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NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
2015 MAI-COC GRANTEE VIRTUAL MEETING

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(standing by, hearing music).

>> Because the host has not joined the meeting. It will end
in approximately two minutes until the host joins.

(hearing music).

(Beep).

>> Hi, this is Rose.

>> Hi, Rose, this is Patrick Gauthier with AHP.

>> Hi, how are you?

>> PATRICK GAUTHIER: Pretty good.

(beeps).

>> Were you able to log into Adobe Connect?

>> PATRICK GAUTHIER: Yes, I'm looking at the screen right now
with the slides.

>> We don't have slides on our end. Is there somewhere else
we need to log in at?

>> You should see slides on the left-hand side of your Adobe
Connect screen. It says, day one, breakout. Under files.

(background noise) (lots of noise on the line).

(Beep) (pause).

>> We have yours. You have day one breakout? (background
noise).

>> I'm sorry, this is Natasha again. I went to the files and
it says openings sessions day one, am I supposed to see
something else?

>> You are supposed to see day one breakout 3.

>> Okay.
>> That is on the left-hand side?
>> Correct.
>> I don't have that. Where do I go? (background noise).
(buzzing).
>> Hold on one second. I'll put that in the chat (Beep).
>> Thank you.
>> I logged out and when I logged back in, it says it's still waiting for a host to approve me to get on the site.
(echo) (overlapping speakers).
>> They are probably still being boarded into the room. You all have a host (background noise).
>> Patrick is here.
>> [inaudible] host facility.
(faint voice in background).
>> I made him the host.
>> Great, thank you so much. I will say on the conference line, give them a couple more minutes to board.
>> Even though it's [inaudible] still people out.
>> Yeah.
>> Thanks.
>> You are in a breakout session.
(typing).
>> That's all, but there is no slide. (background noise).
>> Hi, everyone. This is Rose. I'm helping to moderate this session with Patrick (background noise).
I want to let everyone know that everyone is still being sorted into their individual breakout sessions. So give it a few minutes. You will be able to see the slides (background noise).
(traffic noise).
>> Okay.
>> I have gotten out of the connect share so mine still reads that I need a host to approve me back into the connection.
>> Who was that speaking?
>> This is Gloria.
(footsteps in the background) (pause) (Beep).
>> Walk around with a shopping bag ... (background noise).
>> (Beep).
(phone ringing).
>> Your call has been forwarded to ...
(someone typing).
(indecipherable voice).
>> What's up.
>> I got kicked out of my breakout session.
>> Here is what we are going to have to do. We are going to send the slides to all the people. The presenter can go through

the slides with them [inaudible]

>> Yes.

>> We are going to [inaudible] Adobe Connect.

(sorry, audio quality is very poor) (Beep).

(voice in background).

>> Each breakout.

>> Okay.

>> Presenters can go ahead and start (Beep) (overlapping speakers).

>> Okay, I'll just wait for the slides to be sent to me. Correct? (overlapping speakers).

>> Technology is down, we are having issues. Who is presenting the slides now and if Patrick wants to get started with introductions (overlapping speakers).

>> They are sending the slides.

>> Hi, everyone. I hope everyone is in the correct breakout session. This is for third-party billing with Patrick from advocates for human potential.

We are having some technical difficulties. So those that have registered for this breakout session (Beep) will receive the slides (Beep) via E-mail.

Please log out of Adobe Connect and just wait for the slides via E-mail.

Patrick, if you wanted to go ahead and get started with your presentation, and introductions, you can go ahead and do so.

>> The screen that, went from my presentation to looks like questions from the last presentation.

>> Correct. Everyone will just receive your slides via E-mail.

>> I need to open the Power Point, walk through my Power Points.

>> Correct. Everyone will just get the slides via E-mail. We are abandoning Adobe Connect.

>> PATRICK GAUTHIER: Okay. (background noise).

Give me a second to catch up with you.

(very muffled audio).

>> Assigned for group 4. (background noise).

>> No one is [inaudible]

>> I feel terrible (chuckles) oh, my gosh.

>> PATRICK GAUTHIER: Okay. Will you let me know when I can go ahead?

>> Patrick, you can go ahead. And everyone who is on the line, please stand by. We will send the slides to you via E-mail. If you do not get the slides within the next ten minutes, please E-mail Hannahc@thenationalcouncil.org.

>> PATRICK GAUTHIER: Why don't we go ahead and get started. (background noise).

Despite our technology woes, this afternoon, I wanted to share with you a primer to billing operations and some basic questions that we will answer today.

(muffled audio).

I wanted to start by welcoming all of you and introducing myself. I'm the director of healthcare --

>> This meeting is now being recorded.

>> PATRICK GAUTHIER: And by background, I spent eight years working (background noise) as a provider in a number of different settings. I spent the next twelve years (buzzing) managed behavioral health organization, managed care organization, and was someone for operations.

(ping).

Within that company, and have been consulting with providers and the federal agencies and state agencies and the insurers for about the last ten years.

I've known both the provider and the payer side very well. The three questions we want to address today are first of all with respect to organizational readiness for billing, and what key questions should agencies or organization, provider organizations be asking themselves with respect to billing. Who should be involved, secondly, in the preparation and readiness. So if an agency is starting down a path where they are willing to (buzzing) Starting to bill or be really raising the bar in terms of billing (background noise) with respect to whether it's a Medicaid managed care plan (Beep) or Medicare advantage plan or commercial health insurance, who in the organization should be involved. And then where can people turn for help and guidance as they begin to either prepare or build their billing operation. Those are three questions that have to do with getting prepared and/or growing billing operations.

