Fiscal Policies & Procedures

Name: **Billing**

Number: **FIS 15.00**

Purpose

To establish written policy and procedures for reimbursement of clinical services.

Eligibility

This policy applies to those involved in the reimbursement process.

Definitions

Medical Systems, Inc. (MSI) is the external billing company used by Greater New Bedford Community Health Center, Inc. (GNB).

Policy and Procedures

Actions

- When MSI assigns an action to a GNB staff member, MSI will copy the action message to the claim note and assign the claim to Pending-GNB.
- When MSI receives an action from GNB, MSI will copy GNB's response to the claim note and remove the claim from Pending-GNB.
- If MSI does not receive a response within 1 week for an action assigned to a clinician, MSI will assign the action to the GNB Billing Specialist for follow-up.

Medical Records Request

All medical record releases are processed through GNB's Medical Records Department. When a Patient, Payer or Attorney requests medical records for a patient, MSI will do the following:

- Place all medical record requests on the GNB Server as follows:
    - Medical Record Requests\YYYY\XXXX where "YYYY" equals the year and "XXXX" equals the patient's account number. For example: For example: Q\|MSI\Medical Record Requests\2018\123456
- Notify GNB Medical Records via an eCW Action that a medical record request has been received for Account Number "XXXX"

MSI will manage all billing inquiries from payers, patients and attorneys that do not involve medical information.

PAYMENT POSTING

Appeals

MSI will process appeals which cannot be submitted online as follows:

- Create appeal letters using the Chief Financial Officer's electronic signature
- Name the letter file with the format "INS claim# date.doc", such as "BMC 12345 033118.doc".
- Place a copy of the letter file on the GNB server in this folder mis\Appeals, under the correct year and Payer, such as, msi\Appeals\2018\MassHealth.

Credit Balances

After MSI posts a remit, if the claim has a credit balance:

- Check the payment and confirm it is not a duplicate of a previously posted payment. In the Payment screen, you can search by Check Number.
- If the credit balance is between -$.01 and -$1.00, MSI will adjust off the credit balance with SMBAL adjustment and close the claim.
- For all other balances, MSI will place the claim in the Pending-Takeback or Refund queue for review and processing.

Posting Write-offs and Adjustments

- Inclusive services are adjusted in the CPT Payments section of the Payment Posting screen using CAS:97 (inclusive) or CAS:234 (not paid separately) so they appear as contractual adjustments on reports.
- Non-covered services are adjusted under Financial Adjustments using the Claim adjustment reason code so they appear as write-offs on reports.

GNB Employees

- For GNB Employees' Workmen Compensation claims, MSI will write off the balances using the adjustment code EMPWK without submitting to insurance.
- For GNB Employees and their family members (relatives), we will write off the following balances when all available insurances have denied a medical charge:
    - MSI will adjust off the co-pays, and the employee will pay the remaining balance.
    - MSI will write off all charges for flus and immunizations, including administration fees, and E&M code if the flu and/or immunizations were the only charges.

Employment Office Visits and Physical Examinations

- Sports Physicals
    - When the claims includes 99429 "Sports/Camp Physical Exam – Self pay":

- If the ICD-10 code is <u>not</u> Z02.5, “Routine Sports Physical”, MSI will assign an action to GNB Medical Records to confirm that this was a Sports Physical and MSI should change the ICD-10 code.
- If the ICD-10 code is Z02.5, “Routine Sports Physical”
- If the patient doesn’t have insurance, or the payer denied the claim, MSI will adjust the charges to $0 using adjustment code “SPORTS”

<u>Medicare PPS Codes</u>

When adjusting Medicare PPS claims, Payment Posters will write-off either the Medicare G payment code or the E&M code, whichever code is not paid on the remit. They will write it off as a Contractual adjustment CAS:97 (top section of the payment posting screen).

<u>Medicare Claims to Secondary Payers</u>

- If the remit indicates that a claim was forwarded to another payer, Payment Posters will move the claim to the Submitted queue.
- If the remit indicates that Medicare did <u>not</u> forward the claim to a secondary insurance and the patient has a secondary insurance, Payment Posters will submit the claim to the secondary insurance.
- If the remit indicates that Medicare did <u>not</u> forward the claim to a secondary insurance and the patient does <u>not</u> have a secondary insurance, Payment Posters will bill the patient for the coinsurance amount.

<u>Medicare Claims that do NOT contain G Payment codes</u>

- If there are multiple codes on the claim:
  - The billers will split the claim to create a Medicare A (Institutional) and Medicare B (Professional) claim
  - Please continue through the rest of this section for instructions on the resulting split claim
- If 99211 is the only code on the claim:
  - The Billers will assign the claim to the ERA PAYER DENIED queue
  - Payment Posters will write off the charge with a 99211 denial code and close the claim
- If the institutional claim contains multiple codes but NOT a G payment code
  - The Billers will assign the claim to ERA PAYER DENIED
  - Payment Posters will write off the charges for pneumococcal and influenza vaccines and administration with CAS 246 (inclusive) code.

- If 99211 exists on the claim, Payment Posters will write off the charge with a 99211 denial code.
- For codes which Medicare includes with a visit, Payment Posters will write off with a CAS 97 (Inclusive).
- Payment Posters will write off the remaining charges with a CAS 96 (Non-covered) and close the claim.

Claims Denied for Incorrect Procedure Codes

- If a claim is denied due to procedure code 97802 (MEDICAL NUTRITION, INDIV, IN, 15 min) and this is not the patient's initial assessment, MSI will replace procedure 97802 with 97803 (MED NUTRITION, INDIV, SUBSEQ) and resubmit the claims. MSI will not notify GNB.
- If a well visit (9938x, 9939x, G0402, G0438, G0439) is denied because the patient received a well visit in the last 12 months, MSI will replace the well visit CPT code with 99213 and resubmit the claim. MSI will not notify GNB.
- If 99441 (Telephone evaluation 05-10 MIN by provider or other qualified health professional) is denied by an AARP Medicare Advantage Plan, MSI will:
  - If the progress note is signed by a provider, replace 99441 with 99212.
  - If the progress note is signed by an RN, LPN or MA, replace 99441 with 99211.
  - If the progress note is signed by a nutritionist, replace 99441 with 97802.
  - If the progress note is signed by a behavior specialist, replace 99441 with 90832.
  - If none of the above, make a financial adjustment using the adjustment code that appears on the payer remit.

