Healthcare Management
Reimbursement Operations

Education - Mitigation - Strategy - Technology

Integrity

Edward Stone

Program Portfolio

Operational Efficiency – Technology - Compliance – Training
Customer Centric and Advocacy Development
Contracting & Contract Administration
Health Claim Operations - Integrity Specialties
Reimbursement Recovery Programs

A Consolidated Approach to Reimbursement Outcomes

Over 25 years of strategic program development, tactical operational guidance and training have resulted in a suite of programs designed to influence reimbursement outcomes and operational efficiencies while protecting and enhancing revenue and profitability.

This sequential approach to ensuring the desired outcome has been consolidated into a Reimbursement Operations Playbook. The playbook contains every aspect necessary to ensure marketing, sales, and the subsequent revenue cycle results in timely and accurate reimbursement.

Reimbursement Operations Playbook 2015

Silver  *Edition*

This guide establishes a process that creates a functional working environment for healthcare providers and third party billing services. This guide works sequentially through every aspect of a business entities operation that impacts the ultimate goal of timely and accurate reimbursement for services provided. This guide establishes operational guidance, integrity programs, training programs, system efficiencies and then enters a revenue cycle management program to ensure the desired outcomes for the provider and patients served.

Playbook Sequence

*Customer guides deliver written methods and standards in which services can be offered, rendered, billed and finally collected.

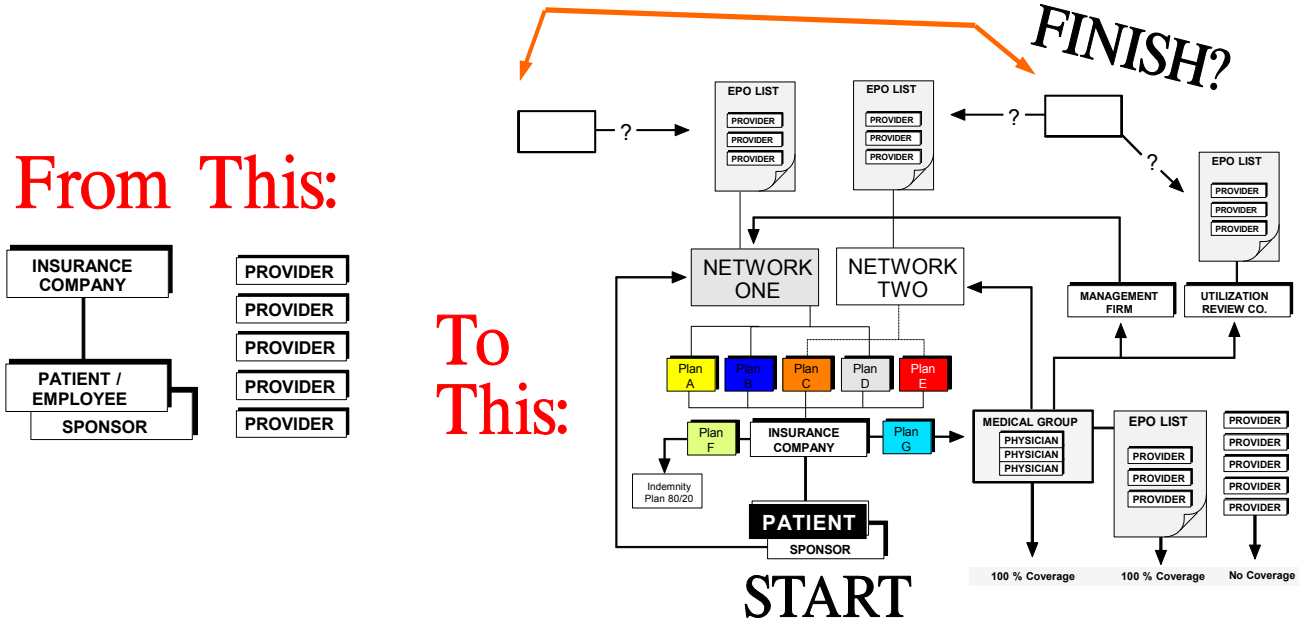
Playbook Sequence

Premier Program Development Samples

Introduction to Healthcare Reimbursement

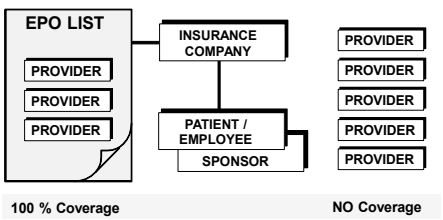
This program introduces staff to health care reimbursement methodologies. This two hour program enables intake staff, field personnel and reimbursement personnel to understand their necessary interactions with patients, payers, and referral sources. This program also discloses the legalities associated with various payer types.