Let me first take this question of building organizational capacity and readiness for billing. Billing operations, can say this about billing, is that it's an area of operation like most other areas, that calls on providers to be able to [inaudible] billing revenue and management into their overall strategic plans.

(audio is very muffled, I'm having trouble understanding).

For human resources or quality assurance. The other is the organization is going to require, particularly if you haven't done any third-party billing at all, you will require adequate resources, and some of those resources will be expert human resources, some of them may be software, some of them may be training type resources and a host of different tools that will be put to work for you on a day-to-day basis, when you entertain billing and engage in billing practices.

The people who are managing your revenue cycle, your billing

process, are going to need a host of different competencies, that will be born out of that training. The other thing I can tell you about billing, depending on your experience with it, is it's a highly dynamic and very interdependent activity. It really ties together a great number of operations and administration that takes place within your agencies, very very interdependent.

There is a great deal of information in that interdependence that has to be shared from the clinician to the front desk to people coding claims, to finance, and other folks within the company or within the nonprofit organizations that are all involved in the very interdependent way.

There are a great number of business rules and in some case, many cases frankly, regulations and rules at the state and federal level that govern billing operations, highly formulaic and highly standardized and highly regulated. Of course we are all familiar (Beep) with instances of waste, fraud and abuse. So this is, to the extent that some of you may be beginning to bill, some of you are continuing your operation, bear that in mind. This is a highly regulated area.

Those business rules translate into business process, and work flow within your organizations, that as you set out to begin billing or to change your billing, that is going to be a area of tremendous focus. So it cuts from strategy all the way through to day-to-day, minute operations.

At an executive level, we think about the walking through that continuum I just laid out. I think it's critical that the executive team be very well oriented and educated as to what billing will mean for your shop, that that translates to some extent into, in terms of vision and mission, while it might not be articulated that way, that it be considered that the importance of the revenue management of the lifeblood of your organization which is revenue, moving through and taking care of your employees and your facilities and your program and your clients that you are serving, that it really be understood at that level, then translate, at the strategic level and at a business plan level, into any number of goals (Beep) and objectives with respect to your revenue cycle.

I also think it's really very critical that there be an executive champion or sponsor for your revenue cycle, and oftentimes that will be the chief financial officer, the financial director, or it will be a chief of operations or an administrative lead (background noise) whatever particular position is within your organization, title (background noise) main person, just understand the real importance of having an executive sponsor.

This is not the kind of thing where it's enough to hand it

off to a business office staff or a manager of administrative kinds of operations and hope that that's enough. This is real critical work that needs to be championed at the highest level. I think that champion is going to require some project management resources, particularly if you are beginning to bill third parties, we will discuss what it means to have a project plan in place, but to the importance of having some project management (background noise) so that you can detect when things are falling behind, or that there is a problem that needs to be escalated.

I talked earlier about the importance of resource allocation, having the budget to do this, and in terms of building something new, the human resources including some outside expertise, external expertise if you needed some technology, that will support your billing. And then an overall approach to evaluation of performance.

Once we have begun or once we have expanded our billing operation, how do we know in fact that, from day-to-day or week to week or month to month, we are keeping pace with where it is that we should be, and what is our revenue cycle looking like? Are we billing in a successful manner. That is looking at it from an executive standpoint.

I don't know if you have the slides yet or not but we are going on to the next slide that looks at the relationship between finance and billing, and of course that relationship is very tight, that billing in many respects is going to reflect your overall budget, what you are anticipating for the year or for whatever recording period, as it relates to revenue, performance, oftentimes they will be evaluated by finance. That is where the analysis takes place, that we were projecting a million dollars in revenue, by way of billing these third-party payers over this period of time, and how are we doing in relation to that target?

It's also in finance that your cost accounting is being done, and you can through your finance department compare what are actual costs in relation to our revenue, and how are we performing. Is there a margin in any of the work that we are billing, and if not, what can we do about that. Those are the questions that finance people tend to ask, of course.

Finance folks are going to be instrumental in devising an approach to recognizing what your billable services are and the corresponding code, and making sure that from a formulaic standpoint, do you have the tools in your charting and in your own billing office to capture services, which service was delivered and what rate are we being reimbursed at for that service.

(voices in the background).

Having billing forms in place, managing the overall billing process, and then ensuring that any of those bills that are submitted, that require attention, perhaps because they have been denied, or they are missing vital information, that billing staff, the oversight from finance to correct, amend, and resubmit any claims that have been denied (background noise) provided by finance.

I'm going to move on to the contracting and legal dimension.

>> Patrick, this is Rose. Before you move on, I wanted to check in with everyone. Did everyone get an E-mail from Hannah Cohen receiving the slides for this breakout?

>> Yes.

>> No.

>> Yes.

>> Rose, I did not receive that E-mail. (overlapping speakers).

>> I did not, either.

>> If you could E-mail Hannah Cohen and that's hannahc@thenationalcouncil.org, if you did not get those slides within the next couple of minutes.

>> Okay.

>> Thank you. Patrick ... (overlapping speakers).

