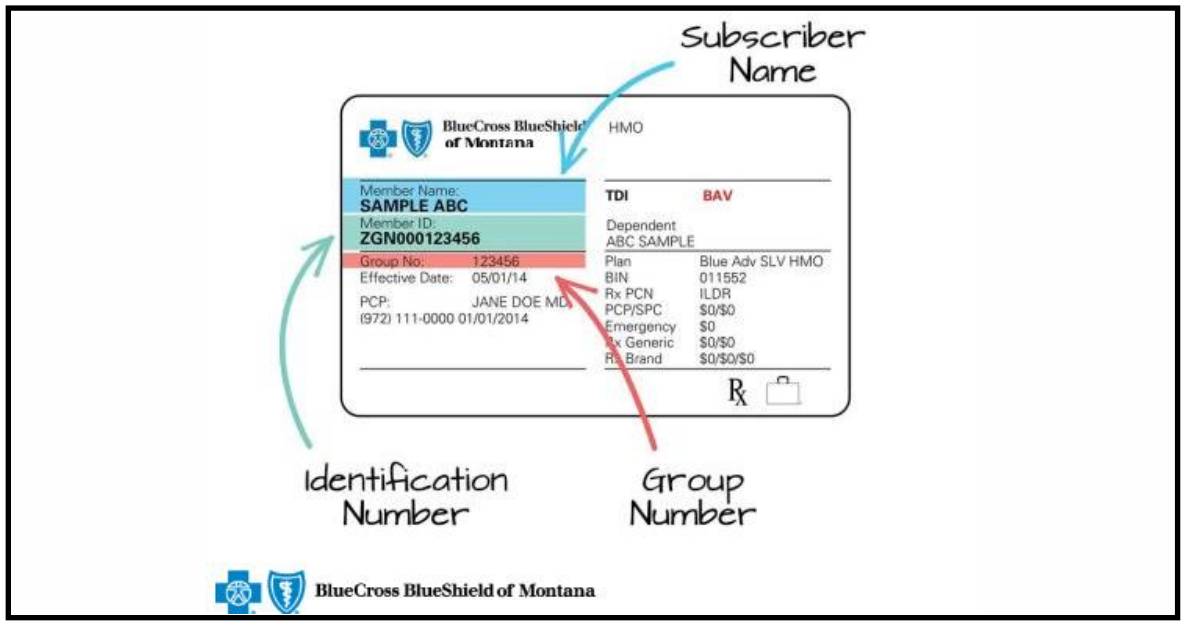
medco
Rx Bin: 610014
Rx Grp: UHEALTH
Choice plus
DOI-0501
Underwritten by UnitedHealthcare Insurance Company


myCigna.com
Administered by Cigna Health and Life Insurance Co.
Coverage Effective Date: MM/DD/CCYY
Group: 1234567
Issuer (80840)
ID: U23456789 01
Name: John Public
PCP: James Smith
PCP Phone: 860.123.4567
XYZ Company
RxBIN 600428 RxPCN 02150000
Open Access Plus
No Referral Required
PCP Visit $10/$20
Specialist $10
Hospital ER $50
Urgent Care $25
Rx $10/20/30
Network Coinsurance:
In 90%/10%
Out 70%/30%
Sample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BlueCross BlueShield of Montana
HMO
Member Name:
SAMPLE ABC
Member ID:
ZGN000123456
Group No: 123456
Effective Date: 05/01/14
PCP: JANE DOE MD
(972) 111-0000 01/01/2014
TDI BAV
Dependent
ABC SAMPLE
Plan Blue Adv SLV HMO
BIN 011552
Rx PCN ILDR
PCP/SPC $0/$0
Emergency $0
Rx Generic $0/$0
Rx Brand $0/$0/$0
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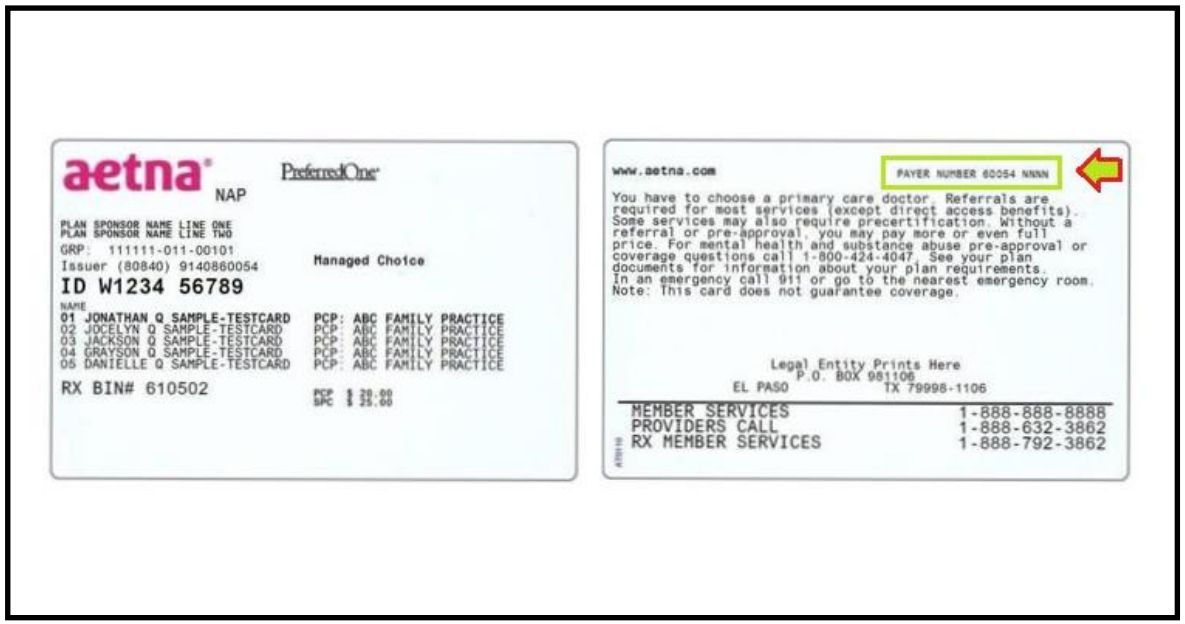
Group Number
BlueCross BlueShield of Montana