Where does your company fit in?



The entire program begins with indemnity plans and graphically illustrates the evolutionary process that became the model illustrated above. The complex model illustrated above is a matrix of risk possibilities that must be assessed and an outcome known before reimbursement operations (billing) can begin. Each model presented in the program includes **special operations requirements** for accepting and billing services. Additionally, sales representatives that pursue payer based contracts must understand the matrix of possibilities since contract applicability can change depending on the risk schemes utilized by the target insurance company.

The sample below illustrates one graphic and the special operational consideration section.



Special Operations Considerations

Under this plan it is imperative that the provider know if they are a member of the EPO list. Provders need to know limitations and/or exclusions. Additionally, most EPO's require pre-authorization. There should be an inquiry as to each of these items during a benefits assessment process.

Premier Program Development Samples

ERISA, Insurance, Managed Payer
Contract Review

Contract Review & Implementation

Program Includes:

Identification and Certification
Effective Dating and Orderly Termination
Service Area and Lines of Business
Payment and Default Terms
A/R Dispute Resolution
Price and Code Issues
Most Favored Nations Restrictions
Sales Tax
Medical Certification Documents
Coverage and Benefit Classifications
Licensure and Payer Requirements
Authorization Process
Risk Party Disclosure
Coordination of Benefit Requirements
Modifications and Notices
Interim Price Agreements
Attachments and Addendums
Utilization Review
Equipment Cap and Maintenance
Other Products and Services
External Review and Management
Audit and Claims Review Limitations
Billing Operations
(a separate list)
Assignment and Multi-Company Language
Administrative and Participation Fees
Insurance and Indemnification
Subcontracting Services
Competitive Restrictions
Disclosures

This program begins with a checklist of issues associated with a payer based contract as well as non-payer based contracts. The program establishes a definition and a policy statement for each checklist item to ensure each item is clearly weighed in the review process. The program is based on operational, legal, and regulatory issues.

A partial list of review items is illustrated to the left. Each product line or type of healthcare provider may have additional items (operation specific) and may be able to delete items based on the benefits class, marketplace (region).

When this program is initiated a comprehensive review of the operation, marketing and sales representations must be considered for each statement and accompanying policy.

It is recommended that a prelude to imposing this plan include the imposition of the Billing Integrity Plan to ensure all aspects of a product line are included in the language of any contract and are measured in the final agreement.

Not every item on this checklist is considered a "deal breaker" and in fact policy statements should so not any mandates or requirements that could make any specific point a deal breaker.

Keep in mind this process is a component of a contract administration program. Healthcare contracts often fail due to a lack of implementation and testing. Providers should not wait to review and test the contract terms. Pro-active review and testing is the key to a successful contractual relationship and a positive reimbursement outcome.

The review process is likely to result in exceptions, concerns and challenges. Each of these should be measured against the desired outcomes and mitigated through contract implementation.

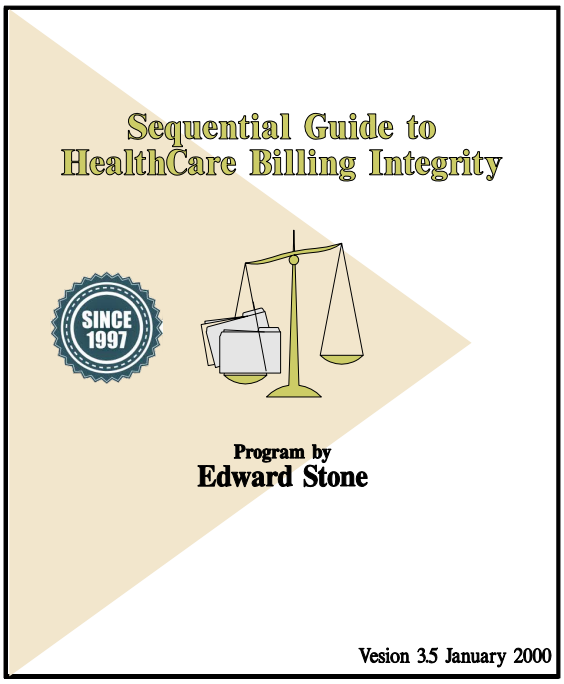
SAMPLE STATEMENT

Interim Price Agreements

These unwritten agreements are often "placed on the table" as a gesture pending the ratification of a formal agreement. These scenarios pose an exposure due to the lack of language and signature to support any misinterpretation's or disagreements including pricing, payment terms, indemnity and others. Price discounts should not be offered without the benefit of a formal/written agreement to ensure that a uniform non-discriminatory pricing policy exists for the company.

