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STREAMLINING OUT-OF-STATE MEDICAID CLAIM MANAGEMENT THROUGH AUTOMATION

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YOUR PRESENTERS

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COMPANY OVERVIEW

COMPREHENSIVE SUITE OF REIMBURSEMENT SOLUTIONS

VETERANS ADMINISTRATION	WORKERS' COMPENSATION	MOTOR VEHICLE ACCIDENT/TPL	OUT-OF-STATE MEDICAID
A/R RESOLUTION SERVICES	DENIALS PREVENTION AND RESOLUTION	"SAFETY NET" DENIALS	ZERO BALANCE REVIEW

SOLUTIONS ACROSS REIMBURSEMENT LIFECYCLE

DAY ONE BILLING	A/R RESOLUTION	ZERO BALANCE	NEGOTIATED SETTLEMENTS
Team of revenue specialists dedicated solely to your facility to ensure each claim is sent to the correct payer, the first time, for the maximum allowed reimbursement.	Revenue specialists and litigators manage aged accounts once placed with us. Claims are analyzed, resubmitted, and if necessary, appealed on your behalf.	Claims designated as zero balance are reviewed for underpayment and appealed for correct payment.	Specifically focused on situations where organization is presented with a prompt pay request by a payer to assure proper payment.

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AGENDA

- **Out-of-State Medicaid Complexities**
  - Complicated Provider Enrollment Process
  - Billing Challenges
- **Out-of-State Medicaid: Our Process**
  - Pillars of Success
  - Pre-Bill Process
  - Follow-Up Process
  - Summary
- **Q & A**

*You will receive a copy of this presentation shortly after the webinar.

WHAT ARE COMPLEX CLAIMS?

- Workers' Compensation
- Veterans Administration
- Motor Vehicle Accident/ Third-Party Liability (TPL)
- Out-of-State Medicaid
- Durable Medical Equipment (DME)
- Denials

Complex claims aren't always complicated. Sometimes they are just tedious.

OUT-OF-STATE MEDICAID: COMPLEXITIES

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WHY IS BILLING OUT-OF-STATE MEDICAID COMPLEX?

- Complicated and complex Provider Enrollment process required
  - Each facility must be enrolled with each state
  - Each physician must also be enrolled with each state
- Complex Billing and Coding requirements
- Validation/Registration/Verification of coverage (MCO v FFS)
- Timely filing requirements
- Higher denial rate
- Document requirements
- Pre-auth and utilization review
- Complicated appeal process

Billing Out-of-State Medicaid is like flying an airplane...
Make sure you have safety checks during take-off and landing.

POLL QUESTION #1

- **Does your hospital currently bill for your Out-of-State Medicaid claims?**

  a. Yes

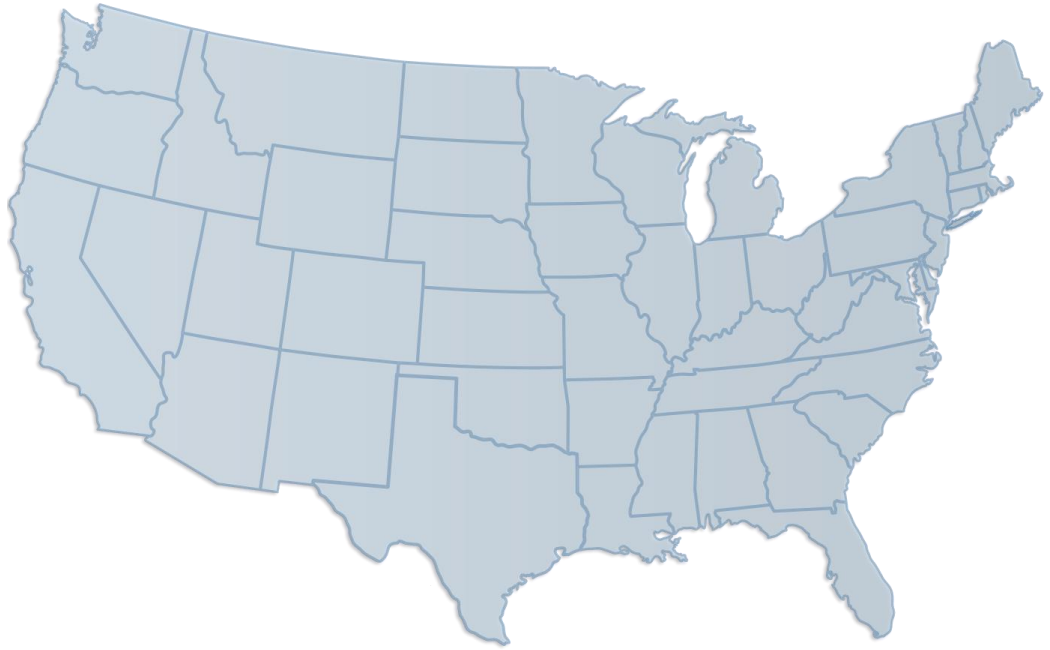
  b. No

  c. We only bill for border states

WHY IS BILLING OUT-OF-STATE MEDICAID COMPLEX?

