Virginia's Free Clinics as Medicaid Providers: Mechanics and Considerations in Establishing a Billing Infrastructure

This document is one in a series of tools and white papers produced by the Virginia Health Care Foundation to help Virginia's free clinics professionalize various aspects of their operations.

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Virginia's Free Clinics as Medicaid Providers: Billing Medicaid

As 2014 approaches, Virginia's free clinics recognize that the *Patient Protection and Affordable Care Act* could change the insurance eligibility of a majority of their patients, with estimates showing that on average, about 70 percent of free clinic patients could be eligible for Medicaid coverage. This percent is so high because Virginia's current Medicaid eligibility criteria for adults is among the lowest in the nation (*30% Federal Poverty Level*).

This significant change in eligibility and the shortage of Medicaid providers in many areas is leading many free clinics to consider the adoption of a hybrid model of operation – where both the uninsured and those newly covered by Medicaid are offered services. For free clinics that elect to become a Medicaid provider, a number of operational changes will be required.

This paper is designed to help clinics with one aspect of those changes – billing for services for Medicaid patients. It explains how to obtain a National Provider Identification number, the credentialing of providers, and describes options for billing. Separate papers and resources address other requirements of becoming a Medicaid provider. They can be found at www.vhcf.org and www.vafreeclinics.org.

There is a sequence of activities necessary to become a Medicaid provider. First, a free clinic must determine that the managed care organizations (MCOs) doing business in its service area are willing to contract with it (*they are not required to do so*). Then, it should work through the details of the MCO contracts and reach agreement with each MCO. There is no need to embark on billing and credentialing preparations until these steps have been completed.

Preparing to Bill Medicaid

I. Obtaining a National Provider Identification Number

To begin, the free clinic administrator will need to secure a National Provider Identification (NPI) number for the clinic. This is a fairly simple process and can be completed in about twenty minutes. To complete the process online, visit https://nppes.cms.hhs.gov. Have the following information ready before starting the process:

- Organization Name
- Federal Employer Identification Number (EIN)
- Name of Authorized Official for the Organization
- Phone Number of Authorized Official for the Organization
- Organization Mailing Address

- Practice Location Address and Phone Number
- Taxonomy (*This defines your clinic's provider type. For most free clinics, it is likely to be 193200000x – Group Multi-Specialty or 208D00000x – General Practice or 207Q00000x – Family Medicine. For a complete list of taxonomy codes, visit www.wcp-edi.com/codes/taxonomy*)
- Contact Person Name
- Contact Person Phone Number and E-mail

II. Credentialing Providers

In order to obtain payment, all providers who will be providing services to Medicaid patients must be properly credentialed by the Virginia Department of Medical Assistance Services (*DMAS*) and each of the seven managed care organizations (MCOs) with which the free clinic intends to contract.

To achieve this, the free clinic administrator will need to ask each of the providers who will be treating Medicaid patients and billing for services to supply the background information required for credentialing. Specifically, each provider must:

1) Complete a one-time, online credentialing form. This process typically takes about 90 minutes to two hours and can be done online at www.caqh.org. A provider only has to complete this process once, and then every health plan can access the information from the secure website. *Note: If a provider has already completed this process for his/her own practice, it does not need to be done again.*

2) Complete a separate credentialing form for DMAS. This form is shorter than the one used by the MCOs. It will take about 45 minutes to complete the 38 required questions and sign the agreement. This form is available at www.virginiamedicaid.dmas.virginia.gov, (*select "provider enrollment."*). Again, if the provider has completed this process for his/her own practice, it does not need to be done again.

The free clinic administrator will then need to complete a Virginia Medicaid enrollment package for the entire clinic. It is located at www.virginiamedicaid.dmas.virginia.gov (select "group enrollment packet." It includes 30 questions and will take about 30-45 minutes to complete.

After these steps have been completed, the free clinic administrator should contact each health plan with which the clinic wants to participate, and provide a complete list of providers who will be linked to their clinic's National Provider Identification Number. (*Please note that one provider's number can be linked to multiple groups*).

Once this list is approved by each of the health plans, the credentialing process is complete!

Which Option For Your Clinic: In-House vs. Third Party Billing?

Billing is not a task that should be taken lightly. To bill correctly and effectively requires special expertise and training, especially as it relates to coding and documentation. In order to submit a claim, a clinic will need to have someone knowledgeable about the proper codes to be used (now ICD-9 codes, will become ICD-10 codes in 2014) and the rules and regulations regarding time and quantity limitations for certain services. This requires a real expertise, and continuing education is a must, as the requirements are continually changing.

While the submission of claims does not require extensive documentation, there is a legal expectation that the necessary documentation can be found in the patient's file at all times. **Failure to document properly is the biggest mistake made by both new and established Medicaid providers**.

The consequences of inadequate documentation can be serious and may lead to lost revenue when the services provided are inappropriately identified or not captured. They may also lead to costly legal defense fees when it appears that a clinic is "over billing" by charging for services not provided and/or billing for a higher level of services than were provided (called upcoding).