>> PATRICK GAUTHIER: Thank you, Rose.

Okay. So with respect to contracting and legal, the relationship here is, I think one of on two fronts. The first is compliance, from a compliance standpoint, having somebody within the organization, whether they are on your staff or, it might be somebody on our Board of Directors or might be somebody that you have engaged in the community to ensure from a legal standpoint that you are in compliance with your contract, with billing rules and regulations and with the policies that help plans, managed care plans, might have as attachments to your contracts, and understand that a contract with a third party payer will very often have exhibits like it's a billing manual or pointing to other policies and procedures. In some cases they include provider newsletters, as a function of the contract or exhibit to the contract.

So, bearing in mind all of the varieties of documents that need to be controlled for, having somebody who can [inaudible] from a compliance standpoint is critical. And that the contracts themselves, is the other dimension of contracting, legal oversight in billing as it relation to billing, knowing, for example, which services are we in fact contracted to provide, and (background noise) ever contracted with a third-party payer or managed care, one time or another, you will begin to understand very quickly, they are very discrete about the types of services that you are able to provide, the coding,

procedural coding and so forth, that is reflected in the contract and in the rates of the inversement to support those services.

While in some ways it's quite complex and requires a very careful attention to and bringing those billable services and codes to light in your billing system, whether you are billing out of your own shop or you have outsourced that, that alignment, continuity from the contract to your billing system to your clinicians, so they know these are the services that I can bill for, that alignment is critical to maintain, and that is what having a compliance person do for you, in relationship with finance and other areas. It's critical.

>> Can you please elaborate on what slide you are on, since we just got them? Thank you.

>> PATRICK GAUTHIER: Sure. I'm now on the slide that has a green box with, "marketing and sales on it. I don't know what number, but on my slide it says marketing and sales at the top and a red box with billing operations [inaudible]

>> Not to interrupt, but so you know there are several of us who do not have the slides and I've E-mailed twice. I'm not really following anything except the conversation.

>> PATRICK GAUTHIER: I understand.

>> On the BBF file it's page number 8.

>> Those that have not received the slides, could you provide me with your name? This is Rose. I will try to get them to you.

>> I E-mailed Hannah twice.

>> Can you spell your first name for me?

(echo).

>> Gloria, the last name is Hanania.

>> Great. I will send those to you shortly.

>> Rose, I haven't received them, either.

>> Who is this?

(echo).

>> This is Maria Rodriguez.

>> I will send those to you as well.

>> Thank you.

>> PATRICK GAUTHIER: Let me pick back up, at marketing and sales, is another dimension of your organization, and many of you are going to use different words for marketing and sales. Some of you may use business development or development, or, and there are any number of other words you can use to describe marketing and sales.

I try to distinguish it from development on purpose, and the reason being that development often has to do with fund-raising, whereas billing operations and the kinds of contracts that you are going the run into or may have already entered into with

managed care organizations and other health insurers are very different function of somebody's job description than would be fund-raising.

So bear with me. I use these terms a little bit differently from conventional marketing and sales. But suffice to say that anyone who is responsible for engaging your organization with a third party payer ought to be doing some market research ahead of any contracting, to make sure that they understand who it is that they are reaching out to, to join a network, or to be considered an in-network provider, to have that contract process begun, to understand, for example, how many members do they cover. Many of you may be in a market where the Medicaid population might be served by more than one managed care claim for example and knowing who those payers are and what proportion of the market share they have I think is going to be very important in making some projections around the numbers, the volumes that you might expect, the rates of reimbursement they are making available, the ease with which you are going to be able to get help from that payer, in terms of understanding their billing practice and requirements.

That person on your staff is responsible for, let's call it payer relations. You will need a plan of engagement, a plan of action that you as leaders within an organization can keep track of, at what rate can we expect these contracts to come on, and people in finance are going to need to know that kind of information, to make their projections as it relation to your budget, what you can expect in terms of revenue.

What services are you bringing to the table, what services might a managed care claim be looking for, most of the time that is a fairly static endeavor to understand what it is they cover, what's excluded, what it is you provide and how those things line up.

But this is a period of tremendous change and innovation of course, with all of the healthcare reforms (Beep) and it is the case where, I'm working with providers around the country who are in fact able now to go to some of these managed care organizations and other insurers, with a slight twist on whatever their program offering might be, the services that they are able to reconstitute, combine some of them and launch entirely new services like care coordination, for example, and bring those to the table, present them, promote them, develop some pricing around them and negotiate some new services with payers.

So, don't lose sight of that aspect as well.

Oftentimes, from a marketing and sales or payer relation standpoint, having somebody who is well-versed in understanding the difference between (background noise) the rate of

reimbursement and the cost of actually providing that service, they are going to need that information, so that you are not entering into contractual relationships that are upside down, where from the get-go you can anticipate, we are going to lose money hand over fist here if there is a problem.

(voices in the background).

That person or that group of people will also maintain on a day-to-day and week to week basis relationships with that payer, so that you have got a consistent point of contact, and it will be their responsibility to understand the different approaches to reimbursement.

I mentioned the healthcare reforms, and all of the new opportunities. Well, with those new opportunities are arising new approaches to reimbursement.

(buzzing).