Complex rules from state to state

- **Each state administers its own Medicaid plan**
  - State specific provider enrollment requirements
  - State specific reimbursement
  - State specific timely filing
  - Different billing and coding requirements (i.e. cross-coding requirements)
  - Different appeal rules/guidelines
  - Different document requirements (i.e. itemized statements, medical records)
- **Rules and requirements change frequently — usually without notification**



COMPLICATED PROVIDER ENROLLMENT PROCESS

- **The provider enrollment process is different for every state and can change without warning**
- **Requirements to begin enrollment process vary**
  - Active claim requirements
  - ER claim requirements
  - Border state requirements
- **Enrollment application requirements vary by state**
  - Board of Director disclosure requirements (all but 11 states require disclosure of at least 1 BOD member)
  - Documentation requirements (CLIA, DEA, Accreditation, Medicare provider number, etc.)
  - Enrollment submission requirements (paper v portal, wet signature v not)
- **Enrollment is required for each *facility* with each state**
- **Enrollment is required for each *physician* with each state**
  - At times, enrollment required for attending, operating, *and* referring physician on a single claim
- **State and physician enrollment is required — even for MCO plans in most states**
  - These requirements can fluctuate among different MCO plans within the same state

COMPLEX BILLING CHALLENGES

- **Medicaid is administered at the state level and each state has different billing requirements**
  - State and plan specific reimbursement fee schedules
  - State specific timely filing (ranges from 60 days to 365 days)
  - Different billing requirements (i.e. cross-coding, modifiers, rate codes)
  - Different authorization requirements
  - Different appeal rules/guidelines
  - Different document requirements (i.e. Medical records for all IP stays, itemized statements)
- **Each state can also have multiple different plans – MCOs vs FFS, which are each administered with different billing rules**
- **Claim submission requirements vary across states and even among different plans in each state (i.e. bill some MCO plans to the local commercial administrator)**