POLICY STATEMENT: A written agreement must exist when any offering is made whereby prices are modified from the standard rate schedule. In the event an interim price agreement is introduced and accepted, a firm termination date and default terms must be a part of the language.

Premier Program Development Samples



Topics Outlined in the Program Include

Products and Services "Knowing the Market"

Market Value and Pricing

Presentation of Services

Contract Initiation and Review Process

Universal Intake (field/branch order intake operations)

Billing Center Operations

Communicating and Resolving Reimbursement and Regulatory/Compliance Matters

The entire program is based on a sequential process perspective. From the point of how a company markets its products and services to how it reacts to issues and negative outcomes is outlined.

At The Beginning:

Products and Services "Knowing the Market"

Clinical Efficacy

Each product and service should be able to stand a clinical debate with supporting documentation from peer review journals.

Coding Certification

All products and services should be able to stand a code review audit. The company should ensure all product and service codes are valid as assigned by the appropriate agency.

Coverage Standards

Coverage criteria (by payer type) should be documented and available in a universal format.

At The End:

Communicating and Resolving Reimbursement and Regulatory/Compliance Matters

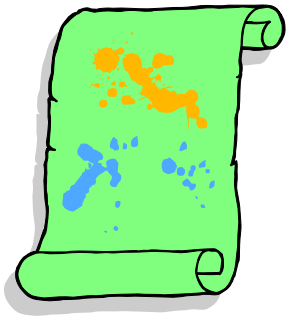
Local Standards (communicating issues, solutions, and standards) *A formal, yet simple process to document issues from discovery to resolution at the local level and with no required regional or national management intervention.*

Regional Standards (communicating issues, solutions, and standards) *A formal, yet simple process to document issues from discovery to resolution at the local/regional level and with no required national management intervention.*

National Standards (communicating issues, solutions, and standards)

And MORE...

Premier Program Development Samples



Contract Administration

This process begins after implementation and continues for the life of the contract and associated account receivable.

The end result is a monitoring process that tracks all aspects of a contract and produces reports or "score cards" for each contract. The score card is a global view of financial results, statistics, and department by department "one liners" that offers a text statement of how that department's interactions with the payer are working. This summary can be used as a negotiating document for future revisions to terms and/or prices. A database administrative process includes a tracking system of variables such as rate changes, code changes, termination dates, revision dates, and any other time sensitive article that requires a review or action on the part of either party.

Payer Score Card

Payor Name	XYZ Insurance	**AE**	
Address	123 Main Street	**Eff Date**	10/99
City-state & Zip	Any Town USA	**Updated:**	

Agreement # 12345	**Term (date)** 10/00	**Pmt Terms** Net 60

Service(s) ❒ ❒ ❒ ❒ ❒ **Other**

Billing Methodology ❒ **Routine** ❒ **Non Routine (Describe)**

Financial Data:

Monthly Overview

Month	Revenue	Claims	Rebills	Cash	Denials	A/R	DSO
Oct-99	10,500	9,300	0	0	0	10,500	29
Nov-99	11,900	10,200	930	2,745	2,410	19,655	44
Dec-99	14,420	13,992	2,240	8,639	3,111	25,436	62
Jan-00	13,121	12,202	5,200	12,860	3,964	25,697	63
Totals	49,941	45,694	8,370	24,244	9,485	25,697	63
% of Total	*100%*	*91%*	*17%*	*49%*	*19%*	*51%*	

Aged A/R

Total A/R	0-30	31-60	61-90	91-120	121-150	150+	DSO
25,697	13,121	7,624	5,497	0	0	0	63

Aged Cash

Total Cash	0-30	31-60	61-90	91-120	121-150	150+	DSO
24,244	2,745	9,950	11,549	0	0	0	63

Stats

Month	Revenue	% of List	Margin	# New Patients	# Patients	# Claims	# Re-bills
Oct-99	10,500	68%		4	5	18	2
Nov-99	11,900	59%		3	6	20	3
Dec-99	14,420	63%		4	7	21	5
Jan-00	13,121	71%		3	7	19	3

Attached Narration: ❒ **Intake** ❒ **Benefit Assessment** ❒ **Clinical** ❒ **Billing** ❒ **Collections**

The Payor Score Card is one example of a comprehensive administrative program. The example illustrated to the left is the first page of a multi-page summary.