Those methods include everything from pay for performance to incentives for positive outcomes and quality all the way up to capitated arrangements where providers are assuming a great deal more risk, financial risk, and any number of different methods in between (overlapping speakers).

(voices in the background).

We can talk about some of the different approaches to reimbursement as we go along.

I'm going to go ahead to the next page, or slide, which is the IT related slide. Here my assumption and I want to pause for a moment, and see if we can pull up a little verbal straw poll, and that is, how many of you are billing third-party payers whether it's a commercial insurance company like a Blue Cross or an, Aetna, and how many of you are billing Medicaid managed care plans today and [inaudible]

(overlapping speakers).

(many voices in the background).

Maybe sound off. Are you doing some billing today? Or are all of you doing no billing today?

>> We are billing.

>> Doing some billing.

>> Not billing.

>> PATRICK GAUTHIER: Okay.

>> Not billing, but we have the potential for billing.

>> PATRICK GAUTHIER: Okay. If we take that sample, again, small sample but it's enough for us to, enough for me to (buzzing) where some of you are at, for those of you who are doing some billing, there are a number of different ways that people approach billing.

(echo).

Sometimes they are doing their own billing, and they are pushing electronic billing out of their practice management

system or out of a EHR, electronic health record. And there are some providers that are using what is called a clearinghouse, which takes paper billing and turns it into an electronic bill.

But regardless of where you are at, I think if you are on this call, on some level you are wondering how do we take what we are doing today, and either build it or enhance it, and from an IT standpoint, it's really the first step is about understanding where are we at today, what resources do we have, do we have a practice management system in place, software, do we have any HR, are we planning to implement EHR. Does it have a going component or module.

So getting a baseline understanding of what capacity do we have today from an IT standpoint, and developing a plan around that, and knowing that our systems, if we want to bill in-house, are going to have certain requirements of them related to electronic data, interchange, or EDI, standard transaction code sets that are governed by HIPAA for electronic billing. We will talk in a minute about ICD-10.

>> Can you tell us what slide you are on, please?

>> PATRICK GAUTHIER: Yeah. You have to forgive me because I'm on a different slide set than I think is the final one that you have been E-mailed. But I'm on slide 10 on my deck, and at the top is a green box that says "IT. "and joined by a arrow to a red box that says, "billing operations."

I'll give you a minute to catch up. (background noise).

Have you found it? (background noise).

>> Yes.

>> PATRICK GAUTHIER: Okay. Great.

In many cases, because providers are starting from scratch, and they are wondering, we have the opportunity to begin billing.

(voices in the background).

Or we plan on it, we are being required to begin billing, IT will often benefit from having a strategic approach to a plan (background noise) for acquisition of hardware and software that you need. And taking the strategic approach that understands what your goals and objectives are both from a financial standpoint and from a functional standpoint, what functions you need your system to provide, and from a standpoint of cost and interoperability with third-party payers, taking the time to map that out and really carefully understand from a strategic standpoint what you need is critical. That goes into your future state, your to-be, whereas the first step in the process gives you your current state or as-is.

This is the way we are doing it now, or what we are capable of now. We have now set the bar for where it is that we are going. And the gap between the two informs that requirements we

have for information technology.

(buzzing).

And based on those requirements, and I understand this is a large and important step that deserves its own half-day workshop, but in having identified what system requirements we have, then we can start to look at different vendors and different solutions and can evaluate.

(loud buzzing).

And hope to make a solution. No small task. And I think what I want to recommend is that you not do it backwards. There are some people that look at vendors and start to evaluate their options, and only afterwards do they start to consider, what is it that we really require. And we find a lot of buyers' remorse there, because vendors are very good at letting us know that they can.

(buzzing).

Just about everything.

(sounds like someone is receiving texts on their cell phone).

Be sure what it is you need before engaging with vendors. IT will then need a comprehensive approach to implementation, if in fact you are going to be billing electronically in-house, having a well thought out and standardized approach to implementation and having a vendor that is well-versed in how it is their solutions are going to be implemented. From a IT standpoint engaging your staff in a new software solution, staff will need training, and as we go through this list, it starts to get big and hairy for some folks, and they sit back and say, would it make more sense for us to outsource.

Outsource becomes an option for some providers, when they go to that billing clearinghouse or to an external billing shop, and look for relief there, to say, rather than build all of the capability ourselves, it might make sense for us to outsource it. If in fact you are going to keep it in-house, you may have [inaudible] (background noise) as we go forward and you are entertaining new contracts, new services, new codes, your systems configuration needs to keep pace with that new contracting. From an IT standpoint, system configuration, reconfiguration is important.

(lots of background noise on the line).

I wonder if maybe we can ask people to mute their lines, if you haven't already muted. I know some of you are doing some other things, multi-tasking. And if you could mute your lines, that would be great. (background noise).

The other important aspect ...

(voices in the background).

... of IT or from a IT perspective is ICD-10 readiness. I

don't know how many of you are familiar with ICD-10 and the requirements for ICD-10 readiness by October 1 of this year.

If you are not, I want to encourage you and can share resources with you, to ensure that in fact you are ready for ICD-10 because it's coming, October 1 is coming rapidly. Again, that is a talk that we can spend a great deal of time.

(background noise increasing, very hard to hear).

From a readiness standpoint, interoperability is the ability for you to exchange information with third-party payers, critical, that becomes [inaudible] (Beep) essential to IT planning (background noise).