aetna
NAP
PreferredOne
PLAN SPONSOR NAME LINE ONE
PLAN SPONSOR NAME LINE TWO
GRP: 111111-011-00101
Issuer (80840) 9140860054
Managed Choice
ID W1234 56789
NAME
01 JONATHAN Q SAMPLE-TESTCARD PCP: ABC FAMILY PRACTICE
02 JOCELYN Q SAMPLE-TESTCARD PCP: ABC FAMILY PRACTICE
03 JACKSON Q SAMPLE-TESTCARD PCP: ABC FAMILY PRACTICE
04 GRAYSON Q SAMPLE-TESTCARD PCP: ABC FAMILY PRACTICE
05 DANIELLE Q SAMPLE-TESTCARD PCP: ABC FAMILY PRACTICE
RX BIN# 610502
www.aetna.com
PAYER NUMBER 60054 NNNN
You have to choose a primary care doctor. Referrals are required for most services (except direct access benefits). Some services may also require precertification. Without a referral or pre-approval, you may pay more or even full price. For mental health and substance abuse pre-approval or coverage questions call 1-800-424-4047. See your plan documents for information about your plan requirements. In an emergency call 911 or go to the nearest emergency room. Note: This card does not guarantee coverage.
Legal Entity Prints Here
P.O. BOX 981106
EL PASO TX 79998-1106
MEMBER SERVICES 1-888-888-8888
PROVIDERS CALL 1-888-632-3862
RX MEMBER SERVICES 1-888-792-3862

Pitfall #2:

Inattentiveness on Credentialing & Incident-To

Credentialing & CAQH Basics:

*Start early and allow enough time.

*Put together a credentialing checklist.

*Do not start seeing patients until you have an effective date in writing.

*Keep in mind there may be different rules/regulations when credentialing specialties such as mental health.

*Use a group contract vs. individual whenever possible.

*Ensure your provider is being credentialed correctly (ie-PCP vs specialist).

*Frequent follow-up is a MUST!

*Encourage your providers to keep their CAQH updated on a regular basis.

*Ensure all documents are up-to-date and have not expired.

*Re-attest whenever possible.

*Don't forget to enable insurances to use your CAQH for credentialing!

Avoid those Incident-To Headaches:

First off- What is incident-to billing? Under certain circumstances, supervising physicians can bill NPP (non-physician practitioner) visits under their own National Provider Identifier (NPI) number for full payment. The Centers for Medicare & Medicaid Services defines such services as “incident-to” because they are incidental to the physician’s diagnosis and treatment of an injury or illness.

*** Do not avoid credentialing your mid-levels in order to use incident-to to collect 100% of the fee schedule.**

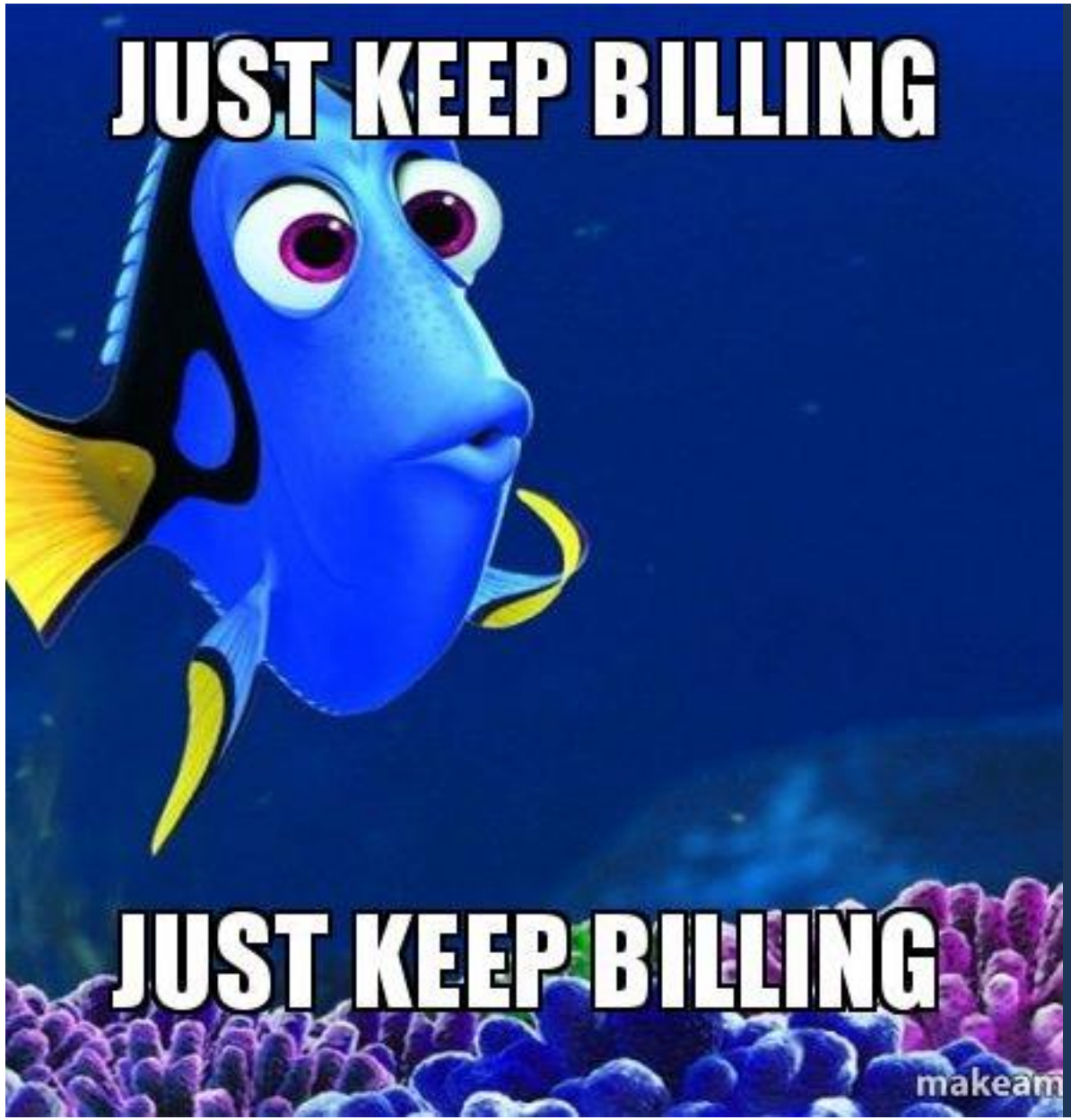
*** Do not use this to bill providers who are "in the process" of being credentialed.**

*** The physician and provider billing MUST be employed by the same group.**

*** Have the overseeing physician on site (varies by state).**

*** No new problems or patients!**

*** Remember there are outliers.**



Pitfall #3:
Lost Revenue

Codes Frequently Left Off Billing

- All Aspects of a Nebulizer Treatment
- Bilateral Cerumen Removal
- Sick Visits with Well Checks

Nebulizer Treatments

Nebulizer

94640- "Pressurized or non-pressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device"

Repeat Nebulizer

94640-76- "Repeat procedure or service by same physician or other qualified health care professional" for the second treatment, since the return visit would be considered a separate episode of care." Use this when the patient receives a nebulizer treatment of less than 1 hour during an episode of care.