Claims Denied for "NDC Missing or Invalid"

If a claim is denied for "NDC Missing or Invalid" and the charge is < $2:

- If the clinician did not provide the NDC code in the Hub's Imm,T.Inj tab, then MSI will adjust the charge as a financial adjustment using the adjustment code NDC (NDC Missing or Invalid).
- If the clinician did not provide the correct NDC code in the Hub's Imm,T.Inj tab, then MSI will adjust as a financial adjustment using the adjustment code NDC (NDC Missing or Invalid)

Additional Counseling

When a claim includes an E&M code (9921x, 9938x, 9939x) and 9940x (P/M COUNSEL, INDIV XX MIN), MSI will review the note for documentation that states an additional XX number of minutes was spent counseling the patient and the subject that was discussed.

- If the documentation is present, MSI will add the 25 modifier to the 9940x code.
- If the documentation is not present, MSI will not add the 25 modifier and will adjust of the charge when the payer denies it as bundled (CAS 97) with the E&M.

Bypassing Secondary/Tertiary Submissions

With the exception of Medicare and Medicare Advantage Plans, HSN does not pay co-pays. HSN pays deductibles and co-insurances only.

Payment Posters will not submit claims to HSN as the secondary/tertiary insurance when all of the following applies:

- The balance is a co-pay only
- The patient has HSN Medical as the secondary insurance
- The patient has no tertiary insurance
- The primary insurance is not Medicare A, Medicare B, or a Medicare Advantage plan, such as “AARP Complete-United Health”.

Balances due to Missing Patient Information Required by Payers

If a Payer denies or rejects a claim because the payer requested information from the patient:

- Payer sent paperwork to the patient to complete
  - MSI will bill the patient with the statement message detailing the missing information required by the payer, such as “Please contact your insurance company regarding PIP form.”
  - MSI will create an eCW global alert for the Front Desk to remind the patient of the missing information during the patient’s next visit.
- Patient demographics in eCW do not match patient demographics in the Payer system
  - MSI will assign an action to the GNB Billing Specialist to confirm the patient demographics are correct in eCW.
  - If the patient demographics are correct in eCW:
    - MSI will bill the patient with a statement message detailing the information required by the payer, such as “Please contact your insurance company to update your date of birth.”

Patient Balances - General

Step One: MSI will make the following adjustments prior to processing a claim for patient balances:

- Dental
  - When the claims include D9450 and/or D9410
    - MSI will adjust off the charges for these services using one of the following Dentrix adjustment codes based on the type of insurance that denied the charges:
      - MassHealth Denial
      - HSN Denial
      - Commercial Denial.
    - Continue to Step Two.
- Sports Physical
  - When the claims include 99429 “Sports/Camp Physical Exam – Self pay”:
    - If the ICD-10 code is not Z02.5, “Routine Sports Physical”, MSI will assign an action to GNB Billing Specialist to confirm that this was a Sports Physical and MSI should change the ICD-10 code.
    - If the ICD-10 code is Z02.5, “Routine Sports Physical”
      - If the patient has insurance, MSI will submit the claim to the payer.
      - If the patient does not have insurance, or the payer denied the claim, MSI will adjust the charges to $0 using adjustment code “SPORTS” and close the claim.
- Vaccines
  - When all available insurances have denied the vaccine charges:
    - For CPT Code 99211, MSI will adjust off the charge as non-covered for all insurances.
    - For vaccines and vaccine administration codes:
      - MSI will bill the patient if the patient does not have one of the following insurances as primary, secondary or tertiary:
        - Medicare
        - Health Safety net
        - MassHealth Standard, excluding Limited
        - BMC Health Net, excluding Connector (QHP)
        - Tufts Health Public Plan, excluding Connector (QHP)

        - MSI will adjust off the charges as non-covered if the patient has one of the following insurances as primary, secondary or tertiary:
            - Health Safety Net
            - Medicare
            - MassHealth Standard, excluding Limited
            - BMC Health Net, excluding Connector (QHP)
            - Tufts Health Public Plan, excluding Connector (QHP)
    - If the claim balance includes a vaccine administration code for a state-supplied vaccine, and the patient does not have MassHealth and is uninsured (self-pay), underinsured, or the patient is American Indian or Alaskan Native, the patient is considered VFC-eligible patients, MSI will
        - Reduce the administration code balance to $23.29.

- <u>COVID Vaccine Administration Codes Balances (0001A, 0002A, 0011A, 0012A, 0031A)</u>
    - If a claim balance includes a COVID vaccine administration code, MSI will:
        - Adjust off the administration code balance using financial adjustment code “COVID”.
- <u>COVID Vaccine Nurse Visit Balances (T1015 for 99211)</u>
    - If a claim includes a COVID vaccine (9130x), does <u>not</u> include a COVID vaccine administration code, and the claim balance includes T1015 with the description “T1015 for 99211”, MSI will:
        - Adjust off the remaining balance for T1015 using financial adjustment code “COVID”
- <u>G Payment Codes</u>
    - If the claim balance includes a G payment code (G0466, G0467, G0468, G0469, or G0470), and the E&M code has a payment applied, MSI will
        - Adjust off the G payment code balance using financial adjustment code 97 (inclusive).
- <u>Diabetic Foot Exam</u>
    - If the claim balance includes G9226 and the E&M code has a payment applied, MSI will:
        - Adjust off the G9226 balance using financial adjustment code 97 (inclusive).
- <u>Urgent Care</u>
    - If the claim balance includes 99050 (Services After Office hours), MSI will:
        - Adjust off the 99050 balance using financial adjustment code 96 (non-covered).
- <u>Telephone Encounters</u>
    - For any telephone encounter (98966, 98967 or 98968) with a balance not covered by insurance, or the remaining balance is a patient deductible, coinsurance deductible, or co-pay, MSI will:

        - Adjust off the remaining balance as a financial adjustment using adjustment codes 1 for deductibles, 2 for coinsurance and 3 for copays.