OUT-OF-STATE MEDICAID: OUR PROCESS

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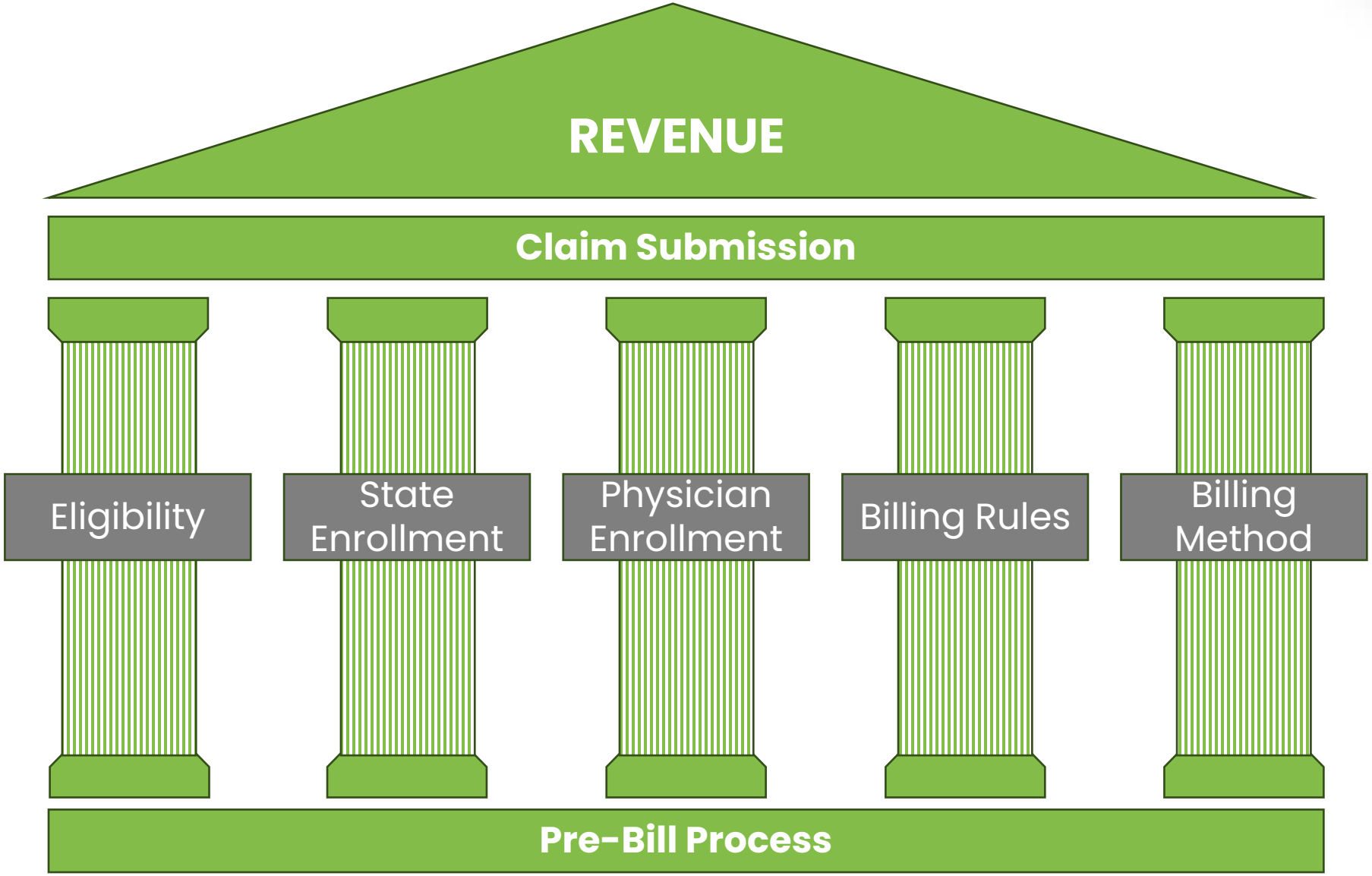
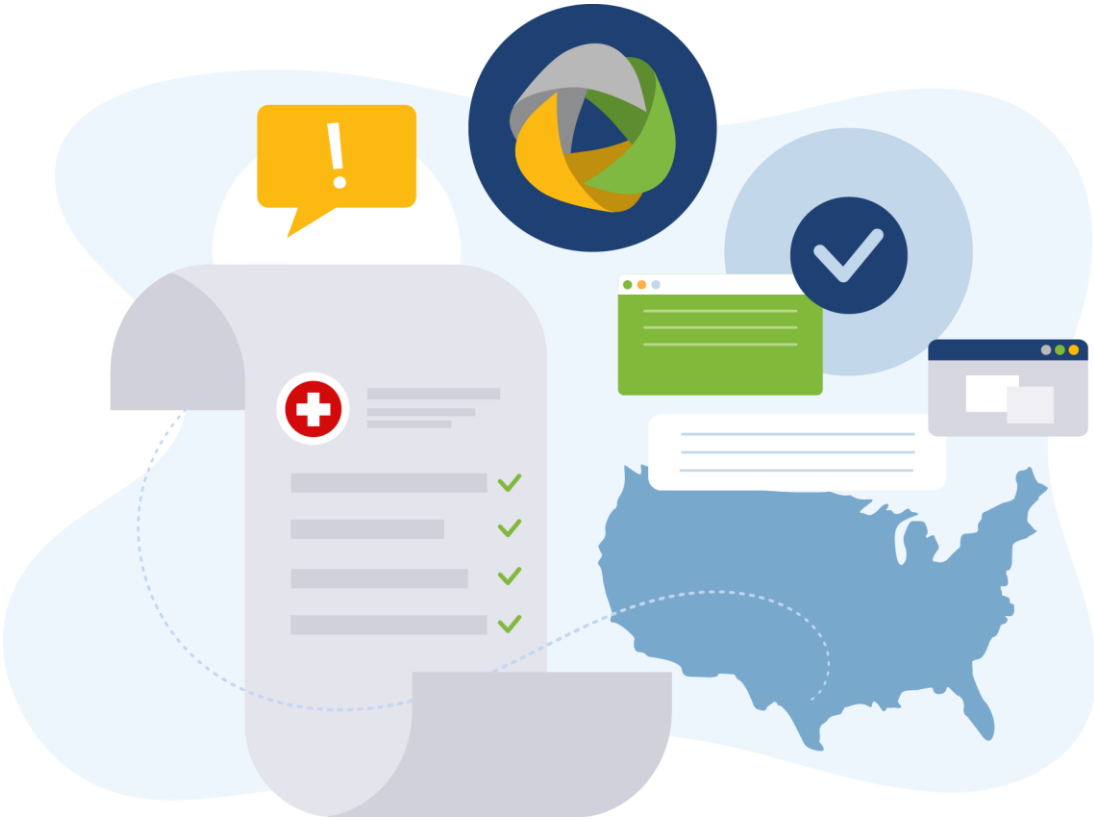
PILLARS OF SUCCESS