A clinic must make certain that it has the people and systems in place to ensure quality coding and documentation. To do this, a clinic has two choices. It can hire an experienced professional and conduct the billing "in-house", or contract with a vendor that specializes in billing for medical practices. Both are viable approaches; each has its pros and cons.

Billing In-House:

A free clinic can handle its own billing by hiring experienced professionals to complete this task on-site as clinic employees.

There are two main benefits to this option.

- Timely identification and resolution of inadequate documentation. An onsite employee engaged in coding and billing can actively review the clinic's supporting documentation and make certain that it is sufficient to meet all MCO and Medicaid requirements. When a problem in documentation is spotted, an onsite employee can readily identify the individual that needs additional training and/or develop a new system to ensure improved compliance. This service may be especially valuable in a free clinic setting, where the transition to detailed documentation may be difficult for some volunteer providers.

- Enhanced collection of Medicaid payments. Successfully financing free clinic operations requires leveraging every dollar. A free clinic employee who fully appreciates the true impact of lost Medicaid collections on patient care may be more likely to be both persistent and consistent in following up on denied or delayed payments. Conversely, third-party billing companies, which are typically paid a small percentage of total collections or a flat fee, may only pursue the easier, quickly secured revenue.

To conduct billing in-house, the clinic would need to hire one or more individuals with training as insurance specialists (*CMIS credential is recommended*) and as billing specialists (*AMBA, ACPC, or PMCC credential is recommended*). The **insurance specialists** will know which services offered by the free clinic are time-limited or quantity-restricted under Medicaid (i.e. a patient can only get a mammogram once a year) and are skilled at following up on submitted claims with the insurance companies. **Billing specialists** will know how to code for the service appropriately (which ICD-9 or ICD-10 code to use). A well-qualified individual will have both of these sets of credentials but may be difficult to find. Many more individuals have one or the other set of credentials.

These insurance and coding requirements can be a lot to keep track of and can significantly affect the clinic's financial viability. Most MCOs follow the Medicare regulations for Medicaid. To get a good sense of what will be covered under Medicaid, there is a 60 page publication titled "Medicare and You" (http://www.medicare.gov/publications/pubs/pdf/10050.pdf) that defines the time and quantity restrictions for Medicare. Additionally, individuals who are trained as insurance specialists or coders will complete frequent continuing education to stay current on changes in the regulations.

The typical salary for an individual with the recommended 3-5 years of experience in either coding or insurance billing is about $36,000 a year, plus benefits. An apprentice coder could be hired for the second position at an annual salary of $27,000 plus benefits. Another option for the second position would be to redirect an existing clinic staffer to this position and send him/her to training.

The American Association of Professional Coders (www.AAPC.com) offers extensive training, both on-line and through classroom courses. This training is designed to take beginners and prepare them to pass a national certification exam in their specialty area (private practice, outpatient hospital, radiology/cardiology, etc).

To sit for an exam, an individual must first complete at least 80 hours of coding education. The cost of this training from AAPC is $1,935 per specialty. Similar training is also provided more locally by The Practice Management Institute (www.pmimd.com) and The Medical Society of Virginia (*www.msv.org*). Training sessions typically cost between $999-$1699. Individual consulting is also

available for those that desire it. In Virginia, it is offered by the MSV practice management team and by Medical Consultant Concepts (www.medicalconsultantconcepts.com) at $150/hr.

It may be difficult, especially in some rural regions of Virginia, to find and retain qualified insurance and coding specialists. The 2010-2011 *Occupational Outlook Handbook*, published by the U.S. Department of Labor, cites a national shortage of medical coders. With a projected need for as many as 35,000 new coders by 2018, this could increase the competition for experienced, certified professionals. One option may be to post an ad on the job board of the American Association of Professional Coders (www.AAPC.com). This is fairly inexpensive ($60-$150 depending on duration of the posting).

During this period of transition, it may be difficult for free clinic administrators to gauge the anticipated volume of coding and billing work, and therefore, the number of staff necessary for those activities. The rule of thumb in a private practice setting is to provide 2.5 FTEs of administrative support (*combination of office manager, receptionist, coder and billing specialist skills*) for each FTE physician. But private medical practices are different from free clinics in several ways. Their number of physicians is smaller because they don't utilize volunteers. They typically see a greater volume of patients a day, because they don't spend as much time with each one. They also bill for privately insured and Medicare patients in addition to Medicaid.

A good guess regarding initial manpower needs is two people. To get a better handle on volume and financial return, some clinics are conducting a "dry run" by asking their providers to complete a coding form at the completion of each patient visit. This enables them to measure the actual volume of patients and coded activities within each week/month, and the likely amount of manpower needed. (*It will also provide data that can be used to determine the payment likely to be generated from Medicaid.*). Another approach would be to contract with a billing vendor until the clinic has a better sense of the workload and reimbursement potential.