- <u>Pandemic (COVID-19) Services for Self-pay Patients</u>
    - If the patient does not have insurance, send an action to the GNB Billing Specialist to determine if the patient qualifies for “COVID19 HRSA Uninsured Testing and Treatment Fund”:
        - If the patient qualifies, MSI will add “COVID19 HRSA Uninsured Testing and Treatment Fund” as the insurance on the claim and submit the claim.
        - If the patient does not qualify, MSI will bill the patient with the statement message: “Patient not eligible for insurance on date of service.”

Step Two: MSI will select one of the following options when all available insurances have denied a medical charge:

<u>Option 1: MSI will write off the balance when **ALL** of the following apply</u>:

- The patient is deceased.
- The patient’s family cannot pay.

<u>Option 2: MSI will adjust off the balance when **ANY** of the following apply</u>:

- The claim is denied because the provider is not yet credentialed with the insurance. MSI will adjust off the balance using financial adjustment code 185 (The rendering provider is not eligible to perform the service billed).
- The claim remaining balance is a co-pay and the only charges on the claim are a COVID vaccine and administration, or a COVID vaccine and T1015 with description “T1015 for 99211”. MSI will adjust off the co-pay using the financial adjustment code 3 (Co-pay).
- The balance is less than $2.00
    - Medical: MSI will adjust off the balance using financial adjustment code SMBAL adjustment code
    - Dental: MSI will adjust off the balance using financial adjustment code COURTESY ADJUSTMENT code
- The balance consists only of charges for codes D9450 and/or D9410 and/or 99050.
    - Medical: MSI will adjust off the balance using financial adjustment code SMBAL adjustment code
    - Dental: MSI will adjust off the balance using financial adjustment code COURTESY ADJUSTMENT code

<u>Option 3: MSI will adjust off the balance when **ALL** of the following apply</u>:

- The entire balance was denied for non-coverage, including PR (patient responsibility) codes

- MassHealth Dental did <u>not</u> deny the claim because the patient reached their maximum benefits. The patient has one of the following insurances as primary, secondary or tertiary:
  - MassHealth Standard, excluding Limited
  - Health Safety Net
  - BMC Health Net, excluding Connector (QHP)
  - Tufts Health Public Plan, excluding Connector (QHP)
- For Medical claims, MSI will adjust off the balance using financial adjustment code which appears on the payer remit.
- For Dental claims, MSI will adjust off the balance using the MassHealth Denial or HSN Denial adjustment code

<u>Option 4: MSI will bill the patient when **ONE** of the following applies</u>:

- MassHealth Dental denied the claim because the patient reached their maximum benefits for the year.
- Greater New Bedford is not contracted with the insurance and the patient is not a Qualified Medicare Beneficiary.
- The insurance is a motor vehicle accident insurance, and the claim hasn't been paid 120 days after submission to the motor vehicle accident insurance.
- The balance is greater than or equal to $2.00 and does not consist solely of CPT Code 99050, D9450 and/or D9410. MSI will adjust off 99050, D9450 and D9410 codes before billing the patient any other charges on the claim.
- The balance is greater than or equal to $2.00, and the patient is self-pay.
  - <u>For Medical claims</u>, self-pay must be selected in demographics. (if patient was self-pay on D.O.S., but now has insurance, MSI will apply self-pay adjustment to the specific date only. In this case, it does not have to be selected in Demographics):
    - If the patient was seen by a provider (not an RN), MSI will adjust off the E&M code to $170.00 for an established patient and $180.00 for a new patient using financial adjustment code SPA (Self-pay Adjustment).
    - If the patient was seen by an RN, MSI will adjust the E&M code to $0 using financial adjustment code SPA (Self-pay Adjustment).
    - If vaccines were administered, MSI will adjust <u>one</u> vaccine administration code to $23.29, and any remaining vaccine administration codes to $0 using financial adjustment code SPA (Self-pay Adjustment).
    - If the patient is 19 years or older, MSI will leave the private supply vaccine charges on the claim. Please note: If the patient is younger than 19 years, state supplied vaccines were provided at $0 charge.

        - If there's an E&M code and/or a vaccine on the claim, MSI will adjust all other codes to $0 using financial adjustment code SPA (Self-pay Adjustment).
        - If there is no E&M code and no vaccine on the claim, MSI will bill the patient for the remaining charges.
            - MSI will select "Bill to Patient" on the claim and place it in the Patient queue.
    - For Dental claims, self-pay includes only patients with no insurances listed.
        - MSI will reduce the charges by 50% before billing the patient.

- The balance is greater than or equal to $2.00 and a co-pay, and MassHealth Standard, excluding Limited, and/or HSN FULL are not listed as one of the insurances.
    - MSI will select "Bill to Patient" on the claim and place it in the Patient queue.
- The balance is greater than or equal to $2.00 and a deductible, and MassHealth Standard, excluding Limited, and/or HSN Full are not listed as one of the insurances.
    - MSI will select "Bill to Patient" on the claim and place it in the Patient queue.
- The balance is greater than or equal to $2.00 and a co-insurance, and MassHealth Standard, excluding Limited, and/or HSN Full are not listed as one of the insurances.
    - MSI will select "Bill to Patient" on the claim and place it in the Patient queue.
- The balance is greater than or equal to $2.00, is not included in the above and the patient does NOT have one of the following insurances as primary, secondary or tertiary:
        - MassHealth Standard, excluding Limited,
        - Health Safety Net Full, excluding HSN Partial co-insurance and deductible
        - BMC Health Net, excluding Connector (QHP)
        - Tufts Health Public Plan, excluding Connector (QHP)
    - If all charges were denied because the patient was not eligible, the patient has no other insurances, and no slide has been assigned (see demographics notes):
        - MSI will assign an action to the Front Desk to inquire if the patient has any other insurance.
            - If the Front Desk states that no other insurances are assigned to this patient:
                - MSI will select "Bill to Patient" on the claim.
                - MSI will add the appropriate Billing Message Codes to print on the statement, such as "Please contact our Benefits Coordinator at (774) 627-1238 to determine if you qualify for assistance."
                - MSI will place the claim in the Patient queue.