As does analysis and reporting. Having a plan for and [inaudible] (background noise) one of those things that people come back to only later to discover that, boy, if our analysis is difficult, our reporting to our Board of Directors or to a payer [inaudible]

(sorry, background noise is so loud I can't hear his voice now).

Needs to be considered ahead of time.

IT, idea of meaningful use, and understanding before you start making commitments to one system or another, do you have provider staff, clinical staff who qualify for meaningful use incentives. These incentives are financial incentives, that may in fact help underwrite the cost of any IT that you are procuring.

IT is a big one. We spent quite a bit of time on that. Let me go to partners and payers that you have, themselves. Here the partners may be again, made a decision that you prefer to outsource.

(buzzing).

To another party, one type of outsource might be a billing clearance house. Those vendors or all vendors they exist all over the country, there are people who do that for a living, for the very reason that I was talking about before with respect to IT, that some of the (background noise) ramp up would be so onerous and expensive for smaller agencies that it makes more sense, contract with a vendor to do that for you.

The last thing in here is just a reminder that you have payers that you are engaging with (background noise) and the payers, customers of yours (background noise) impress them, make sure they are happy [inaudible] (background noise).

(sorry, background noise is very loud).

Your front office, I'm now on a slide that has a green box at the top, it says "front office" in my deck, it's slide 12. Here are your billing operations, are going to rely heavily on what is happening from a business process work flow documentation standpoint, at the point of intake, patient registration.

Certainly and critically as it relates to eligibility verification, understanding what benefits people have when they come in through the door, any requirements for preauthorization that relate to scheduling, and understanding what those benefits, are there co-pays, coinsurance, deductible that apply, that then require us to collect cash.

That last bullet, frankly, this whole slide is absolutely essential (background noise) revenue cycle management.

(very loud background noise).

Establish from the very beginning [inaudible]

>> Hi, this is Rose. I'd like to remind everyone to please mute their lines. There seems to be a bit of background noise that we are hearing. If you have not done so, please mute your lines. Thank you.

>> PATRICK GAUTHIER: Thank you, Rose. Okay. I'm going to move on here just in the interest of time to clinical operations on the next slide. The green box, with "clinical operations" at the top, and here this is where the rubber really begins to hit the road, in terms of having properly documented services that you can in fact [inaudible] (background noise) begins with making your assessment and diagnosis, and moves through a continuum of treatment planning, day-to-day clinical documentation, and then having staff who are well-versed in taking what is in document and clinically in the delivery of your services to then reflect billable services in what is called service capture.

I need to be able to look at a narrative (buzzing) in a chart that is organized in such a way that I can then derive what the service was, that service has a corresponding code, and the code has a corresponding rate of reimbursement. This relationship between how it is that your clinicians are documenting, what it is that they are documenting, what it is they are documenting in, and how it is that you bill, those things are integrally related to, just the one-to-one relationship is so strong that failure to appreciate the importance of what clinicians are entering into a patient's chart is a setup for failure on the billing side.

Like I said earlier, that relationship needs to be very carefully understood, and it affects the training that your clinicians might need, the clinical supervision (background noise) it affects downstream auditors coming in to look for, and I can't emphasize enough the importance of clinical documentation as relates to service capture (background noise).

The other operation that is important is concurrent review as it relates to denials, managed care utilization review, your ability to appeal a decision that was reached by managed care organizations, all of these things have a bearing on your

revenue cycle and your billing operations. (background noise).

I'm going to go to the next slide which at the top reads, "medical records" or "charts" and here again is an expansion of what was on the previous slide, that your forms, your templates you are using, will need to reflect what you have in contract, what is required for compliance, that all of that is maintained, that someone is managing the relationship between these, what would otherwise, you might consider, these are just our forms and are just our patient records, what do they have to do with compliance and with a potential audit down the road. They have everything to do with that.

(laughter in the background).

Making sure they reflect each of your payer agreements and the rules and regulations that govern. Some of you have I'm sure electronic health records in place, and it's no different. They are your electronic health records or EMR systems or practice management systems configured to reflect your contracts, and do your folks who are using, who are interfacing with systems, do they understand the difference between someone who might be covered by a Blue Cross plan or Aetna plan, someone who might be covered by a Medicare advantage plan and someone who might be a dual eligible, Medicare and Medicaid, how does that manifest on the screen, and in your system configuration, so that the right information is being captured to produce your billing.

We talked about audit and the importance of being able to go through and tie these things.

>> Are we not using ...

(voice in the background).

>> PATRICK GAUTHIER: Lastly there is a quality assurance measurement to this that we are able to go through and ensure that before we start billing and before we get too far down the road that our payers [inaudible] accurately reflecting what we are doing, we don't have any risk of (background noise) bad outcome in an audit later on (background noise).

To bring this all together, I'm on a slide that at the bottom says critical success inhibitors.

(door closing).

There are three boxes on the right-hand side. Here are the problems that I've tended to see over the 25, 30 years I've been doing this. One is that there is a tendency, from an inventory standpoint for providers not to [inaudible] (background noise).

(background noise is so loud I can't hear his voice now).