Continuous Treatment

If a patient receives "back-to-back" nebulizer treatments exceeding 1 hour bill CPT code 94644, "Continuous inhalation treatment with aerosol medication for acute airway obstruction; first hour," and CPT code 94645, "Continuous inhalation treatment with aerosol medication for acute airway obstruction; each additional hour," as appropriate, instead of CPT code 94640.

Nebulizer Treatments

Albuterol

J7611, "Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg"

J7612, "Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DEM, concentrated form, 0.5 mg"

J7613, "Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg"

J7614, "Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg"

J7626, "Budesonide inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit"

Demonstration

You can also bill the 94664 code for the demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device

Modifiers

Try the -59 mod on the 94664 and NOT on the 94640 if you are seeing bundling denials.

Mask and Tubing

A7003 *Administration set, with small volume nonfiltered pneumatic nebulizer, disposable*) – Because a nebulizer mask is used only once by one patient, report only one unit. The payer may want modifier NU *New equipment* appended for a new purchase. Documentation must support that the item was provided to the patient at the time of treatment.

A4616 Tubing (oxygen), per foot

A4617 Mouthpiece

A7015 Aerosol mask, used with DME nebulizer

Bilateral Cerumen Removal: Oh, the possibilities....

1. 1 line: 69210-50, 2 units, ICD-10 code H61.23

2. 2 lines: 69210-LT, 1 unit each, ICD-10 code H61.22, 2nd line 69210 RT, ICD-10 H61.21

3. 2 lines: 69210, 1 unit, ICD-10 H61.22, 2nd line 69210-59, 1 unit, ICD-10 H61.21

4. 2 lines: 69210, 1 units, ICD-10 H61.23, 2nd line 69210-59, 1 unit, ICD-10 H61.23

5. 1 line: 69210-50, 1 unit (but double the price!) and ICD-10 H61.23

If you do a cerumen removal the same day as an audiologic function test you can try billing code G0268 instead of the cerume removal code.

Some insurances may only reimburse the second procedure at a reduced rate but you should not allow a zero dollar payment for one or both of these procedures!

Billing a Sick Visit during a Well Check

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.

If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine E/M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E/M service was provided on the same day as the preventive medicine service.

While CPT does not define what qualifies as "insignificant or trivial" vs. "significant," consider the following key issues before reporting a separate E/M service in addition to the preventive medicine service:

1. Significant – Would the presenting problem have required a separate encounter?

2. Separately identifiable – Did the E/M service require the key components: history, exam and medical decision-making (MDM), or considerable counseling or coordinating care time?

3. Documentation – Is there *additional* documentation for the E/M service? While not absolutes, some issues that can support separate E/M reporting include: a new condition that requires additional work (e.g., strep throat, depression); exacerbation of a chronic condition (e.g. worsening acne); new or changed prescription; and required follow-up for certain conditions (e.g. asthma, attention-deficit/hyperactivity disorder). The following are likely to be identified as incidental: refill of medication with no exacerbation (e.g. nasal spray, acne medication); minor complaint or finding with very minimal work (e.g. mild diaper rash, mild upper respiratory infection) that may not have resulted in the patient coming in for a separate appointment; and chronic condition that is stable and not required to be addressed (e.g. atopic dermatitis).

Frequently Left Behind Bright Future Codes

Check your state's periodicity schedule to see if there are any different recommendations from the Bright Futures

- **Dental Varnish/Oral Eval.**
- **Maternal Depression Screening**
- **Depression Screening**
- **Health Risk Assessments such as TB and Lead**
- **BMI**
- **Appropriate hearing/vision equipment per age**
- **Pay attention to the Well schedules and try to follow the recommended age visits**

CDC Footnotes: My favorite "secret"!

- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2023

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2023.

Additional information

- Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-2, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Barnett ED, Lynfield Ruth, Sawyer MH, eds. *Red Book: 2021–2024 Report of the Committee on Infectious Diseases*. 32nd ed. Itasca, IL: American Academy of Pediatrics; 2021:72–86).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All vaccines included in the child and adolescent vaccine schedule are covered by VICP except dengue, PPSV23, and COVID-19 vaccines. COVID-19 vaccines that are authorized or approved by the FDA are covered by the Countermeasures Injury Compensation Program (CICP). For more information, see www.hrsa.gov/vaccinecompensation or www.hrsa.gov/cicp.

COVID-19 vaccination
(minimum age: 6 months [Moderna and Pfizer-BioNTech COVID-19 vaccines], 12 years [Novavax COVID-19 Vaccine])

Routine vaccination

- **Primary series:**
  - **Age 6 months–4 years:** 2-dose series at 0, 4-8 weeks (Moderna) or 3-dose series at 0, 3-8, 11-16 weeks (Pfizer-BioNTech)
  - **Age 5–11 years:** 2-dose series at 0, 4-8 weeks (Moderna) or 2-dose series at 0, 3-8 weeks (Pfizer-BioNTech)
  - **Age 12–18 years:** 2-dose series at 0, 4-8 weeks (Moderna) or 2-dose series at 0, 3-8 weeks (Novavax, Pfizer-BioNTech)
- For **booster dose recommendations** see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

Special situations

Persons who are moderately or severely immunocompromised

- **Primary series**
  - **Age 6 months–4 years:** 3-dose series at 0, 4, 8 weeks (Moderna) or 3-dose series at 0, 3, 11 weeks (Pfizer-BioNTech)
  - **Age 5–11 years:** 3-dose series at 0, 4, 8 weeks (Moderna) or 3-dose series at 0, 3, 7 weeks (Pfizer-BioNTech)
  - **Age 12–18 years:** 3-dose series at 0, 4, 8 weeks (Moderna) or 2-dose series at 0, 3 weeks (Novavax) or 3-dose series at 0, 3, 7 weeks (Pfizer-BioNTech)
- **Booster dose:** see www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html
- **Pre-exposure prophylaxis** (monoclonal antibodies) may be considered to complement COVID-19 vaccination. See www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromised

For Janssen COVID-19 Vaccine recipients see COVID-19 schedule at www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html

Note: Administer an age-appropriate vaccine product for each dose. Current COVID-19 schedule and dosage formulation available at www.cdc.gov/vaccines/covid-19/downloads/COVID-19-immunization-schedule-ages-6months-older.pdf. For more information on Emergency Use Authorization (EUA) indications for COVID-19 vaccines, see www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-

Dengue vaccination
(minimum age: 9 years)

Routine vaccination

- Age 9–16 years living in areas with endemic dengue **AND** have laboratory confirmation of previous dengue infection
  - 3-dose series administered at 0, 6, and 12 months
- Endemic areas include Puerto Rico, American Samoa, US Virgin Islands, Federated States of Micronesia, Republic of Marshall Islands, and the Republic of Palau. For updated guidance on dengue endemic areas and pre-vaccination laboratory testing see www.cdc.gov/mmwr/volumes/70/rr/rr7006a1.htm?s_cid=rr7006a1_w and www.cdc.gov/dengue/vaccine/hcp/index.html
- Dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix® or Quadracel®])

Routine vaccination

- 5-dose series at age 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Timely Completion of Charts

& After Hours/Weekend/Holiday Codes

Timely Completion of Charts

Most insurances have a timely filing limit- don't let your charts sit too long and risk having to write off for timely. I typically recommend completing your charts no later than 48 hours after the patient is seen.

99051 should be used for when you have scheduled office hours but are open later than a standard M-F business. "Services provided in the office during regularly scheduled evening, weekend or holiday hours"

99050 should be used for when your office is NOT scheduled to be open and you go in to see a patient. "Services provided in the office at times other than regularly scheduled hours or days when the office is normally closed (holidays or Sundays, etc.)"

Pitfall #4:
Failure to Know Your Payers

Insurance Info and Timely Limits

Sample only! This is info is to be used as an example on how to set up your own sheet

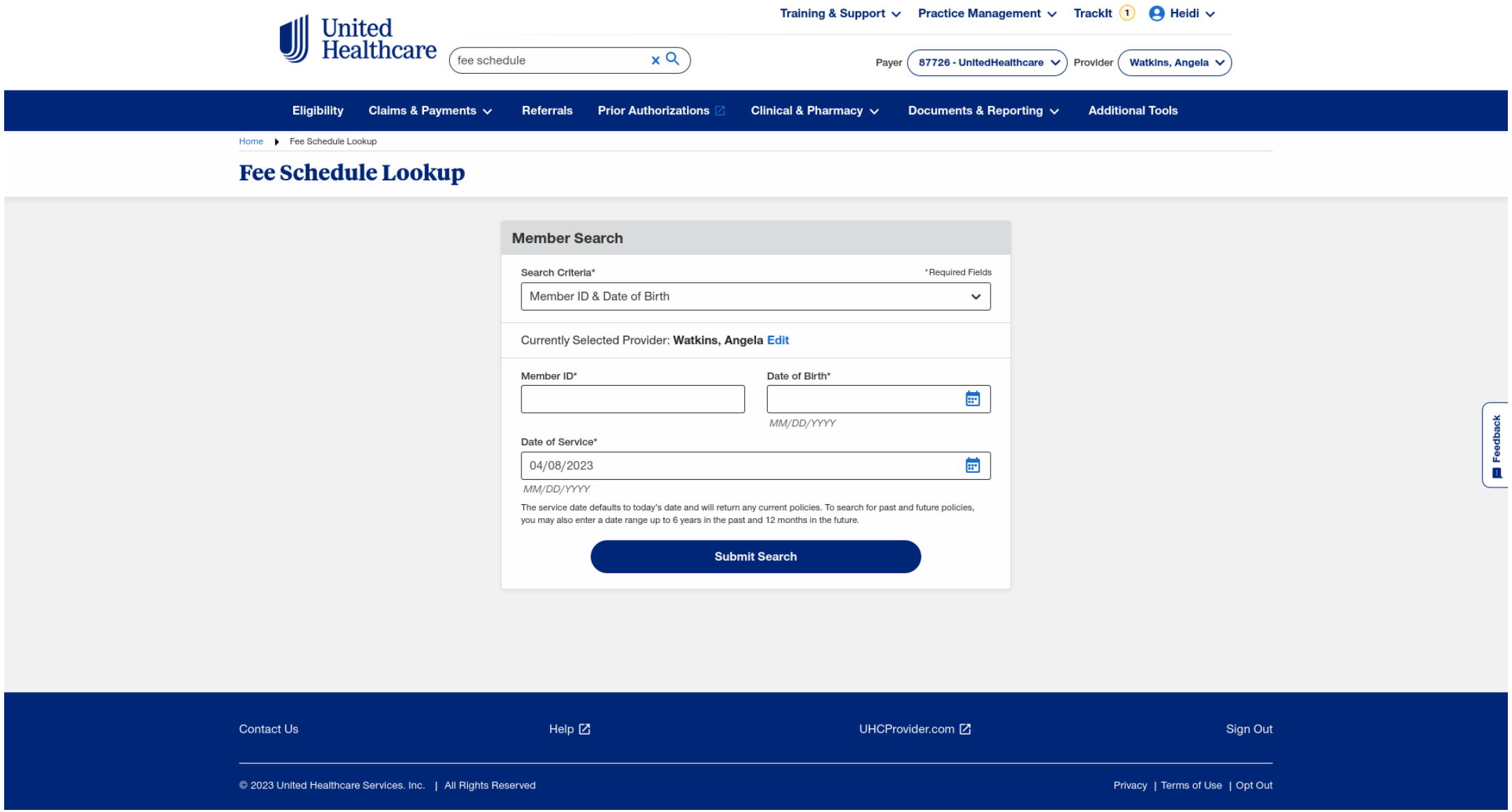
Insurance	Website	UN/PW		Provider Rep	Timely
Aetna	Availity		888-632-3862	N/A	Original claims 90 days from DOS/corrected claims 90 days from date of denial/appeals 6 months from date of last denial
BCBS	Navinet		866-688-2242 IVR	Faye H. (insert email or phone)	180 days for original and corrected from DOS/60 days for appeals from date of denial
Cigna	www.cignaforhcp.com		800-244-6224	Matthew F.	90 from DOS for original/180 days for corrected/appeals
UHC	www.unitedhealthcareonline.com		877-842-3210	Elaine R.	90 days from DOS for original/180 days for corrected or appealed claims from last date of denial
Tricare	www.mytricare.com		844-866-9378	N/A	210 days from DOS/210 days for corrections from DOS/90 day disputes from date of denial