Included is:

- Monthly summary numbers including:
  - Revenue $
  - Claims Submitted $
  - Claims Resubmitted $
  - Cash Received $
  - Denials Received $
  - A/R Total $
  - DSO
- Aged A/R Summary
- Aged Cash Receipts
- Census Data (referral stats)
- Other Company data as required…

Additional pages are reserved for text messages and department operational comments and issues.

The score card is an early indicator of dysfunction and/or default. The data is designed to prompt a contract performance review that assesses the entire process and compliance with bilateral terms, conditions and processing standards. When the score card is utilized for contracted payers, any external defaults should be reported to the payer in accordance with the agreement language and in bulk, not on a claim-by-claim basis. For non-contracted payers the score card can be used to assess the impact on specific territories and regions.

Premier Program Development Samples

Performance review begins with the knowledge of all terms and conditions contained in each contract.

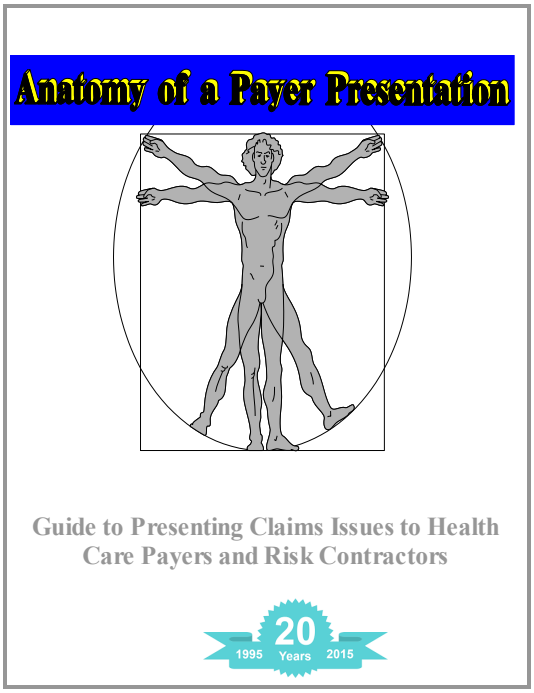
General Inclusions:

- Score Card Analysis
- Contract Analysis
- Data Mining
- Pattern Analysis
- Authorization Analysis
- Claim Submission
- Documentation Analysis
- Adjudication Outcomes
- EOB Analysis
- Appeal Outcomes
- Timing Analysis

- Categorization
- Financial Analysis
- Supporting Evidence
- Sample Cases

Following the performance review the outcome data is assembled into a formal presentation that includes representative samples of each default category as presented in a financial analysis. Each representative sample (exhibit series) would be presented in accordance with the guidelines illustrated in the program "Anatomy of a Payer Presentation."

Premier Program Development Samples



Anatomy of a Payer Presentation

This program outlines a process that results in an evidence gathering technique that would include irrefutable documentation for presentation to payer executives. This entire program is based on the concept of consolidating claims into a process that moves the "paper via mail debate" from the claims shop to the executive offices.

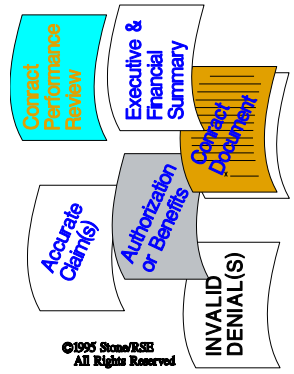
The program begins with the end result and moves towards supporting that outcome.

