Momentum Billing

Your Progressive Partner in Healthcare

Using a Foolproof Verification System to Avoid Claims Denials

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Presenters

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About Us

- Momentum Billing (Momentum) provides technology and revenue cycle management services to rehab practices throughout the U.S.
- Based in San Diego, CA
- Comprehensive expertise in PT, OT and Speech
- Sponsors of various PT groups; Speakers at major conferences; Experts at political roundtables; Forefront of industry and payer changes; Preferred billing vendor for PTPN and PTP

Momentum provides:

1. *Billing and collections services*
2. *Contracting and credentialing assistance*
3. *Compliance training and billing education*
4. *Technology – PM & EHR (full integration with* WebPT®*)*
5. *Advanced Practice Reporting and Analytics*

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Introduction

- What, why, when, how??

- What is a “verification”?
  - The process by which one determines a patient’s eligibility to receive treatment using their insurance for payment
  - Determines the patient’s portion owed (may be estimated), who to bill and what treatment(s) is approved
- Why are they important to perform?
  - So you don’t treat for free!
  - Manage patient expectations
  - Accurate billing
- When should they be done?
  - Prior to seeing a new patient
  - When plan effective dates are expired, or calendar/fiscal years
- How should they be done?
  - Performed through a comprehensive, guided template

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Why are Verifications Important?

- So you are not treating for free
  - Authorization may be required when not expected
    - Aetna, BC MC Advantage, Tricare Prime vs Select, Cigna, UHC, HMO's
  - Patient's coordination of benefits
    - Patient may present as MC but actually MSP or MCO
    - Patient's primary payer vs secondary payer
  - Providers contracted?
  - Understand benefit limitations
    - Is there a Therapy max and has it been met through another provider?
  - Is a referral required?

- To manage patient's expectations
  - Prepare patients for their costs / patient portions
  - Prepare patients for how they can be scheduled depending on benefits with insurance
  - Prepare patients to potentially visit their MD depending on coverage specifics

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Why are Verifications Important? … Continued

- To know coverage limitations so treatment plans can be adapted
  - Adjusting intensity of visits given authorized visits,
  - Adapting to specific interventions, etc

- Accurate billing and claims routing
  - Does the payer require attachments to claims (daily notes, Rx, invoices for DME, etc)?
  - Does the claim go to the payer or to an intermediary?
    - Sedgwick as a payer can go to Corvel or Medrisk or One Call depending on employer or provider's contracts
  - In some states, if a provider is contracted with Cigna, everything is handled by an intermediary … American Specialty Health
  - Treating veterans … depending on how the referral was received, claims are routed to different intermediaries (VA Medical Center or Humana / Triwest)

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When should Verifications be Performed?

- Before patient comes in for their first visit (or before scheduling)
  - So you know if patient can be treated at your facility
  - To prepare patients for their costs
  - To obtain all necessary elements the insurance requires (Patient Summary Forms, Rx, School Injury Forms, Claim Numbers, Authorization, Referral, etc)
- When effective dates expire
  - Capture if patient is on a calendar or fiscal year plan
  - Re-verify when these dates are met to determine continued eligibility or changes to patient costs
- If patients coverage has changed or patient is Medicare aged
  - Consistently ask if patients coverage has changed
    - Patients may change jobs, or become of age for different coverage
    - Patients may have cobra or “exchange plans” that are 30 day coverage cycles
- If patient has been away for more than 30 days
  - Re-verify if patient’s coverage has changed

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How should Verifications be Performed?

- Develop comprehensive forms/templates that ask all necessary questions
  - May consider a different form for each payer scenario (Comm'l, Medicare, WC, Auto, etc)
- Below is a snapshot of the "musts" for a complete verification. Every slot mentioned is important to avoid gaps in knowing exactly what treatment can be paid and how much the patient will owe.
- Color coding certain fields or identifying which fields to capture from the patient and what information to capture from the payer will make obtaining information more efficient.

	Office Completes
	Info to get from Patient
	Info to get from Insurance

PRIMARY INSURANCE	Type:							
Insurance :				Cust Serv #:				
Name of Insured:				Relationship:			DOB:	
Insurance ID #:					Grp #:			
Claims Address:								
Effective Dates:		Choose one:				Date Vrfd?		
In Network Benefits:								
Copayment:		Insurance Coverage:			Coinsurance:			
Deductible Amount:		Deductible Met:			Visit Limit:		Visit Limit Met:	
Out of Pocket Max:		OOP Max Met:			Max Benefit Paid:		Max Met:	
Preauth Req?:								
Out of Network Benefits:								
Copayment:		Insurance Coverage:			Coinsurance:			
Deductible Amount:		Deductible Met:			Visit Limit:		Visit Limit Met:	
Out of Pocket Max:		OOP Max Met:			Max Benefit Paid:		Max Met:	
Preauth Req?:								
NOTES:								

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How should Verifications be Performed? … Continued

- Make sure verification person knows practice contract specifics
  - Develop a grid with all contract scenarios identified and make sure it stays up-to-date
- Understand which payers can be verified online vs calling
  - Use online access for Medicare and check all tabs HHA, MCO, MSP
  - Use ASHLINK for Cigna instead of calling Cigna
  - Use OPTUM for UHC instead of UHC
- Let's review actual VOB templates and a sample reference guide

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Summary

- Verifications are imperative to your practice's success as it relates to accurate billing, satisfied patients and consistent cash flow.
- Key to getting clean claims out the door
- Have tools that assist in sharing knowledge and drive consistency of process
- Don't skimp on this precious step in your practice!

Questions?

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