Sample Payer Rule Sheet

This is an example only and not valid specific payer data- have your billers research individual payer rules and policies for your practice

Codes	Aetna	BCBS	Cigna	Medicaid	UHC
96160	Usually need to submit reconsideration with medical records	Limited to 1 per day	Multiple units on 1 line	Limit of 2 units per day	Not payable
96161	Usually need to submit a reconsideration with medical records	Payable with a mod -59 and dx code Z13.89	Payable with a -59 mod	Paid without any modifiers	Not currently allowed
96127	Usually need to submit reconsideration with medical records	Payable with separate lines, -59 mod on 2nd line and after	Payable with 1 line and multiple units	Only covers 2 a day	Payable - separate lines and with the -59 mod
69210, 69209	Bilat needs to be 1 line with 69209 and 2nd line 69209-59 with R and L dx codes	Billed as 2 lines 1 unit with bilat dx code	Bill separate lines, 2nd line -59 mod, RT and LT dx codes	Requires the -50 mod, 1 line 2 units	Billed as 1 line with mod -50 and 1 unit (but double the price)
87502	Payable with a QW mod	Payable with a -59 mod		No modifier	QW modifier required
99401-99403	Only payable with dx code Z71.89	Wants a well check dx code with mod -25		Not on the fee schedule	

Accessing Your Fee Schedules



BlueCross BlueShield of Illinois

Fee Schedules via Availity® (Professional Providers)
The Availity® Fee Schedule viewer tool allows professional providers participating with BCBSIL to electronically request a range of up to 20 procedure codes and immediately receive the contracted price allowance for the patient services you perform. This tool is located in the Availity portal under Claims & Payments navigation menu.

For navigational assistance, refer to the Availity Fee Schedule User Guide .

If you are not yet registered, sign up today at Availity , at no charge. If you need registration assistance, contact Availity Client Services at 800-282-4548.

Note: If you don't have online access, you may continue to fax and/or mail your requests using the Fee Schedule Request forms located on the Forms page of our website.

Pitfall #5:
Absence of Effective Policies and Procedures

Sample Financial Policy

Thank you for choosing (insert practice name here) as your child's health care provider. The following is a copy of our financial policy. Patient care is not permitted without the written consent of the receipt and acknowledgement of the understanding of this policy.

Payments: Payment, in full, is due at the time of service. This includes applicable co-pays, co-insurance and payments for services not covered or denied by the insurance company. (Pra name) accepts cash, personal check, debit cards, and all major credit cards. We also accept Apple Pay. _____ (initials)

Self-Pay Accounts: If you do not have insurance, please come prepared to pay for your visit in full upon check-out. We offer a 20% discount for all self-pay services paid in full on the day of the service. _____ (initials)

Missed Co-Pays: (Practice name) is required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays puts the responsible party and (practice name) in default of the insurance contract. A $25 service fee will be charged in addition to your co-payment, if the co-payment is not paid by the end of that business day. _____ (initials)

Missed appointments: Missed appointments represent a cost to us, you, and to other patients that could have been seen during the time set aside for your child. Cancellations are required 24 hours prior to any well visit appointment and two hours prior to any sick visit appointment via phone call to the practice. A "no show" fee of $50 will be applied if an appointment is missed and not cancelled within the stated time frame. _____ (initials)

Outstanding Balances: If you have a personal balance on your account, a monthly statement will be sent. Unless authorized in writing, payment is due upon receipt of statement or within 30 calendar days. _____ (initials)

Payment Plans: (Practice name) understands that full payment may not be possible in certain circumstances. As a courtesy, (practice name) may offer the assigned account holder a payment plan. Payment plans are approved on a case-by-case basis and may be discussed with our management team. Patients with a payment plan must be in full compliance with all conditions of the agreement at time of visit. Failure to make scheduled payments on the payment plan, or not paying off a balance in full, may result in your account being turned over to a collection agency and your family being dismissed from the practice. _____ (initials)

Collection Accounts: If your account is submitted to a collection agency, all associated fees are the responsibility of the assigned account holder, including a collection fee equal to 50% of the collection balance. The assigned account holder will receive written notification by way of a dismissal letter and given 30 calendar days to find a new health care provider. If your account is sent to collections and then paid in full, the assigned account holder may request the practice to reinstate the account. If the practice permits reinstatement, there is a $25 reinstatement fee to be charged to the account holder. The fee must be paid prior to scheduling any future appointments. _____ (initials)

Sample Financial Policy

Returned checks: A $30 fee will be charged for any checks returned for insufficient funds. _____ (initials)

After Hours/Holiday Care: There is a $40 fee for non-preventative care visits that occur after 5:00 pm (EST), daily, on weekend days and federal holidays. If that fe not covered by your insurance carrier, the assigned account holder is financially responsible for the charges. _____ (initials)

Insurance: We accept most insurances including most Medicaid plans. Please contact your insurance company to verify we are listed as a contracted provider before scheduling an appointment if you are unsure. Please bring a copy of your insurance card to every visit. A scanned copy of the assigned account holder's current insurance card and driver's license is required to be kept on file. Please present newly issued insurances cards upon check-in at the next scheduled visit. If you have an HMO insurance plan, please assign one of the physicians in our practice as your child's primary care physician (PCP) prior to your visit. If we cannot confirm that one of our providers is listed as your child's PCP, we will ask that the appointment be rescheduled. _____ (initials)

Change of Insurance/Change of Account Information: Please notify the office as soon as possible of any and all account changes, including co-pay amounts, insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of these changes, the assigned account holder becomes responsible for any and all charges. _____ (initials)

Billing Inquiries: Questions about a bill should be directed to our billing department at 1-866-371-6118. If you have any questions regarding the conditions and ter outlined in this document, please call our office and request to speak with a manager.

Review and consent of this policy is required prior to services rendered

Patient's first name: _____ Last name: _____ Birth date: ____/____/____

My initials above and signature below certifies that have read and consent to the outlined policies and procedures.