            If the Front Desk assigns another insurance to this patient:

- MSI will bill the insurance.

- If all charges were denied because the patient needs to update their insurance information:
  - MSI will select "Bill the patient" on the claim.
  - MSI will add the appropriate Billing Message Codes, and the SLIDE Billing Message Code "Please contact our Benefits Coordinator at (774) 627-1238 to determine if you qualify for assistance." to go out on the statement.
  - For Medicare claims denied erroneously because Medicare thinks the motor vehicle accident or worker's compensation insurance is still active, MSI will add the MCRP statement message (Please contact Medicare to remove the motor vehicle accident or workmen's comp insurance responsibility) and add the global alert, "Medicare not Primary Ins" so the Front Desk knows to the remind the patient to contact Medicare.
  - MSI will place the claim in the patient queue.

- If all the charges were denied because the patient was not eligible, and a slide has been assigned (see demographics notes):
  - MSI will assign an action to the GNB Patient Benefits Representative to inquire if the patient was approved for state insurance or if MSI should apply the slide.
  - If the GNB Patient Benefits Representative states insurance is available, MSI will update the payer information on the claim and submit to the payer.
  - If the GNB Patient Benefits Representative states insurance is not available, MSI will apply the slide (see section "Applying the Sliding Fee" in this document).
    - If there's a remaining balance, MSI will select "Bill to patient" and place the claim in the Patient queue.
- If the patient has only Medicare and no secondary insurance, MSI will select "Bill to Patient" on the claim and place it in the Patient queue.
- If the patient has only a commercial insurance and no secondary insurance, MSI will select "Bill to Patient" on the claim and place it in the patient queue.
- If the patient has CMSP or a commercial insurance as the primary, and HSN as the secondary, and the balance is a co-pay only, MSI will select "Bill to Patient" on the claim and place it in the Patient queue.
- If the denied charges are due to a missing referral and/or prior authorization for the date of service and the front desk has confirmed that a referral and/or prior authorization cannot be obtained, MSI will select "Bill to Patient" on the claim and place it in the patient queue.
- All other claims with patient balances, MSI will select "Bill to Patient" on the claim and place it in the patient queue.

CHARGE ENTRY - MEDICAL

- **Medical Nutrition (MNT) Services**
  - MSI will place all new MNT claims in the Pending-Medicare Nutrition queue for review by MSI Medicare Payment Poster.
  - For MNT claims without a diagnosis of diabetes, kidney failure, and/or renal failure, MSI will prepare the claim as a non-covered claim and submit to Medicare.
  - Medicare allows only one unit of 9780x per day. If the provider billed multiple units of 9780x, MSI will change the units to 1.
  - MSI will confirm there is a referral signed by a physician:
    - If there is no referral, MSI will send an action to the front desk for a referral.
      - If the front desk confirms that a referral cannot be obtained, MSI will prepare the claim as a non-covered claim and submit to Medicare.
  - MSI will confirm there is a completed and signed ABN in the patient's documents.
    - If there is no ABN in the patient's documents, MSI will send an action to the front desk to obtain a completed and signed ABN.
    - If the front desk confirms that an ABN cannot be obtained, MSI will prepare the claim as a non-covered claim and submit to Medicare.

Employment Office Visits and Physical Examinations

- Sports Physicals
  - When the claims include 99429 "Sports/Camp Physical Exam – Self pay":
    - If the ICD-10 code is not Z02.5, "Routine Sports Physical""
      - MSI will assign an action to GNB Billing Specialist to confirm that this was a Sports Physical and MSI should change the ICD-10 code.
    - If the ICD-10 code is Z02.5, "Routine Sports Physical"
      - If the patient doesn't have insurance, or the payer denied the claim, MSI will adjust the charges to $0 using financial adjustment code "SPORTS"

- Office Visit with TB Test
  - For 86580 (TB Tests) visits where the patient pays for the TB test:
    - If the encounter has the ICD-10 code Z11.1, "Encounter for tuberculin skin test", or no appropriate diagnosis code, MSI will replace/add ICD code Z02.9 "Encounters for administration examinations", to the claim and link it to the 86580 CPT code.

        - If insurance doesn't pay 99211 and/or or 99050, MSI will place the claim in the ERA PAYER DENIED queue so Payment Posters can adjust off the balance using financial adjustment code "99211".
    - If the patient was seen in Urgent Care, the patient pays a $25.00 flat-fee, and MSI will:
        - Adjust the office visit and TB test (86580) to $25.00 using financial adjustment code SPA (Self-pay Adjustment).
        - If there's no remaining balance, MSI will close the claim.
        - If there's a remaining balance, MSI will assign an action to GNB Billing Specialist to inquire if MSI should bill the patient or the insurance company for the remaining balance.
            - If GNB Billing Specialist states to bill the insurance company, MSI will unselect the office visit and TB test on the claim to exclude it from the insurance billing.
            - If GNB Billing Specialist states to bill the patient, MSI will add the statement message PR96, "This service is not covered by insurance", and place the claim in the patient queue.
    - If the patient was not seen in Urgent Care, and the patient pays $75 for an office visit without a TB test or $85 for an office visit with a TB test:
        - If the ICD-10 code is not Z00.8, "Encounter for work capability", Z02.89, "Physical examination of employee", or Z02.1, "Encounter for pre-employment examination":
            - MSI will assign an action to GNB Billing Specialist to confirm that this was a work-related visit and MSI should change the ICD-10 code.
        - If the ICD-10 code is Z00.8, "Encounter for work capability", Z02.89, "Physical examination of employee, or Z02.1, "Encounter for pre-employment examination":
            - The fee of $75 covers the office visit without a TB test, so MSI will adjust off the balance > $75 for the office visit using financial adjustment code "SPA", Self-pay Adjustment.
            - The fee of $85 covers the office visit and TB test, so MSI will adjust off the balance > $85 for the office visit and TB test using adjustment code "SPA", Self-pay Adjustment.
            - If there's no remaining balance, MSI will close the claim.
            - If the remaining balance is a co-pay only, MSI adjust it off using "SPA", Self-pay Adjustment.
            - If there's a remaining balance, MSI will assign an action to the GNB Billing Specialist to inquire if MSI should bill the patient or the insurance company for the remaining balance.

