HiMS Health Information Management Systems

Maximizing Revenue Potential for Integrated Health Care Organizations

A White Paper

Many integrated health care providers are challenged with reimbursement issues arising from their unique service niche in the health care market. Whether your organization is a Community Mental Health Center, FQHC or a Patient-Centered Medical Home, there are several factors to consider to enhance profitability.

The four top items of reimbursement information needed from an integrated health care provider to maximize reimbursable services are:

- Provider type billing (CMHC, FQHC, other)
- CPT Codes
- Diagnosis
- Licensure and credentials of practitioner

Many times, this information is missing or incorrect, and working the claims denials that result is an expensive and time-consuming process.

Medicare and Medicaid billing codes for mental health services occur within Evaluation and Management (codes 99201-99340) and the medicine sections of the CPT codes, and within this section, the two areas applying directly to mental health services are Psychiatry codes (90801-90899) and the Health Behavioral Assessment and Intervention codes (96150-96155).

For commercial payors, these codes can vary. The trick is in knowing which codes will allow for the reimbursement of mental and behavioral health services in an integrated setting. Accurately recording the licensed location of where these services were provided and the credentials of the practitioner are essential to being reimbursed correctly. Understanding the practice scope of each licensed practitioner and how they align to payor reimbursement requirements allow agencies to create workflows that will enhance financial performance.

Managing Denials

Typically, many organizations use the “net denials as a percentage of net revenue” as the primary KPI when measuring denials, which involves tracking the total amount written off that has not been challenged with an appeal. Most healthcare associations rate a 2-4% net denials rate as top performing, 4-6% as very good and anything higher as a significant problem. Within this metric, denials are defined as claims that are justifiably denied by a payer and therefore need to be written off.

This metric can be somewhat misleading, however, because it doesn’t cover accounts that have been denied partial or full payment but remain on active A/R during the time the claim is being investigated. By using this narrow definition of net denials, it also leads to the situation of denials management programs that measure effectiveness primarily on net revenue denied or

the net receivables lost based upon something the provider did or didn't do, which can mask operational deficiencies resulting in higher costs and lower reimbursement levels.

A strategy for managing denials revolves around identifying root causes, and necessitates conducting an analysis by identifying accounts where the primary payor has been changed after the final billing date, segregating service areas (inpatient, outpatient, ambulatory clinics, specialty units), then sorting by payer comment codes to group payment delays by reason and priority. Finally, sample select accounts to verify suspected trends, root cause, and account resolution activity. Looking at denials trends in this way will provide a much broader view of the impact of denials mismanagement.

Maximizing Revenue Potential

Looking ahead to identify new avenues of reimbursement can help organizations leverage the existing workforce and reinforce high-quality service through recognition in reimbursement. Misalignment of reimbursement with value of care can act as a disincentive toward high-quality, coordinated care. With the health care system's move toward integrated and coordinated value-based contracting, the barriers to reimbursement can be organically addressed as payors begin to acknowledge the value of non-licensed professionals, team-based care, and other approaches that drive down healthcare costs and result in higher quality and better client experiences.

Other billing opportunities exist to maximize revenue potential. The National Council for Behavioral Health presented a list of recommendations for agencies that may seem counterintuitive at first glance. These opportunities include:

- Billing two services in one day (behavioral and medical)
- Using the 96000 series of codes
- SBIRT
- Obesity Counseling
- Tobacco Cessation

Medicare will cover a physical health and mental health visit on the same day with the same provider, according to CFR Title 42 Volume 2, Part 405. Section 405.2463. Medicaid rules vary by state, with 26 states paying for same day services. In states where this is permitted, the behavioral health provider bills for the behavioral health service under their provider number, and the primary care physician bill for their services under their number.