_____ _____ Date: ____/____/_____

Signature of parent/guardian Printed name of parent/guardian

Newborn Protocol

* Get the insurance information up front
* Use a dummy placeholder when needed
* Use flags or alerts depending on your system
* Allow 30 days for the newborn to be added
* Remind parents they need to inform their insurance
* Remember not all plans have the 30 day automatic coverage
* Send out a bill and a letter

COB Protocol

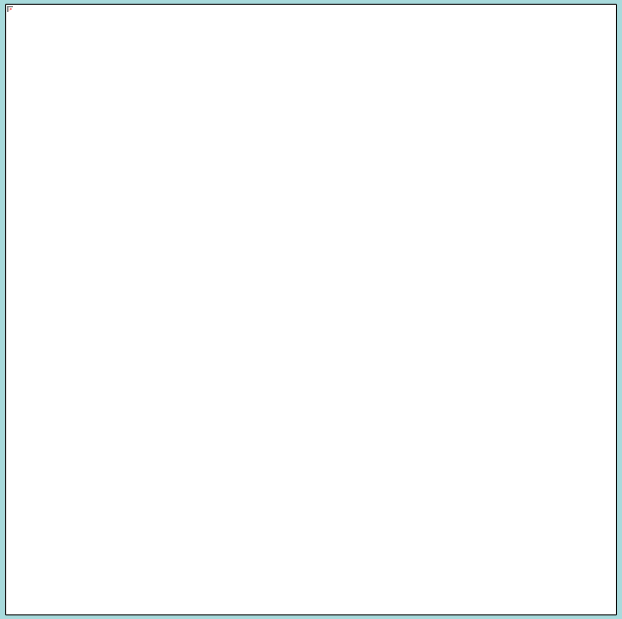
Sample COB notice:

"We have received notification that your insurance company has requested a Coordination of Benefits update from you. Please call your insurance company right away and let them know if you have other insurance coverage. They will ask you a short questionnaire to verify and rule out other insurance coverage. During that call, please request that any outstanding claims for your child/children be reprocessed.

********** VERY IMPORTANT **********

Please get a confirmation number for your call. Please call us with this information. Your insurance company will not pay for these claims until you provide this information. The balance will remain your responsibility until your insurance is updated and we hear from you with this confirmation number. We will be able to follow up with your insurance, but only if we have this confirmation number."

Self Pay Policy 💰



* Everyone should be charged the same
* You can discount after the fact
* Make sure you're in compliance with your medicaid guidelines

* Do not charge more for a vaccine admin that what your state medicaid allows
* Have a clear, formal written policy
* Decide if you're only going to allow a self pay discount if it's paid at time of service

Recoupments

* Find your state's recoupment law:

Florida 627.6131

All claims for overpayment must be submitted to a provider within 30 months after the health insurer’s payment of the claim. A provider must pay, deny, or contest the health insurer’s claim for overpayment within 40 days after the receipt of the claim. All contested claims for overpayment must be paid or denied within 120 days after receipt of the claim. Failure to pay or deny overpayment and claim within 140 days after receipt creates an uncontestable obligation to pay the claim.

Refund Requests

- Validate every refund request
- Let a valid refund be recouped in lieu of mailing a check
- Research your state's laws for patient credits
- Have your patients sign a form stating they want to have their credit sit on file

Pitfall #6: Inadequate A/R Management

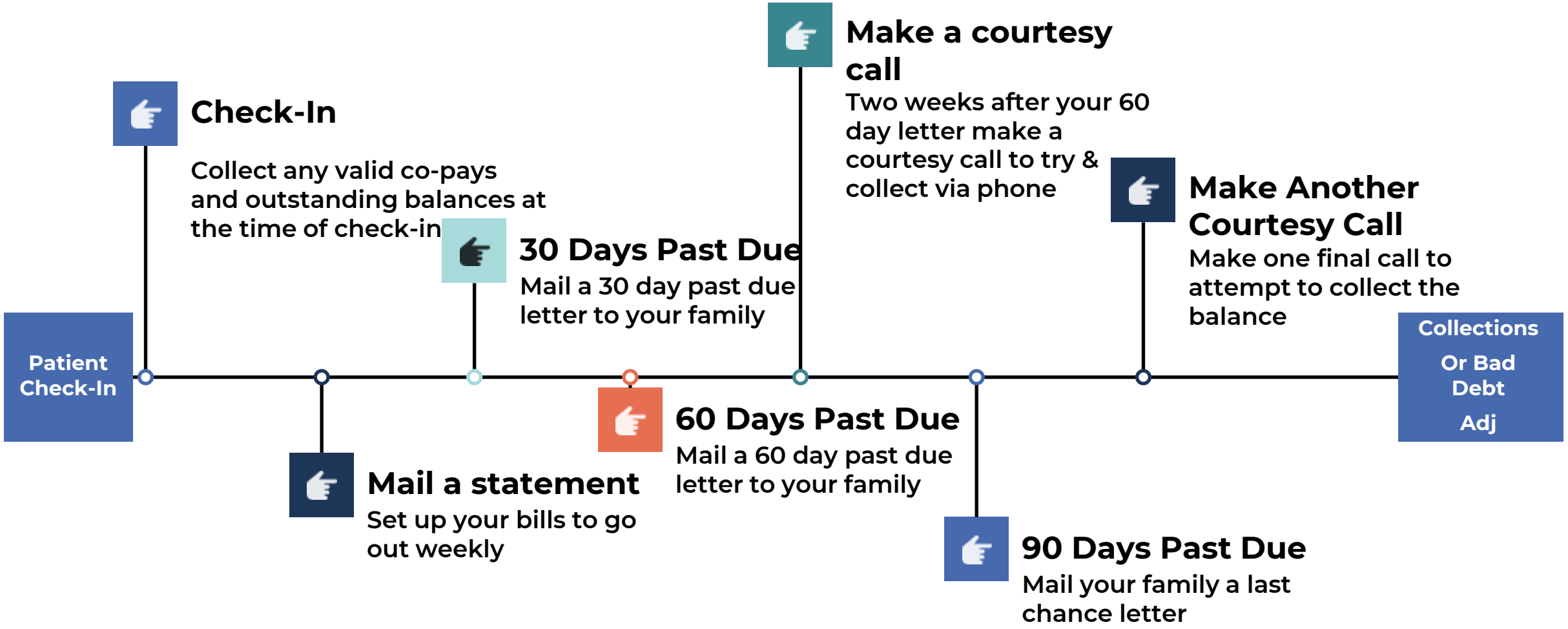
Ensure A/R is Being Worked

- **Find a system that works for the individual**
- **Have large write-offs be approved**
- **Be strategic! Know your timely filing guidelines and work payers with the shortest timely filing guidelines first**
- **Have your staff utilize websites as much as possible**
- **Set calendar reminders to follow-up**
- **Don't forget about your personal A/R**
- **Make sure your staff are entering notes in the same fashion**
- **Review staff A/R regularly to ensure all are getting touched and not missed**