If we think of billing as inventory, many providers in my estimation let their inventory of reimbursable claims build up. Those claims will sit for a month and I'll ask, how often are you billing? Say once a month we do our billing. And I'm not

alone in saying that kind of shelf life for a bill is not in [inaudible] your best interests and frankly if there is a overarching goal with billing and revenue cycle management (background noise) it's that you are doing it on a 24-hour basis, every day at the end of the day billing is going out to your payers. If it's once a week, that can do for a while, but ultimately, you want to be billing on a day-to-day basis so that your inventory is always as low as absolutely possible because it increases your cash flow. Your cash is going to be coming back in faster, and it also very importantly allows you to detect when claims have been denied, clean them up and resubmit them as quickly as possible.

What providers who are new to billing don't often appreciate or understand is, if I send a batch bill at the end of the month and there is one thing wrong with it, that payer very often is going to deny the entire batch and send it back to me. Now I've got to go through, find the error, correct it and resubmit it (background noise) which is why I really emphasize that you need to be billing as often as you can, so that you can keep your cash flow as fluid as possible.

The other critical success inhibitors, motion, where there is a tremendous amount of wasted time and effort. Things are not well articulated, the [inaudible] (background noise) I can have people handing things off back and forth, I need this, I need this, but form is traveling around the office, and [inaudible] bill is taking too long.

>> Patrick, this is Rose. Sorry to interrupt. I wanted to tell folks on the phone that we did get technology back up and running. If you are able to join us via Adobe Connect, you can go ahead and do so. (background noise).

>> PATRICK GAUTHIER: The other is in waiting, as motion begins to suffer bottlenecking, for ineffective planning, poor work flow, you can have things (background noise) sitting as a form, a billing form, or chart, sitting somewhere, literally while somebody is on vacation, and you haven't accommodated for the fact you are on vacation, these things are not farfetched. Your work flow has an inefficiency or bottleneck built into it that causes your cash flow to suffer.

Anything that requires tremendous handling we refer to that as overprocessing or in some cases underprocessing, where people aren't keeping up with rules and regulations, things are coming back to you, you are having to adjust on the fly to new procedures, new policies, and your production time, the time it takes to get from an encounter (buzzing) to a paid claim, that lag gets longer and longer as people are reprocessing, correcting things. Anticipating that, feed back to what I was talking about earlier, that having a real comprehensive

understanding from the beginning, configuring your approach, your system, your forms is critical, and that of course relates to the last bullet on this slide which is defects and rework, where things are truly breaking down, supervision is lacking, people need training that they haven't been getting. And again, all of these things can be avoided by properly front loading your billing project with the kind of understanding that we have walked through here so far.

What I would recommend, as I go to the next slide, the next slide on my deck anyway is 16, at the top it says, "group assessment exercise."

This is something where you can take all of the previous slides, and as a team, you can sit in your conference room, if you have a little conference room, you go through and say, let's use either some dots or some markers or do it in conversation, we can create a little table of, these are all of the things we need to be able to do, if we are using a red dot for example, that we have a column for things that are known barriers. We don't have that competency. We don't have that capability. We are not ready in that area, and begin to identify which are the things that Patrick has been talking about are truly a known barrier today. We just don't have that.

Similarly, the green dot might be a known strength.

(voice in the background).

Or even a perceived strength that we believe [inaudible] (overlapping speakers) very quickly ranking things again in columns if you want, table, barrier in strength. A blue dot is a resource requirement (overlapping speakers).

(lots of voices in the background).

We believe we are fairly confident but we do know we are going to need a billing system or vendor to build capacity quickly. Is there a resource requirement that we have that allows us to bridge the gap between things.

That is something that I think is a two hour meeting sitting around the conference room table, with a comprehensive list of what is going to be required, even establish very quickly, are we able to build a billing competency or are we able to expand our billing competency, and what are we going to do about the gap between these two things? Where are we going to get help?

I'm going to go on to my slide 17, but it's a title slide that reads: Building your billing team.

Here a billing team (voices in the background) Particularly if you are beginning to bill, is going back and recapitulating what it is that we visited so far, on my team I would have, I would suggest you have an executive champion.

(loud buzzing).

From the executive team, who is going to provide oversight,

whose job it is to make sure you have the resources you need, and to go and vie for what it is that you need with the rest of the executive team or the Board of Directors. Your finance person, finance director, a contracting and legal expert, whether that person is in-house or outside engaged, compliance person, payer relations or marketing as we were referring to it earlier. And again that is somebody who, I always urge, be careful who you assign that to, because this is in fact (loud buzzing) a salesperson, somebody who is going to be going out into your market engaging your most important payers and responsible for keeping them happy. I just would urge you not to default in who it is that you assign that task to. I run across that too often, where people say, oh, it wasn't that important so we gave to it this person on our staff who might be new, or they don't have all that much experience or they don't have the expertise. And it was not seen as a vital role. And I would argue vehemently it's a very vital role. That individual is going to be your liaison with your payers.

IT, without question, having your IT director involved on your team, somebody from your front office who truly understands how things are done, somebody from your clinical operations, if you have a clinical director or a clinical supervisor, that they be involved on the team, somebody from your charting or medical records area be involved. You may have, I would encourage, I hope you do have a lot of conversations with your payers to better understand. They can educate you. They have provider relations people whose job it is to make sure you understand how to bill, what it is that you are on contract to provide, and if that person doesn't exist, which is unusual, then they would certainly have billing manuals, provider manuals that become absolutely essential to your success, and that is another thing that I'll warn you, if you haven't been doing a lot of billing, that provider manual is uber important. You have to refer to it, because your contract will refer to it as an exhibit to the contract.

