Billing Scenarios and Potential Denials

As organizations work with health insurance funders, one of the most critical items to thoroughly understand is how to use the Rendering Provider appropriately on claims.

Over the first 4 parts of our Rendering Provider Series, we have set the foundation for elements related to the appropriate set up and use of NPI numbers for each provider type as it relates to the submission of claims.

In this blog, we will discuss some potential denials or recoupments that can occur if these steps are not followed.

Find additional information in the other parts to this series:

- Part 1 = Understanding NPI, Tax ID and Taxonomy Codes
- Part 2 = Payor Contracts and the Connection to Rendering Provider
- Part 3 = Types of Providers
- Part 4 = Details of the CMS-1500 Claim Form

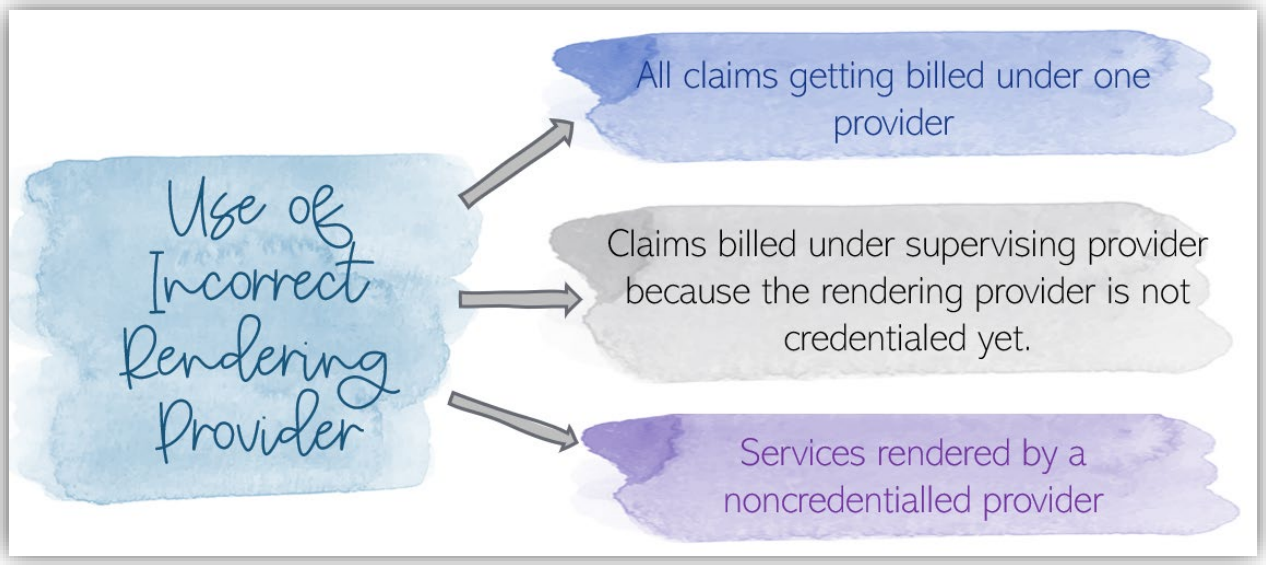
BILLING ISSUES = DENIALS AND RECOUPMENTS

For our ABAB services, we review information sent from our provider organizations and perform a billing scrub to ensure that claims are sent accurately. With our Consulting services, we also perform prospective audits of claims sent.

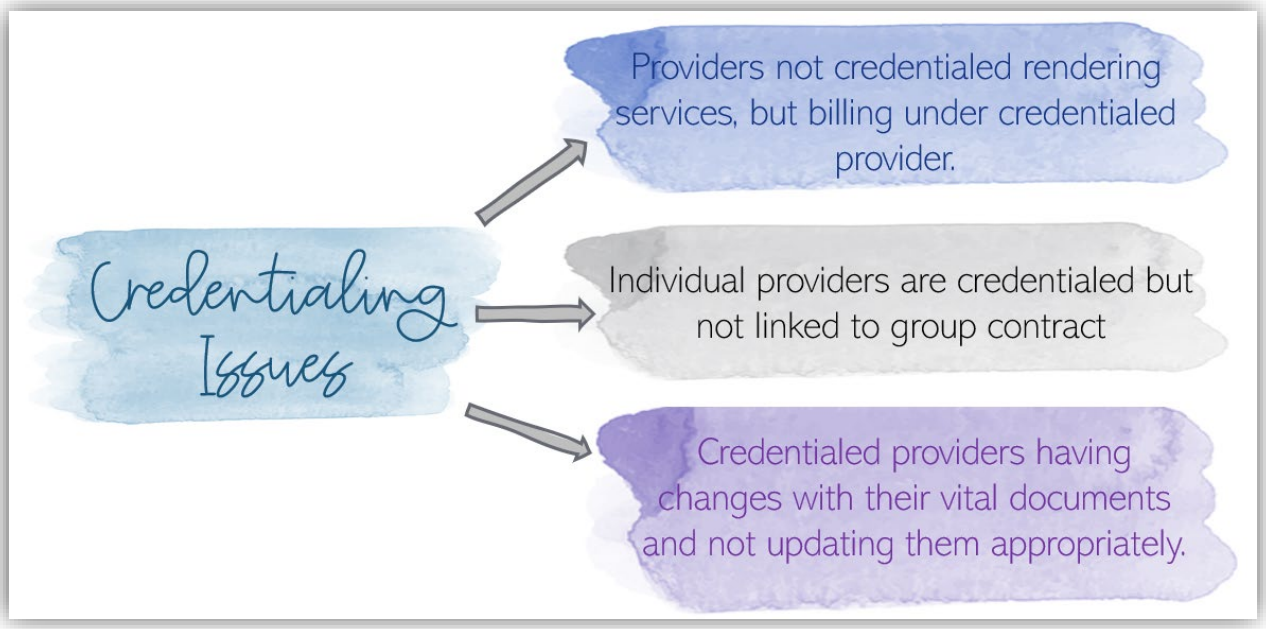
Our team of professionals is trained to look for circumstances where claims can be rejected for errors or where organizations may not pass audits. It is our goal to safeguard providers from recoups and failing audits.