        - If the GNB Billing Specialist says to bill the insurance company, MSI will deselect the office visit and TB test from the claim, so it's excluded from insurance billing.
        - If the GNB Billing Specialist says to bill the patient, MSI will add the statement message PR96, "This service is not covered by insurance", and place the claim in the Statement queue.
    - When the patient returns for the TB reading and there are charges on the claim, MSI will:
        - If the claim does <u>not</u> include 99211 linked to diagnosis R76.11, R76.12 or Z11.1, MSI will send an action to the provider for approval to add these codes.
        - If the claim does include 99211 linked to diagnosis R76.11, R76.12 or Z11.1, MSI will bill the payer
        - If there's a patient balance after the payer adjudicates the claim, such as a co-pay and/or deductible, MSI adjust it off using financial adjustment code SPA (Self-pay Adjustment).

<u>Motor Vehicle Accident and Workers Comp Claims with Other Services</u>

If an MVA/WC claim contains other services, such as flu shot, MSI will split the claim, assigning the Office visit to the MVA/WC claim and the other services to the claim for the patient's priority payer.

<u>Claims with No E&M Code</u>

If an encounter does not contain an E&M code:

- If the provider is an OB/GYN provider, MSI will take no action.
- If the encounter includes a vaccine, MSI will take no action.
- If the provider is a nurse, MSI will add the 99211 E&M code to the claim. MSI will not notify GNB of this change.
- If the provider is not a nurse, MSI will assign the encounter back to the provider to add an E&M code.

This billing procedure is based on GNBC's policy that all encounters must have an E&M code.

<u>Procedure Codes: Linked and/or Not Linked to Diagnoses</u>

- If no procedure code is linked to diagnosis Z59, MSI will:
    - Link an appropriate procedure code to the diagnosis and will not notify GNB.
    - If no appropriate procedure code exists on the encounter, MSI will assign an action to the provider to link Z59 to a procedure.

- If each procedure on the encounter is linked to at least one diagnosis, but not all diagnoses are linked to a procedure, MSI will remove the unlinked diagnoses from the claim and submit the claim. MSI will not notify GNB of the change.
    - Please note: MSI recommends that GNB providers link each diagnosis on the encounter to a procedure.
- If each procedure on the encounter is not linked to at least one diagnosis, MSI will do the following:
    - If MSI knows to which diagnoses the procedure should be linked, MSI will link the procedure to the diagnosis. MSI will not notify GNB of the change.
    - If MSI does not know to which diagnoses the procedure should link, MSI will assign the encounter back to the provider to link the procedure to a diagnosis. If appropriate, MSI will recommend the diagnosis to which the procedure should be linked.
- If a procedure is linked to the incorrect diagnosis, MSI will link the procedure to the correct diagnosis. MSI will not notify GNB of the change.

Procedure Codes: Age and Gender Specific

If a provider selects the incorrect procedure code based on the patient's age or gender, MSI will change the procedure to the corresponding age or gender specific code and MSI will not notify GNB of the change.

For example, the provider selects 99385 (preventive care new pt. age 18-39) but the patient is 17 years old, so MSI will change the code to 99384 (preventive care new pt. age 12-17) without notifying GNB.

Procedure Codes: Obsolete, Incorrect and/or Missing

- If a procedure on the encounter is obsolete (no longer included in the CPT code set), MSI will do the following:
    - Assign the encounter back to the provider to select the correct procedure. If appropriate, MSI will recommend the correct procedure.
    - Inactivate the obsolete code (highlighted in red in the CPT listing) in eCW.
- If procedure code 82607 (B12 lab test) appears on the encounter,
    - If MSI can confirm a B12 injection was administered by reviewing the progress note, MSI will replace procedure code 82607 with J3420 (B12 injection). MSI will not notify GNB of this change.
    - If MSI cannot confirm a B12 injection was administered by reviewing the progress note, MSI will assign an action to the provider to confirm that a B12 lab test was ordered, or a B12 injection was given:
        - If the provider confirms that a B12 lab test was ordered, MSI will delete procedure code 82607 from the encounter because GNB sends 82607 to an outside lab and does not perform this test in-house. MSI will not notify GNB of this change.

    - If the provider confirms that a B12 injection was given, MSI will replace procedure code 82607 with J3420 (B12 injection). MSI will not notify GNB of this change.

- If procedure code 97802 appears on the encounter and this is not the patient's initial assessment, MSI will replace procedure 97802 with 97803. MSI will not notify GNB.
- If a procedure on the encounter is incorrect and will cause the claim to be denied, MSI will assign an action to the provider to select the correct procedure. When appropriate, MSI will recommend the correct procedure.
- If a procedure on the encounter is missing, MSI will assign the encounter back to the provider to add the missing procedure. When appropriate, MSI will recommend the missing procedure.

Procedure Codes: New or Established Patients

If we receive a denial or rejection for a procedure code for a new or established patient, MSI will change the procedure code on the claim to new or established patent, respectively. For example, if the provider used code 99202 (new patient visit) for an established patient, MSI will change the code to 99212 (established patient visit). MSI will not notify GNB of the change.

Procedure Codes: Use of "G" (other than payment codes) and "F" Codes

- If a provider uses a "G" code for an insurance other than Medicare and other insurances who accept a subset of "G" codes, MSI will do the following:
    - If there's a one-to-one match between the CPT and G code, MSI will create a system rule to replace the CPT code with the correct "G" code,
    - If there is not a one-to-one match between the CPT and G code, MSI will assign an action to the provider to replace the "G" code with the correct CPT code. When appropriate, MSI will recommend the replacement procedure code.
- If a provider uses a CPT code for Medicare where a "G" code is required, MSI will do the following:
    - If there's a one-to-one match between the CPT and G codes, MSI will create a system rule to replace the CPT code with the correct "G" code.
    - If there is not a one-to-match between the CPT and "G" codes, MSI will assign the encounter back to the provider to replace the CPT code with the correct "G" code. When appropriate, MSI will recommend the correct "G" code.
- If a provider uses a CPT code that ends in "F", MSI will deselect the "F" code and submit the claim. MSI will not notify GNB of this change.