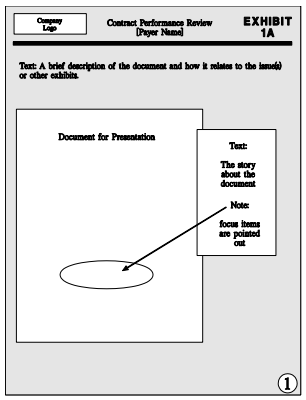
Included in the Plan:

History and Overview
Supporting the Process
Sample Report Format
Determining the Issues
Qualifying the Exhibits
A winning presentation
Form and Format
Sample Presentation

A Winning Presentation

The end result of the process is a professional presentation document as impressive as any sales presentation. Printed in color, bound and organized in a fashion that anyone can follow the story line...





The story line established a basis for an outcome that position the provider in a positive posture for negotiations, requests for advances and/ or global processing commitments. It is critical to make these presentations to the executives to ensure the delivery is clear and poses a risk without being viewed as "a collector."

The Presentation Includes:

- A claim where you are certain that the billing terms of the contract were met.
- An executive summary and financial summary that categorizes the issues into a meaningful failure that pose a liability.
- Copies of or excerpts from the contact that reinforce the provider's position with regards to the claims being presented as evidence.
- Copies of the authorization and/or notes documenting benefits.
- A copy of the accurate claim that clearly matches the authorization.
- A copy of the denial that clearly illustrates a negative outcome for the accurate claim as supported by the authorization or benefit notes.

Each presentation for each scenario is a story line that ends in the payer seeing that the provider should be paid and was not!

The evidence is presented in a legalistic format using exhibit numbers and scanned images of each document along with comment boxes.

Premier Program Development Samples

Compliance - Regulatory Affairs - Executive Resolution

Compliance Regulatory Affairs Executive Resolution

Presentation by Edward Stone

16 years

Painting a Clear Picture

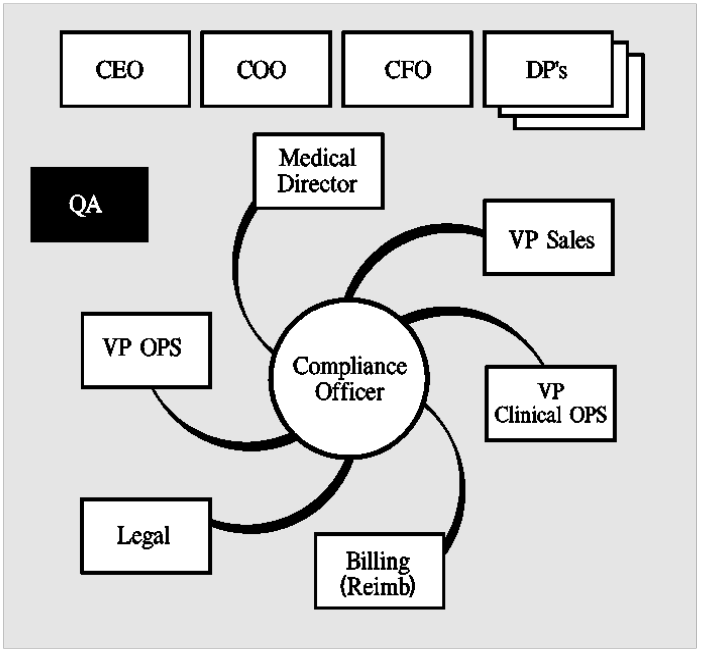
Compliance Exposure #1: Billing matters (methodology/systemic processes)

Compliance Exposure #2: Sales tactics and marketing materials

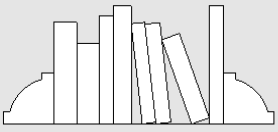
Compliance Exposure #3 Clinical operations and records

The Solution is Clear

Structure



Programs



Field Operations Guide

Sales Operations Guide

Clinical Operations Guide

Reimbursement OPS Guide

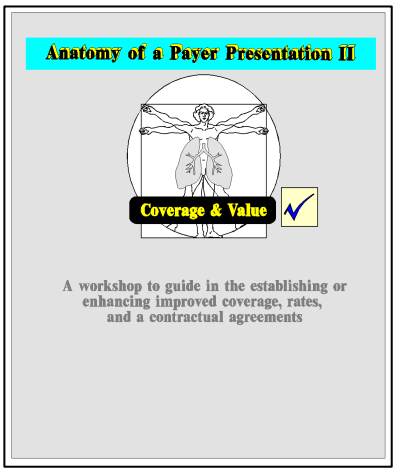
Employee OPS Guide

Executive Resolution Plan

Each program guide is based on a simplistic format that is easy to understand and interpret. The foundation for each program guide is based on a common set of principles that are created for the business following a review of applicable regulatory programs and established standards. An additional review of competitors' common practices is used to benchmark processes and obtain clarity. From this process and an adopted billing integrity program comes a set of guides developed for the specific operation and the risk factors associated with the business focus, products and services.