Below are areas that internal billing teams should keep an eye out for and take corrective action. In this section we will be talking about billing scenarios. These are possible billing events that can or are occurring in the industry. We are seeing the following:

Incorrect billing and use of rendering provider. Often time we are seeing all billing claims getting billed under one provider, claims billed under the supervising rendering provider because the rendering provider is not credentialed yet, or services are rendered under non credentialed providers.



Credentialing Issues. We are seeing providers who are not credentialed with a payor render services to that payor's members. Those services are then billed under a different provider who is credentialed with that payor. We are also seeing that there are individual providers who are credentialed but they are not linked to the group contract. Another area of concern is when credentialed providers are not keeping their information up to date with the payor, such as name changes and renewed licensure.



OFFICE OF INSPECTOR GENERAL

When any of the above are occurring, monetary and consequential risk liability is created. The Office of Inspector General, US. Department of Health and Human Services (OIG) have created regulations for compliant billing. When these regulations are broken there are fines and consequences associated depending on severity.

Details to set up a voluntary compliance program can be found at:
https://oig.hhs.gov/authorities/docs/physician.pdf

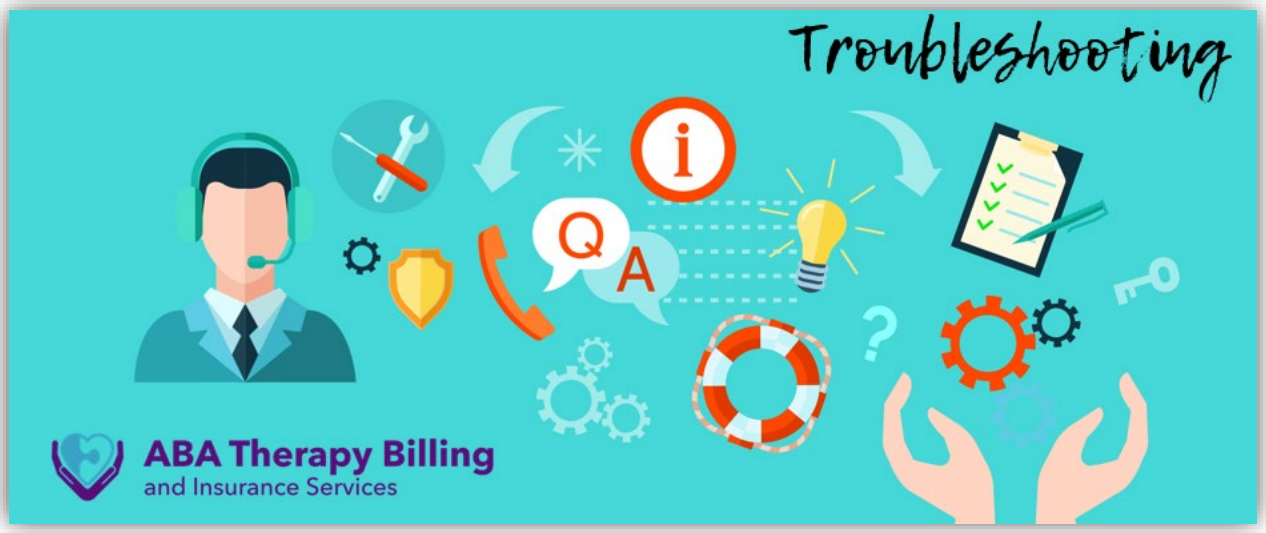
Who is the OIG? They are the oversight division of the Federal and State agency aimed at preventing inefficient and unlawful operations. Their mission is to provide objective oversight to promote economy, efficiency, effectiveness, and integrity of the Health & Human Services, as well as the health and welfare of the people they serve.