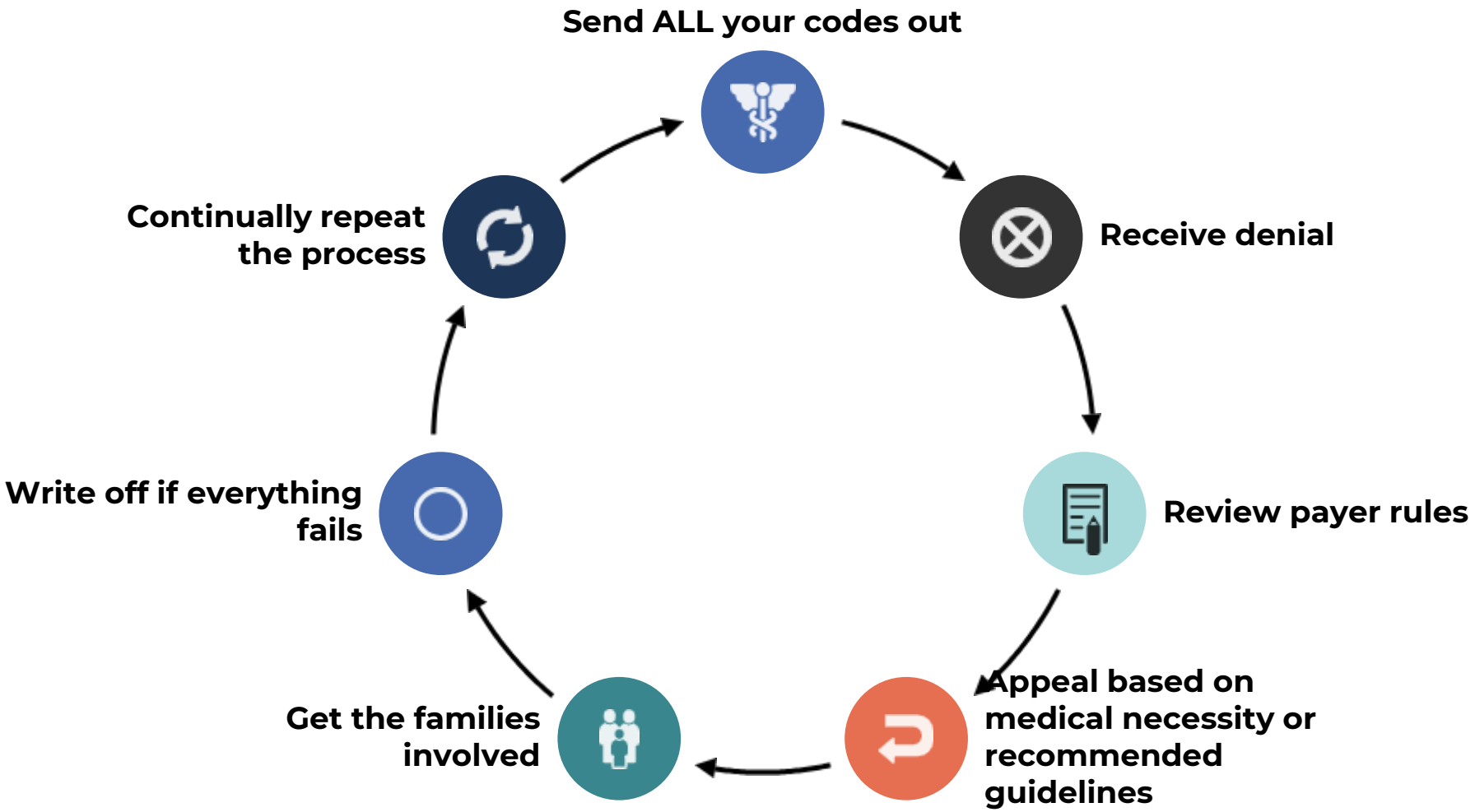
Understanding Denials

1. Watch for trends
2. Utilize claims status via payer portals
3. Look closer at COB denials
4. In pediatrics especially, watch for gender and age-specific denials

1. Do not use cause codes (W codes) as primary diagnoses
2. Use documentation when needed
3. Avoid duplicate denials



Collecting Patient Balances



Remember Things Change!Do not accept a denial as the standard-persistence is the key

Pitfall #7: Lack of Accountability

Billing Manager/Lead Biller

1. Questions from staff
2. Write off approval
3. Training and education
4. Payer projects
5. Vacation coverage
6. Reports
7. Dashboard monitoring
8. Policy updates
9. Fee schedule maintenance
10. Vaccine & NDC updates
11. Coding updates
12. Maximizing revenue opportunities
13. ERA/EFT set-up
14. Manage online payments
15. Proving out deposits

Biller 1

1. Daily charges (including hospital if applicable)
2. A/R for BCBS, Cigna, Tricare
3. Post all incoming payments for assigned payers both ERA and manual
4. Zero pay for assigned payers
5. Reject report
6. Insurance mail (daily) and distribute appropriately
7. Refund requests and distribute appropriately
8. Medical records requests
9. Paper HCFAs and secondaires

Biller 2

1. A/R for Aetna, UHC, HealthNet
2. Personal billing
3. Electronic bills (weekly)
4. Budget plan maintenance (weekly)
5. Phone calls for past due balances (monthly)
6. Past due letters (monthly)
7. Collections/bad debt (monthly)
8. Personal credits and refunds (periodically)
9. Self pay accounts (daily monitoring)
10. Manage CCOF