INFORMATION - EDUCATION - GUIDANCE - COLLABORATION - REVIEW

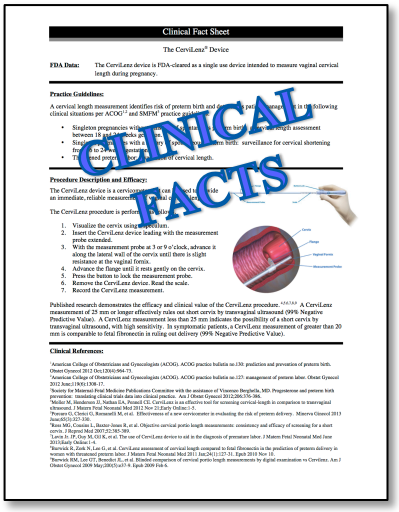
Program Development Samples



Anatomy of a Payer Presentation II

This program was adapted from the Anatomy of a Payer Presentation workshop designed to establish the validity of claims and payment levels through the post-pay appeals process.

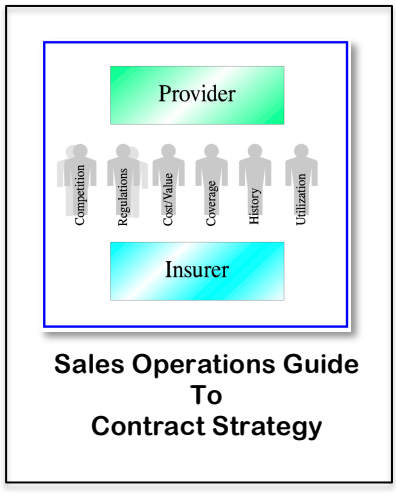
Like the previous workshop this process establishes clear and irrefutable evidence along with clinical and financial value as necessary to influence insurers or at risk entities that a service or procedure should be covered, appropriately valued and contacted. Like the version I program, this process includes a highly organized and sequential message supported by verifiable facts and data.



Clinical Fact Sheet Disclosures

Use of clinical fact disclosures for each specialized product or service establishes a uniform method of communication when discussing the need for approval, coverage or when a benefit exception is necessary to provide the service to a patient. These disclosures are often one of the exhibits presented in the Anatomy of a Payer Presentation II program.

The use of the Clinical Fact Disclosures can also be the basis for summarizing an introductory presentation for the purpose of establishing a contractual relationship.

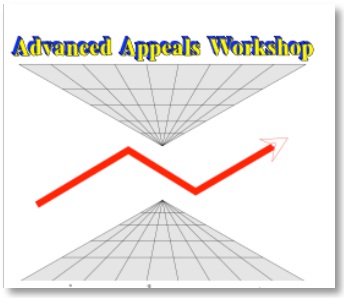


Contracting with C-Level Management

The need to grow revenue is often curtailed by the many obstacles between the provider and insurance entity.

This strategic planning program has been designed to assess each obstacle and establish both strategy and tactics to penetrate the barriers with highly coordinated and organized data. Tactics often include internal and external resources such as the physician community and supporting regulatory/plan language or journals. In general the "story" behind the process must be established with clinical facts presented and supported by the specialty physicians in the payer network. Often these presentations are made to the Chief Medical Officer or Chief Financial Officer when the clinical facts support a verifiable cost reduction.

Program Development Samples



Point-By-Point Appeals

Advanced Appeals Workshops

Each workshop is designed to assess typical and/or routine written denials as a means to establish a **point-by-point** response program. The program develops language that challenges the payer with counter-statements for each point raised in the denial correspondence. This program is designed to accommodate specific devices and services. The language is also a value as talking points in verbal discussions and can be used to debate denied pre-certifications or authorizations for service.

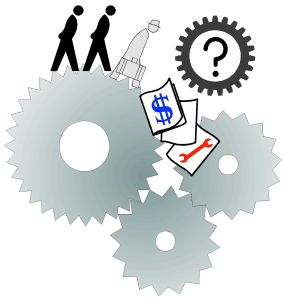
Sales Operations Guide
*
*
Ensuring Payment

Managing Managed Care Markets

The need to grow revenue is often curtailed by the many obstacles between the provider and insurance entity.