The OIG stated the description of unlawful conduct under the Health Care Fraud Act as “a crime to knowingly and willfully execute (or attempt to execute) a scheme to defraud any health care program, or to obtain money or property from a health care benefit program through false representations.”

Unfortunately, when it comes to the OIG the Agency cannot claim "not knowing this was a rule" or "everyone else is doing it". It will not eliminate the noncompliance of the act or hefty fines that will come with the infractions. They state: "it is important to note the provider does not have to deliberately intend to defraud the Federal Government in order to be found liable under this Act." (False Claims Act)

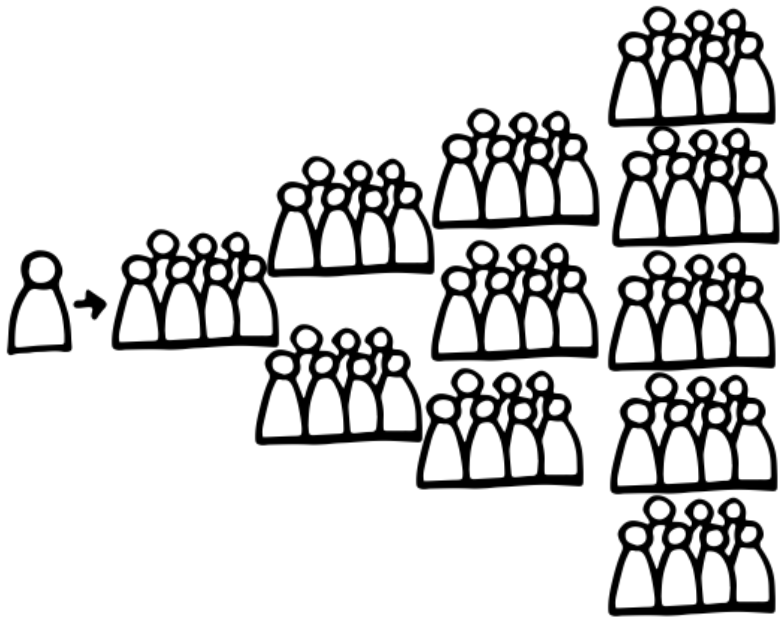
Remember the OIG is aimed at preventing inefficient and unlawful operations. Their mission is to provide objective oversight to promote economy, efficiency, effectiveness, and integrity of the Health & Human Services, as well as the health and welfare of the people they serve.

BILLING SAFEGUARDS

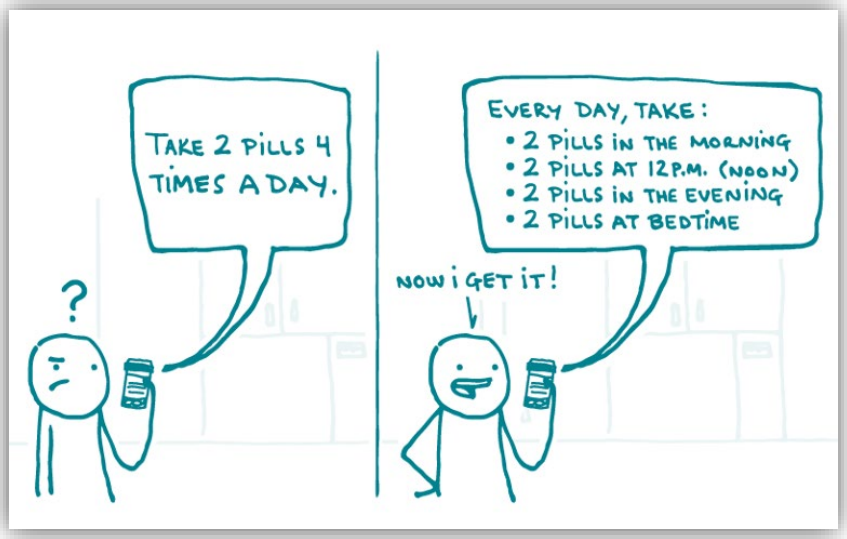


1. Is there Master Contract file with a Roster of all Credentialed providers for the billing team to review?
2. Is there a tracking system to see the work in progress for credentialing?
3. Are supervising providers only assigned to cases once credentialed?
4. Are authorizations secured with credentialed providers?
5. When a case assignment changes from one credentialed supervisor to another, is there a communication flow within the organization to ensure billing compliance?
6. Is the billing team educated on what to watch for when scrubbing and submitting claims?

For example: a red flag may be when one supervising provider is used for all patients.



7. Do you have clear written policies and procedures for billing?



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For additional information on working with health insurance funders, check out our book at www.capecodcollab.com – Revenue Cycle Management for ABA Therapy.

We offer full cycle Revenue Cycle Management services, for additional information, please contact us at https://www.ababilling.net/new-client/