Procedure Codes: Vaccines and Administration

- MSI configured eCW to automatically add the administration code of 90471 to the progress note whenever the provider includes a vaccine.
- When a vaccine's specified age is less than 18, MSI configured eCW to automatically add the Peds administration code of 90460 to the progress note whenever the provider includes a Peds vaccine.
- When a vaccine is given orally, MSI configured eCW to automatically add oral administration code of 90473.
- MSI will make the following changes on claims and MSI will not notify GNB:
  - If a vaccine doesn't have an administration code:
    - MSI configured eCW to automatically add the administration code of 90460 or 90471 for injections and 90473 for orals to the note whenever the provider includes a vaccine.
    - MSI will add the correct administration code to the claim and MSI will not notify GNB.
  - If the administration code is 90471or 90472 and the patient is under 18, MSI will change the administration code to 90460 or 90461 (subsequent vaccines and MSI will not notify GNB).
  - If an encounter contains multiple vaccines, MSI will change the administration codes as follows, and MSI will not notify GNB:
    - From 90471 to 90472 for the subsequent vaccines
    - From 90460 to 90461 for the subsequent vaccines (Peds)
    - From 90473 to 90474 for the subsequent vaccines (given orally)
    - Please note: for Medicare, MSI will use the following administration codes:
      - Flu – G0008
      - Pneumovac – G0009
      - Hep B – G0010

Medicare Claims that contain 99211 or No G Payment codes

MSI will process Medicare claims which contain 99211 as follows:

- If 99211 is the only code on the claim:
  - The Billers will assign the claim to the ERA PAYER DENIED queue for the Payment Posters to post a financial adjustment of "99211".
- If there are multiple codes on the claim:
  - MSI will split the claim to create a Medicare A (Institutional) and Medicare B (Professional) claim
  - If the institutional claim does not contain a G payment code
    - The Billers will assign the claim to ERA PAYER DENIED queue for the payment posters to post a financial adjustment of "99211".
  - If the institutional claim has a G payment code

Procedure codes 83036 and 83037

These procedures represent the same test, "GLYCATED HEMOGLOBIN TEST", except 83037 is used with a machine FDA-approved for home use. Payers will pay one and deny the other. Payers pay the same fee for both procedures. When an encounter contains both procedures, MSI will delete 83036 from the claim and MSI will not notify GNB of the change.

Contraception Claims

- When CPT Code J7298 (LNG-RELEASING IUC SYS 52MG 5 YR DUR), J7300 (INTRAUTERINE COPPER CONTRACEPTIVE), or J7307, (ETONOGESTREL IMPLANT SYSTEM), appears on the claim, and the claim does not contain the following:
  - Diagnosis: Z30.017
  - CPT 11981 (INSERT DRUG IMPLANT DEVICE) or CPT 11983 (REMOVE/INSERT DRUG IMPLANT) or 58300 (IUD, INSERTION)
    - MSI will add the diagnosis and the appropriate insertion code to the claim. MSI will not notify Greater New Bedford of the change.
- When CPT Code CPT 11981 (INSERT DRUG IMPLANT DEVICE) or CPT 11983 (REMOVE/INSERT DRUG IMPLANT) or CPT code 58300 (IUD, INSERTIN) appears on the claim, and the claim does not contain one of the following:
  - J7298 (LNG-RELEASING IUC SYS 52MG 5 YR DUR)
  - J7300 (INTRAUTERINE COPPER CONTRACEPTIVE)
  - J7307, (ETONOGESTREL IMPLANT SYSTEM),
    - Based on the progress note, MSI will add the appropriate contraception "J" code to the claim and MSI will not notify Greater New Bedford of the change. If MSI cannot discern the appropriate contraception "J" code from the progress note, MSI will send an action to the provider asking for the correct "J" code.

Diagnosis and Primary Diagnosis Replacement

- For claims with MassHealth Limited as the payer and a COVID vaccine CPT,
  - If diagnosis Z20.828 is on the claim, MSI will link the COVID vaccine CPT to this diagnosis.
  - If diagnosis Z20.828 is not on the claim, MSI will add this diagnosis to the claim and link it to the COVID vaccine CPT.
- For claims with BMC as the payer and multiple diagnoses with pregnancy as the primary diagnosis, MSI will move pregnancy to the secondary diagnosis and move another diagnosis listed on the claim to primary.
- If a claim is denied for "invalid primary diagnosis", and a valid primary diagnosis exists on the claim, MSI will change the priority order and link the procedures to the primary diagnosis. If a valid primary diagnosis doesn't exist on the claim, MSI will send an action

to the provider to change the primary diagnosis. If appropriate, MSI will make a recommendation on which diagnosis should be the primary.

- MSI will replace the following diagnoses on each claim and MSI will not notify GNB:
  - If the claim has a preventive diagnosis but a standard E&M code, MSI will change the procedure code to a preventive visit.
    - For example, if the diagnosis is Z00.00 (Encounter for preventative adult health care exam) and the procedure code is 99214 (Office Visit, Est Pt, Level 4), MSI will change the procedure code to 9938x (Preventive Care New Pt. Age X) or 9939x (Preventive Care Est Pt. Age X).
  - If the claim has an age-specific diagnosis that is not appropriate for the patient's age, MSI will replace the diagnosis with the same diagnosis that's appropriate for the patient's age.
    - When the diagnosis codes Z68.3x (BMI adult) are included on a claim for a patient under 21 years of age, MSI will change the diagnosis code to the match Z68.5x (BMI child) code
  - If Z59.0 (Homeless) or Z62.21 (Child in foster care) is the primary diagnosis on a claim, MSI will make the secondary diagnosis as the primary diagnosis on the claim. If the second diagnosis is not a valid primary diagnosis, MSI will ask the provider for a valid primary diagnosis. When appropriate, MSI will make a recommendation to the provider.
  - If the primary diagnosis is Z76.89 (Encounter to establish care) on the claim, MSI will move the second diagnosis to the primary position. If the second diagnosis is not a valid primary diagnosis, MSI will ask the provider for a valid primary diagnosis. When appropriate, MSI will make a recommendation to the provider.
  - If the "Z23" diagnosis (Encounter for immunization or Vaccination) is missing for a vaccine or immunization, MSI will add the correct "Z23" diagnosis code and link it to the vaccine procedure code.
  - When the procedure code is 99188 (APP TOPICAL FLUORIDE VARNISH) and the linked diagnosis is not Z29.3 (Encounter for prophylactic administration of fluoride), MSI will add Z29.3 to the claim and link it to 99188.