This is most evident in mature managed care markets. To enter and maintain a market while also maintaining low-risk reimbursement process, an ongoing market assessment and operations plan is vital.

These plans include preliminary and ongoing reviews of the referral base in relation to provider network and contract status. To succeed, a contract preempts selling services without the benefit of a payer agreement.



- Engineering Process - Based on Strategy, Tactics and the Desired End Result

Engineering Process with Strategic Planning …And the Desired End Result

Engineering the most efficient process or flow control requires a strategy that begins by designing the desired end result and subsequently working to outline the fewest steps and staff interventions to meet the objective. Once the process is imposed a continual process improvement plan monitors and enhances the program to ensure peak efficiency.

Avoid the trap! Plan, add milestones, document plans and milestones, illustrate plans, initiate plans, change plans, and re-establish milestones …delay success. Or, plan the end result…reverse engineer the process using technology, cost controls, efficiencies and outcomes!

Every step, every touch, every, and every move = cost and inefficiencies. Strategically re-engineering and reverse engineering each process to meet the "current" operational requirements and the desired outcomes should be an ongoing process. …More than just incremental process improvements…it's about reassessing the possibilities!

Program Development Samples

A Marketing Guide To Ensuring Payment

Strategic Marketing

Integrating reimbursement methodologies and strategies into the marketing plan ensures a lower-risk outcome to entering a new market or expanding an existing market. Included is planning for the multi-customer base (physicians, patients, and payers) that generally exists in the healthcare provider community. Marketing to the end result includes plans and disclosures designed for each defined customer.

A Guide To Evaluating and Executing Outsourcing Operations

Outsource Operational Planning

Outsourcing can substantially reduce operational costs. Often, providers execute an outsource plan without imposing their business culture and style. The guide includes checklists, interaction standards, communication style and company directed language for correspondence, key performance indicators, and accountability standards. The program focuses primarily on processes that have limited impact on the customer referral base. Lucrative examples include printing and mailing services, documentation scanning services and payment lockboxes.

A Custom Operations Guide To Regulatory Affairs

Regulatory Affairs Programs

Healthcare entities that routinely interact with government sponsored payers and/or regulatory agencies such as the FDA should create a regulatory affairs program. The program should pro-actively monitor agency proposed changes as well as to react to actual changes in regulations that impact products and/or the service/delivery process. Included is the creation of pre-determined strategies to influence the business future such as involvement with the regulatory agencies and legislators and specifically legislators with committee oversight.

Program Development Samples

A Custom Operations Guide For First to Fourth Party Reimbursement

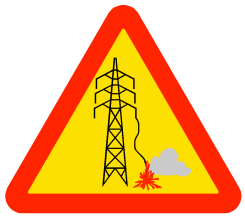
Multi-Dimensional Reimbursement Marketing Strategy

This program is a strategic marketing process developed to produce materials that subsequently support a tactical reimbursement initiative. The initiative would be designed to modify, enhance, or evolve existing reimbursement methodologies as required to support company growth objectives. The process includes tactics within multiple dimensions. They include, but are not limited to governmental and/or private insurer regulations and policy revisions while simultaneous tactics are employed at the referral source and the medical community levels.

Custom Training For Call Center Operations

Customer Centric Call Center Operations

A critical path to success must include a customer centric approach. This approach must be directed to all communications with all parties both external and internal. In the healthcare arena patients are customers, referral sources are customers, insurers are customers, and company staff are customers that together create success. Often customers are happy with the product or service until reimbursement becomes an issue. Integrating a customer centric approach to reimbursement programs ensures the "last word" about the company and the product or service is always positive. This program applies to both call center, electronic, and paper communications.



Business Continuity Plans

Simplistic Customized Plans to Ensure Operational Capabilities Under Adverse Conditions

Business Continuity Planning

Business Continuity Plans are often overlooked and rarely associated with reimbursement. Accreditation entities often require various emergency plans, disaster plans and patient care continuity plans. These requirements often arise in the contracting process. Technology has enabled these processes to be imposed with much less cost and difficulty than in past years. While supply chain and patient care is always a primary focus, business operations must be maintained to ensure the patient care process continues with minimal impact and with no negative outcomes to the final reimbursement for services. These customized programs, developed and tested nationally have been utilized to mitigate losses and enable a rapid return to normal operations.