Sample Task Checklist

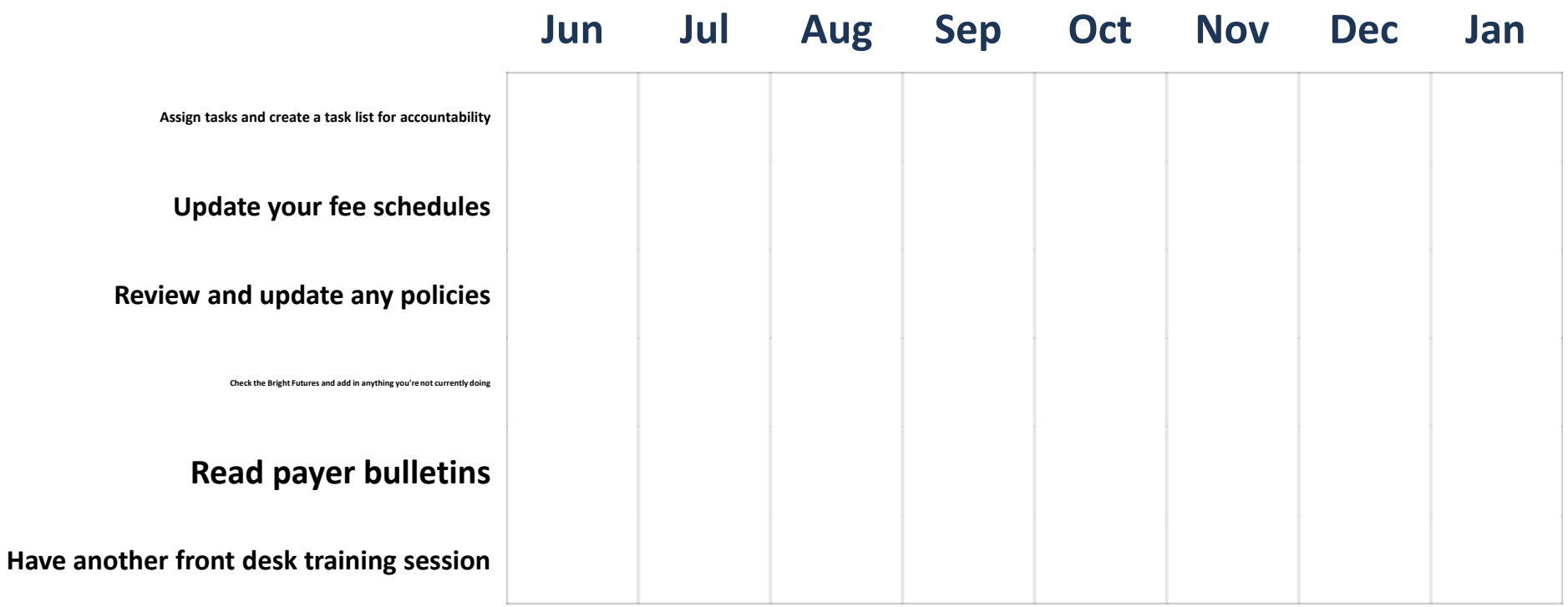
Task	Status	Who	Frequency
Charges and Preptags	06/01	John	Daily
Hospital Charges	06/01	John	Daily
Payment Posting (BCBS, Cigna, Tricare)	06/01	John	Daily
Payment Posting (Aetna, UHC, Healthnet)	05/31	Sally	Daily
Balancing Daily Deposits	06/01	Jessica	Daily
Sort Daily Mail	05/31	John	Daily
HCFA Batch and Secondaries	05/31	John	Weekly
Rejection/Error Report	05/26	John	Weekly
Aging Report	05/31	Jessica	Weekly
Ebills	05/28	Sally	Weekly
Zero/Full Pay Report	05/26	Sally	Weekly
Budget Plans	06/01	Sally	Weekly
A/R for BCBS, Cigna, Tricare	05/01	John	Monthly
A/R for Aetna, UHC, Healthnet	05/27	Sally	Monthly
Past Due Letters	06/01	Sally	Monthly
60 and 90 Day Courtesy Calls	05/14	Sally	Monthly
Collections and Bad Debt Adj	05/31	Sally	Monthly
Collection Approval		Jessica	Monthly
CCOF	05/14	Sally	Monthly
Underpayment Tracking	05/14	Jessica	Monthly to Quarterly
Fee Schedule Maintenance	03/01	Jessica	Monthly

Proving Out/Balancing

Date	Insurance Company	Payment Amount	Check #	Amount Autoposted	Percent Autoposted	Partner Balance	Difference	Notes	Posted by	☐
	Merchant Bank	$656.24		$0.00	0.00%	$656.24	$0.00		HC	☑
	UHC	$2,326.73	1TZ45371851	$1,624.07	69.80%	$2,326.73	$0.00		HC	☑
					#VALUE!		#VALUE!			☐
3/14/2023	Healthy Blue	$97.29	3204689929	$94.01	96.63%	$97.29	$0.00		HC	☑
	UHC MW	$230.90	20230311a2000623	$0.00	0.00%	$230.90	$0.00		HC	☑
	UHC MW	$271.15	20230311A2000624	$0.00	0.00%	$416.31	$145.16	Recoup $145.16	HC	☑
	Merchant Bank	$1,741.47		$0.00	0.00%	$1,741.47	$0.00		HC	☑
	Cash $45								HC	☑
	Deposit $2146.08				#DIV/0!		$0.00		HC	☑
	PCK $371.33				#DIV/0!		$0.00		HC	☑
	CBA	$130.20	0061476170	$130.20	100.00%	$130.20	$0.00		HC	☑
	UMR	$443.17	0000001111	$138.59	31.27%	$443.17	$0.00		HC	☑
	UMR	$105.19	0000560487	$75.43	71.71%	$105.19	$0.00		HC	☑
	Home State	$1,051.19	000309647	$0.00	0.00%	$1,051.19	$0.00		HC	☑
	Deposit $6146.00				#DIV/0!		$0.00		HC	☑
	PCKs $540.86				#DIV/0!		$0.00		HC	☑
	Plumbers	$105.64	15325508	$0.00	0.00%	$105.64	$0.00		HC	☑
	Plumbers	$42.21	15325509	$0.00	0.00%	$42.21	$0.00		HC	☑
	Plumbers	$42.21	15325510	$0.00	0.00%	$42.21	$0.00		HC	☑
	Plumbers	$151.61	15325511	$0.00	0.00%	$151.61	$0.00		HC	☑
	ABS	$115.31	2000345	$0.00	0.00%	$115.31	$0.00		HC	☑
	Maries	$71.83	1493	$0.00	0.00%	$71.83	$0.00		HC	☑
	Osage	$216.23	2566	$0.00	0.00%	$216.23	$0.00		HC	☑
	ABS	$53.03	1999665	$0.00	0.00%	$53.03	$0.00		HC	☑
	ABS	$53.03	1999666	$0.00	0.00%	$53.03	$0.00		HC	☑
	ABS	$92.00	1999667	$0.00	0.00%	$92.00	$0.00		HC	☑
	Home State	$1,704.19	308621	$0.00	0.00%	$1,704.19	$0.00		HC	☑
	Marketplace	$94.46	5018574	$0.00	0.00%	$94.46	$0.00		HC	☑

Create a Monthly Plan

Don't try to get it all done at once- sample implementation plan



Have more questions?

Please feel free to contact me at heidi@pedsone.com

Heidi Chamberlin

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