Patient Names

When a payer denies a claim for incorrect patient name, including misspellings, name change, etc., MSI will enter the payer's version of the patient name in the "Insured's Alternative Name Field" in the patient demographics insurance information. Only claims for this payer will include this name for the patient.

Patient Insurances

- If a medical claim is assigned a dental insurance, MSI will remove the dental insurance from the claim.

- If a medical insurance exists in the patient's insurances, MSI will assign that insurance as the primary on the claim.
- If no other insurance exists, MSI will assign and action to the GNB Billing Specialist with an action type of "Billing Missing Information" to confirm that the patient has no medical insurance, and we should bill the patient.
- If a medical claim is assigned to the patient and the patient has no insurance, MSI will assign the encounter to the GNB Billing Specialist to confirm that the patient has no medical insurance and MSI should bill the patient.

Durable Medical Equipment (DME)

MSI will submit all closet supplies (DME) as they appear on the encounters, such as bandages, crutches, etc. When we receive a denial requesting vendor invoices, MSI will do the following:

- Adjust off any supply worth less than $25 using the financial adjustment code DME.
- Obtain a copy of the invoice from GNB and upload it to the payer website with the resubmitted claim.

Explosion (Automatic Replacement) Codes

Explosion codes are configured in eCW to automatically replace or add a procedure code. This is typically done for government payers who require a different code than other payers. Please note the following:

- Explosion code replacements and additions occur when the provider enters the procedure on the note. As a result, the replacement code appears on the encounter before the claim is created. For example, if the provider selects 99212 for a Mass Health patient visit, "T1015" with the description "T1015 for 99212" will appear on the encounter.

For all of the above:

- If MSI has a recommendation for coding, MSI will include it in the body of the action.
- MSI will assign the action using "Billing Missing Information" as the action type so GNB staff can sort by action type and work through the tasks required for claim submission.
- GNB will assign a staff member to review all providers' tasks with the "Billing Missing Information" action type, and follow-up with the providers to make the corrections. Please note: Most payers provide 60 days from date of service to claim submission then will deny the claim for untimely filing.
- Please note: Any changes made by MSI will appear in the claim on the PM side but will not appear in the Encounter Note on the EHR side.

- When MSI assigns an action to GNB regarding a claim, and the claim cannot be submitted until MSI receives a response from GNB, MSI will place the claim in the Pending-GNB queue until a response is received. Please note: GNB's timely response on billing actions will prevent timely filing denials.

SELF – PAY

HSN Teen Confidential

When a patient has HSN Teen Confidential as an insurance, MSI will set the patient parameter "Statements – do not send" (located at Demographics\Additional Info).

When the patient has a balance and no payment has been made after one year, MSI will adjust the balance using adjustment code PTBAL for bad debt.

Posting Patient Payments

When posting a patient payment, MSI will apply the payment to the patient's oldest balance(s).

In addition, MSI will review all payments posted by the Front Desk and other Client Staff, and when applicable, MSI will apply the payment to the patient's oldest balance(s).

Applying the Sliding Fee

When applying a sliding fee to a patient's balance:

- If the patient has HSNO Partial, MSI will apply the slide to the 20% deductible.
- If the patient has HSN, MSI will apply the slide to the entire balance, including co-pay, deductible and co-insurance.

If GNB notifies MSI that a patient, previously approved for sliding fee, now has insurance, MSI will:

- Reverse the sliding fee for all claims with a date of service starting on the insurance effective date.
- Submit the claims to the payer.

Patient Returned Checks

When a patient check is returned for insufficient funds, MSI will reverse the payment by adding a new "credit" payment for the same amount and check number and add an adjustment using code "SPA" for the $7.50 bank charge for a returned check. For example, if a $15.00 check is returned, MSI will add a patient payment for ($15.00) and an SPA adjustment for $7.50.

Co-pays

If the co-pay doesn't match the co-pay amount on the patient's insurance card ($10 for BMC) and GNBCHC - URGENT CARE" is not the facility:

- If the provider is credentialed as a Specialist. Before billing the patient, MSI will reduce the specialist co-pay using financial adjustment code 3 (Co-payment Amount), to the standard co-pay, except for patients seen by the following providers who are Specialists:
- Crowe (Podiatry)
- Tiwari (Infectious Disease)
- Naz (Infectious Disease)
- If the provider is not credentialed as a specialist, and the co-pay does not match the patient's insurance card (BMC co-pay should be $10), MSI will place the claim in the ERA Payer Denied queue with a note stating, "Provider is not a specialist, please review copay." for the payment poster to review.

Statements

Before statements automatically compile on the second Tuesday of each month, MSI will:

- Post all patient payments
- Post all patient refunds processed by GNB
- Close all patient claims with $0 balances
- Move all patient claims with balances less than $0 to the "Refund - Patient" queue for review to determine if a refund is due.
- Post all patient refunds for claims in the "Refund – Patient – GNB" queue if GNB processed the refund checks.
- Complete adjustments for claims in the "PWO" Collection status queue for which MSI completed all Collections efforts
- In all queues except the "Statements" queue, review each claim with Patient as the payer to determine if the patient should be billed.
- Remove statements with invalid addresses and set a global alert for the Front Desk to obtain a valid address when the patient next presents.