So really, it establishes the policies and the norms and the rules for what it is that you are doing. Then if you have a vendor, a HR vendor or some such that your vendors are engaged, they are part of your team, and it makes the selection, the evaluation and selection of a vendor that truly meets your requirements all the more important, because they become part of your revenue cycle or billing team for the long haul.

The last question we wanted to answer in this time together is, where can we turn to for more information? I've provided and hopefully by now you have been able to either receive the presentation or access it from Adobe Connect, but there is the sample here of some of the information that is available to you.

One of them is a Niatx, University of Wisconsin developed a billing guide that, I was part of developing that billing guide with them. I think it's a great resource, a great starting point for a lot of providers.

(buzzing).

Addresses much of what we talked about today. If you are a Medicaid provider, and you are contracting or going to contract with a Medicaid managed care plan, or Medicare advantage plan, they have billing manuals.

(voices in the background).

Get the billing manuals. Go to your Medicaid website and understand, have them orient you to their website where forms and templates and policies are almost always very abundant. I haven't run across very many state Medicaid websites that don't do a pretty darn good job making sure the resources you need, the information you need are there.

CMS has manuals that are in fact very appropriate for people that are either starting to bill, or expanding their billing operations, whether it's with respect to Medicare or Medicaid. I've given you a link there to begin to take a look at what CMS has available to you. I mentioned ICD-10 and spoke about it earlier. CMS has a great body of guidance and suggestions and recommendations in its CMS ICD-10 quick start guide. I'm giving you a link to it there.

I don't know where you guys are all in relation to ICD-10 readiness. But, and I don't want to be alarmist, but October 1 is coming up, and it will be just essential. Again, uber important to your revenue cycle that you be ready for ICD-10.

SAMHSA and the National Council have been managing this BH business initiative for the last couple of years. On the BH business website there is a billing start-up module that you can avail yourselves of and a billing and compliance module that you can avail yourselves of.

There is great information in there. Again, this is the kind of information you want to make sure your team, if you go back to the, who do we put on our team, and what is it that they are looking at, hopefully now you have got a good sense of who needs to be on your team, why they need to be there, and the information you can point them to.

With that, I'll stop and see if there aren't any questions that I can answer in the little bit of time that we have left. (pause).

>> Folks can unmute their lines if they have questions, or type into the chat box to the right-hand side of your screen, if you are connected to Adobe Connect.

(someone coughing).

>> Thank you for this. This is Amy Graves in Tucson. I

really appreciate your presentation. I was wondering if you would be able to direct us as to where and most efficiently, how to find out what each commercial insurance in our area has for market share. You mentioned doing a market share study. Is there a quick and dirty that you can look at somewhere per region?

>> PATRICK GAUTHIER: Yeah, you know, there were a couple of places you can turn for that. One of them is Kaiser Family Foundation, keeps a fairly up to date inventory of who is enrolled in which plan, and it's, it doesn't have all of the market share information that somebody like me likes to have. But I think if you want to get a sense of who are the top three or four plans, commercial health plans, Medicaid managed care plans in our state, KFF.

>> KaiserFamilyFoundation.org. The other, shortcut to it is state health fact.org, it's all, there is no dashes or underscores. It's statehealthfacts.org. You can also get to it, like I said, through KFF.org, Kaiser Family Foundation.

I think for the purposes of getting a sense real quickly of who's got what in our market, it's a great quick easy solution.

The other more costly approach to it is Atlantic information services or AIS which is owned by AHIP, Americas Health Insurance Plan, has extraordinarily detailed market data for all of the health plans in the country. But it's very expensive. There are consulting firms like ours who buy that because we do a lot of market research for clients who are looking to establish a foothold in a given market. But it's not free and it's not cheap. It's very very expensive.

I think depending on the size of your organization, the breadth and scope of what you do, most of the time state health facts.org will answer your question.

>> Thank you.

>> PATRICK GAUTHIER: Um-hmm.

(voices in the background).

>> Why do you do that (background noise).

>> PATRICK GAUTHIER: Any other questions that people might have?

>> I have another one, if no one else does. But let's see if somebody else has another question.

>> PATRICK GAUTHIER: Okay.

>> Doesn't sound like it. Amy from Tucson, Arizona. My question is related to the commercial insurance batching, when you send off the claims for payment, what is the average return, as you can -- I understand from our billing and claims department that they have to submit them three or four times over the period of about six months. And then at that point, we are only going to get a minimal amount of the usual and

customary services.

Is there an average across the country that would be a benchmark to compare our performance to the market, regular industry?

>> PATRICK GAUTHIER: Yeah, it's a great question.

(voices in the background).

In the time that we have, the way I would answer that is that finance, this goes back to the importance of having finance involved in your billing strategic approach here, is that what we bill is the [inaudible] always adjusted in our contract for usual and customary. I might bill, I'm going to pick a number here, a hundred dollars for a 50-minute session, but the usual and customary, the rate at which I'm aligning in the community with that plan might be \$75.

So there is already a difference of what I think my service is worth, it's worth a hundred bucks, they are telling me it's worth 75. So I have a \$25 gap right there.