One caution about billing in-house is that there is likely to be an initial delay between the time of setting up the new staff and system, and securing the payment from the MCOs. It is important to plan for how the clinic will handle the upfront salary costs associated with new employees, until payment starts to flow.

Contracting with a Billing Vendor:

Another option available to free clinics is to contract with a billing vendor for the provision of services. There are many, many vendors that provide this service, and each has its own terms. In general, however, vendors will:

1) Charge a set-up fee for establishing a system where necessary information can be extracted from the clinic's EHR and routinely supplied to the vendor. Set-up fees generally range from $1,500-$5,000. As part of the set-up, the vendor must also complete a HIPAA business associate agreement with the clinic.

2) Charge either a percentage of what is billed on behalf of the clinic, or a percentage of what is collected. There appears to be a significant benefit to choosing a payment arrangement based on actual collections. This gives the vendor a stronger motivation to aggressively follow-up on outstanding reimbursement. A typical collections arrangement might pay a vendor 8% of total collections.

One significant concern with the use of a third party billing vendor is the potential liability of inadequate documentation. Not all billing vendors see it as their responsibility to verify that the clinic has the documentation in place to support the claims that are being filed. This has led to a number of investigations by the Office of the Inspector General at the Centers for Medicare and Medicaid. Clinics that elect to use a billing vendor will need to be certain that someone on the clinic staff is regularly ensuring that necessary documentation exists in the appropriate places, and that all systems of documentation are working. This responsibility cannot be contracted for. It is one the clinic must own.

To assist with the vetting and selection of a vendor, a series of proposed questions is included as Appendix A to this document. These are designed to help you learn as much as possible about your vendors' qualifications, and the specifics of proposed contractual arrangements.

In Virginia, two vendors that seem to be worthy of consideration include The Focused Group (www.focusedgroup.net) and Community Care Network of Virginia (CCNV) (www.ccnva.com). The Focused Group typically works on a percentage of collections payment model, and will work with individual medical practices of all sizes. They may be approached about individual clinic contracts, or a group contract. The Community Care Network of Virginia handles the billing functions for Virginia's community health centers, and has expressed a willingness to develop a group contract for Virginia's free clinics. Pricing and services offered by either vendor would vary depending on the number of clinics and the extent of services sought. In both cases, a larger group contract could offer a lower fixed cost model to participating clinics.

Conclusion:

Becoming a Medicaid provider and billing for medical services may provide Virginia's free clinics with a viable business model for meeting the access needs of their patients, especially after many of the clinics' existing patients become Medicaid-eligible in 2014. Such an approach could

provide a viable, sustainable funding stream for clinic operations and could offer patients a medical home that is well equipped to meet their needs.

While the amount of Medicaid revenue generated depends on a variety of variables (*number of Medicaid patients, types of visits/procedures, quality of designated outcomes*), the most important factor in billing Medicaid is ensuring the accuracy of coding and the existence of necessary documentation. There are two approaches to billing: acquiring/developing the necessary expertise to keep it all in-house or contracting with a third party billing vendor.

Each clinic will need to weigh the approach best for it, given its unique dynamics and patient caseload. This paper is intended to provide the means by which to think through the options, and to begin to develop a plan of action.

Appendix A.

Recommended Questions to Ask a Medicaid Billing Vendor

- What specific services does the vendor offer and which will be included in the contract? Functions to consider including are: claims generation and submission, follow-up with insurance carriers on submitted claims, pursing and appealing denied claims, insurance eligibility verification, transcription, and reporting and analysis on ways to improve the profitability of operations.
- What pricing model will the vendor employ? A percentage of what is billed or a percentage of what is collected? (*There is typically more financial incentive for the vendor to do a better job if vendor payment is based on a percentage of what is collected*.)
- How much experience does the vendor have? How many claims does the vendor process annually, and who are its clients? Can the vendor provide references?
- How many of the vendor's employees will support your contract?
- How many years experience do these employees have?
- How much experience do the employees have billing for the specific services your clinic provides?
- How much experience do the employees have billing Medicaid?
- Are the vendor's employees credentialed?
- How does the vendor measure employee performance and productivity?
- How does the vendor ensure that its employees will maintain a high level of customer service?
- Are customer service standards in place?
- How does the vendor ensure regulatory compliance?
- How does the vendor keep its staff informed of current state and federal rules, regulations, and guidelines?
- Has the vendor ever experienced a claims review or compliance charge?
- How will the vendor provide your clinic with updates on performance and progress? What specific metrics will it use?
- What IT resources does the vendor have in place?
- How does the vendor's billing system technology work with your clinic's electronic health record?
- Will the clinic need to install and maintain software to work with the vendor, or will the vendor be accessed through an online system?

- Is the vendor’s IT system HIPAA compliant?
- What procedures does the vendor have in place for information sharing, data security, data recovery and data backup?
- Will the vendor share its client list so that you can do a random check for references?