Patient Collections

General Rules

- To avoid duplicate calls, MSI will place calls in the most current Collection Status and work backwards (call order: PWO, C3, C2, C1).
- Before MSI calls each Guarantor:
    - MSI will check the patient's balances and correct any erroneous credit balances by checking off "Bill to Patient" in the claim. These are indicated by the same credit balance for the patient and debit balance for the insurance so the claim totals $0.
    - MSI will check the statement message:
        - If it refers to eligibility, MSI will check the patient's eligibility. If the patient now has insurance that covers the date of service, MSI will check off the appropriate insurance and submit the claim.
        - If it refers to mismatched information between eCW and the payer system, such as name, gender or eye color, MSI will check to see if the information now matches. If it does, MSI will check off the appropriate insurance and submit the claim.

- There are 4 Spanish Interpreter collection cycles (SI-1, SI-2, SI-3, SI-PP) that match standard collection cycles (C1, C2, C3, PP). If a patient needs an interpreter, MSI will move the account to SI-1 (Call 1: >$24.99 >150 days) and MSI's Spanish-speaking staff will assume this account.
- For all calls, MSI will ask for the guarantor.
- If a guarantor makes a co-payment on a recent visit that occurred in the last 60 days or less, MSI will remove the account from collections.
- If a guarantor agrees to a payment plan, MSI will move the account to PP (Payment Plan) and add the PTPLAN statement message to each claim involved. If the guarantor misses 2 consecutive payments, MSI will move the account to C1 and begin the process again.
- For account balances less than $25.00 where each claim balance is older than 12 months, MSI will write off the balances as Patient Bad Debt (adjustment codes PTBAL or PTBALM)
- Months 1 through 5: MSI will send statements
- Month 6 – Call 1 (C1/SI-1):
    - If the guarantor makes no payment on their account and the account balance is greater than or equal to $25.00, MSI will make a collection call then move the account to:
        - PWO (Pending Write-off) if the balance is less than $50.00

        - C2/SI-2 (Call 2: >$49.99 >180 days) if the balance is greater than $49.99

- Month 7 – Call 2 (C2/SI-2):
    - If the guarantor makes no payment on their account and the account balance is greater than or equal to $50.00, MSI will make a collection call then move the account to:
        - PWO (Pending Write-off) if the balance is less than $250.00
        - C3/SI-3 (Call 3: >$249.99 >210 days) if the balance is greater than $249.99
- Month 8 – Call 3 (C3/SI-3):
    - If the guarantor makes no payment on their account and the account balance is greater than or equal to $250.00, MSI will make a collection call then move the account to PWO (Pending Write-off).
- Month 9 (PWO):
    - If the guarantor makes no payment on the account, MSI will write off the balances for the claims for which at least 5 statements were sent.
    - To distinguish between Medicare and other patients, MSI will use 2 distinct adjustment codes, so the Medicare cost report is accurate:

  - For balances that were submitted to Medicare at least once, MSI will write the balance using the code PTBALM – Patient (Medicare) Bad Debt Adjustment.
  - For balances that were never submitted to Medicare, MSI will write off the balance using the code PTBAL – Patient Bad Debt Adjustment.

<u>Finalized script for voicemail messages</u>

Medical – eCW

- Hello. I am calling from Greater New Bedford Community Health Center to remind you of a past due balance of ($ balance). At Greater New Bedford, we understand that it is not always easy to pay your bills on time. That is why we offer payment plans to help you pay the portion of your bill that your insurance will not cover. We can set up a one-year plan, a two-year plan, or an extended plan that works best for your life circumstances. For more information, you can reach us at 866-522-1799. Thank you and have a good day.

Dental – Dentrix

- Hello. I am calling from Greater New Bedford Community Health Center's Dental Department to remind you of a past due balance of ($ balance). At Greater New Bedford, we understand that it is not always easy to pay your bills on time. That is why we offer payment plans to help you pay the portion of your bill that your insurance will not cover. We can set up a one-year plan, a two-year plan, or an extended plan that works best for your life circumstances. For more information, you can reach us at 866522-1799. Thank you and have a good day.

Script when Speaking with the Guarantor

Medical – eCW

- Hi. I am calling from Greater New Bedford Community Health Center regarding your past due balance of ($ balance). Would you be interested in setting up a payment plan?
  - If they say yes, MSI will ask them how much they would like to pay each month. MSI will accept whatever amount they say and tell the guarantor that we will make a note of the payment plan in their record. MSI will:
    - Make a note of the payment plan in the Account Inquiry log.
    - Move the Account to PP (Payment Plan)
  - If the Guarantor commits to making a payment in full, MSI will
    - Make a note of the commitment in the Account Inquiry log
    - Move the account to the next collections cycle.
  - If the guarantor wants to make a credit card payment over the telephone, MSI will instruct them to call 508-992-6553 and ask for the Registration Department. If the guarantor states that they cannot pay the balance, MSI will ask them to call 508-992-6553 and ask for the Benefits Department to determine if they qualify for assistance (sliding fee).

Dental – Dentrix

- Hi. I am calling from Greater New Bedford Community Health Center's Dental Department regarding your past due balance of ($ balance). Would you be interested in setting up a payment plan?
  - If they say yes, MSI will ask them how much they would like to pay each month. MSI will accept whatever amount they say and tell the guarantor that we will make a note of the payment plan in their record. MSI will:
    - Make a note of the payment plan in the Dentrix Collections log.
  - If the Guarantor commits to making a payment in full, MSI will
    - Make a note of the commitment in the Dentrix Collections log
    - Move the account to the next Collections cycle.
  - If the guarantor wants to make a credit card payment over the telephone, MSI will instruct them to call 508-984-7031 and ask for the Registration Department.
  - If the guarantor states that they cannot pay the balance, MSI will ask them to call 508-992-6553 and ask for the Benefits Department to determine if they qualify for assistance (sliding fee).

Documenting the Call

MSI will log the activity in eCW and Dentrix as follows:

- In the Collections Management screen, MSI will move the account to the next Collection Cycle.
- In the Account Inquiry screen's Notes section:
    - If MSI leaves a voicemail: "Collections: left V/M"
    - If MSI speaks to the patient: "Spoke to Patient regarding Collections and Patient"
        - Add patient's response, such as "committed to payment plan for $5 per month".