Furthermore, there is contracting with added discount off UCR so they might contract with me at \$60 for what they deem to be a \$75 visit. So from a financial and strategic standpoint, making some adjustments in our thinking, our culture, our expectations and our projections between what is billed, what is usual and customary, what we are contracted at, and then what is reimbursed. And the reimbursement has to take into consideration coinsurance, co-pay, deductible. I'm never going to get all of what I'm looking for, what I think I'm supposed to get. I'm always going to get my contracted rate minus whatever the adjustments are from the standpoint of coinsurance.

So, being able to project that is a complicated set of financial exercises. But what it does is gives me a target, my projects for the period or for the year, let's say, are now reasonable and rational, not projecting based on what I'm billing. I'm not projecting based on UCR. I'm projecting on what is contracted minus coinsurance.

That takes us then to your, either their refusal to play by the rules, or a provider's difficulty in submitting claims that are clean. We are in an era now where this idea of clean claims, that is where all of the codes correspond with one another, where there is no missing information, where none of the rules have been broken, it's very very tight, you know. When you think about engineering, they use a term called tolerances. The tolerances are extremely tight.

There is no wiggle room for any of this stuff, particularly when you are billing electronically, to be off. Anything that is off is going to come back to you.

That is why batch billing approaches, where if I'm doing it once a month, oh, my goodness, you know, I shudder to think

because one, you might have 1,000 lines of claim in there, there would be one error and the payer system will just spit it back out, rejects it outright.

(buzzing).

The whole batch.

So getting those tolerances, understanding them and making sure that you are billing in a way that is suited to that individual payer is critical. I'm not saying it's right. (chuckles) It's not right for them to be able to do that and make life so difficult but it's where we are at. It's a very highly regulated and very highly engineered billing era that we are in, and as far as getting to the answer to the question as it relates to average performance, when you get good, if you take into account what I just described, sort of remove from your thinking all the deficits that aren't deficits, it's [inaudible] if your billing [inaudible] if you are submitting clean claims, your coding is all crack, then the rate of denial, the people should be shooting for is about 5 percent.

(someone typing).

If I'm experiencing a 35 percent rate of denial, that tells me something about either my numerator or denominator are wrong, or we are not very good at billing, or we are not very good at correcting things and resubmitting them, or like I said, we are waiting too long to bill, and one bad claim line in 1,000 will kick all other 999 out. Now I've got to resubmit those and go back through another 30-day cycle.

It can mean a lot of different things, if you are not hitting the 5, 6, 7 percent rate of denial.

>> Thank you. This is very enlightening with regard to the 5 to 7 percent rate of denial. Final question for me if we have time and no one else wants to ask, pause here (overlapping speakers).

(buzzing).

Does each commercial insurance plan have its own way of requiring the claims to be submitted? The second part of that is, commercial, are commercial insurance billing practices or processes different from that for Medicaid? Thank you.

>> PATRICK GAUTHIER: Two short answers are yes and yes.

While, let me go back and sort of address the first one, can two commercial payers to traditional indemnity health plans process claims differently, there is a longer answer than just yes.

(voice in the background).

The longer answer is that from a HIPAA standpoint, from a remittance and process payment standpoint, they really shouldn't differ, because they all have to comply with HIPAA, but are called standard transaction code sets. Here you sort of, you

might have heard of the acronym, EDI and the standard transaction code sets are those HIPAA coded electronic transactions, and they fall into clusters or families of codes. Some of them are about eligibility verification. It's all been standardized. It's a national standard for an electronic function, relationship that exists between you and the health plan, to verify which [inaudible] you are submitting a standard transaction code set, you are receiving a standard -- and it's a national standard.

The same is true with when you are submitting a bill, that bill meets the criteria of standard transaction code sets, and what you receive needs to meet.

However, what happens between receiving and paying or processing, that is really where one plan can do things very differently from another. How they treat your claim once they have received it can differ and often does.

(buzzing).

It's a two-part answer to your first question. HIPAA governs the electronic data interchanges. But what happens once they have received your claim internally can differ from one plan to another. As far as do they vary, do they differ from Medicaid managed care plan, practically, yes, they do. They can differ a great deal because Medicaid is governed, inoculated at the state level and they can have a, oftentimes do have nuances of [inaudible] (background noise) they have codes that are known as modifiers and use them, the way that a commercial health plan, A, doesn't have to, B, probably won't. (background noise).

They are also [inaudible] services under Medicaid health plan that [inaudible] don't cover. It really does differ from commercial health plans to Medicaid (background noise).

>> Thank you.

>> PATRICK GAUTHIER: Um-hmm. At this point, Rose, before we close out, anything you want people to know? [inaudible]

>> Great. Thank you, everyone for joining us and bearing with us with the issues we had with technology (background noise).

Remind everyone that tomorrow, we will start with day two at 1:00 Eastern time. And 10:00 a.m. Pacific time. Also, as a reminder, this session is being recorded, and will be available on-line.

(someone coughing).

At integration.SAMHSA.gov and the slides will be available on that website as well. Everyone will receive information about how to access the slides within 48 hours.

Did anyone have any additional questions before we close? Thank you. We look forward to seeing everyone tomorrow.

>> PATRICK GAUTHIER: Take care.

>> Thank you.
>> Thank you.
>> Thank you.

(end of session at 3:29 p.m. CST)

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