PRE-BILL PROCESS

As part of our pre-bill process, we validate:

- **Patient eligibility**
  - MCO vs FFS plan type
- **Enrollment status of facility with the state**
- **Enrollment status of rendering physician(s) for the state**
- **Billing rules for the state**
  - It is difficult for hospitals to build claim edit rules for each individual state's billing requirements
- **Billing method**
  - Electronic vs Paper?
  - Directly key into a state portal?
  - Document requirements?
  - Bill to local for MCO plan?



POLL QUESTION #2

- **How many states require disclosure of at least one member of the Board of Directors?**

  a. 50

  b. 39

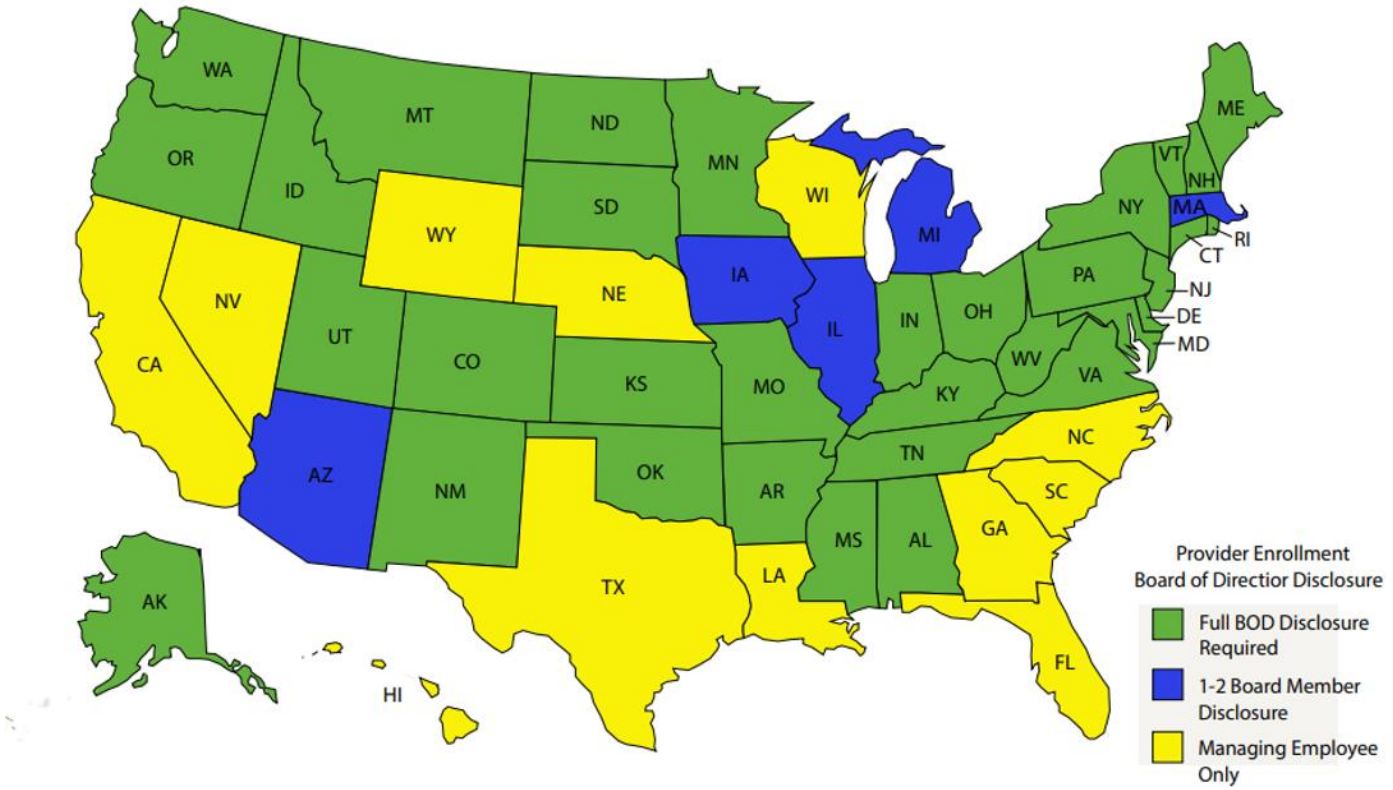
  c. 26

  d. 11

BOARD OF DIRECTORS DISCLOSURE

39 states require Board of Director disclosure during the enrollment process

- **34 of these require full Board disclosure**
- Because of the sensitive nature of BOD information, many hospitals choose to set an expected reimbursement threshold that must be met before a facility will be enrolled with a state.



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FOLLOW-UP PROCESS

As part of our follow-up process, our experts:

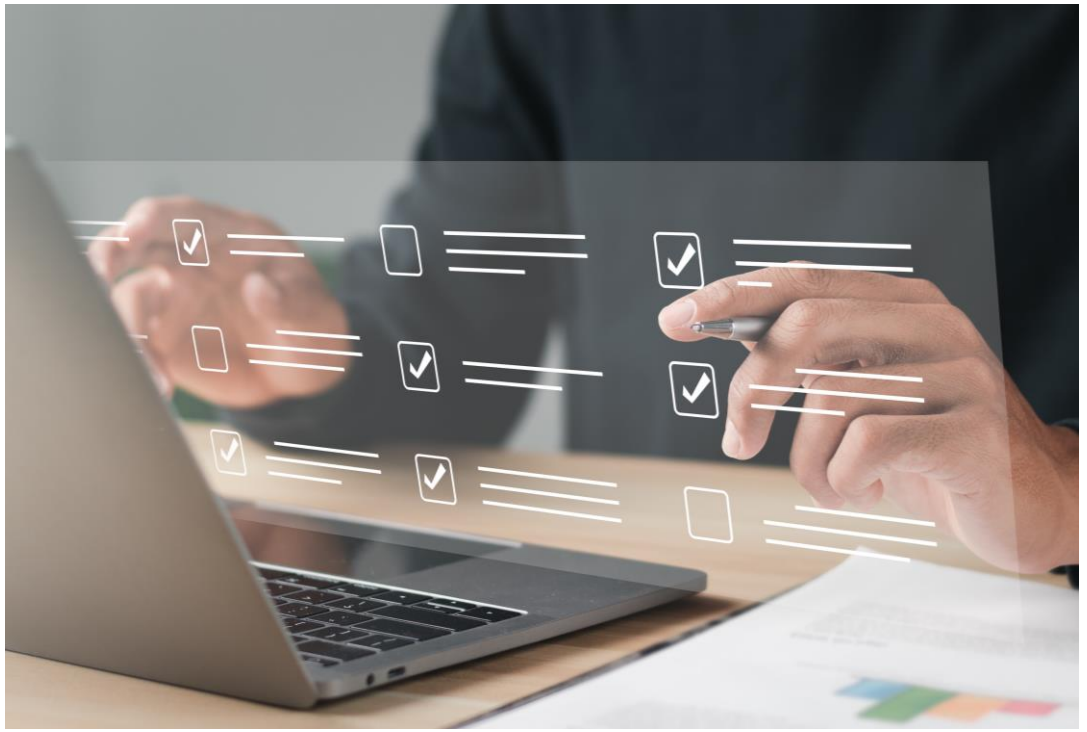
- **Validate claim is received and processing at payer**
- **Review payment or denial details**
  - Ensure payment is accurate per state fee schedule – a lot of hospitals are not able to build fee schedules around out-of-state payers and therefore aren't sure when payment is full expected amount
- **Appeal as needed and share trends:** No Auth? Non-Emergent? Non-covered scheduled services?
- **Review trends**
  - Where does the out-of-state volume lie?
  - What states are border states and are you taking advantage of the benefits of this?
  - What plan codes and claims edits should be built into your system to streamline your process and increase revenue?

POLL QUESTION #3

- **Do you track your out-of-state Medicaid volume by state today?**
  a. Yes
  b. No
  c. Only for border states

IN SUMMARY: THE BIGGEST PAIN POINTS

- **Provider Enrollment process is detailed and tedious**
  - Each state has a different process, and this can be nearly impossible for a hospital to keep up with
- **It is difficult to track Out-of-State Medicaid volumes to know on which states a hospital should focus efforts and develop infrastructure**
- **Billing rules vary among states**
  - Each state has different billing rules that can change as frequently as annually
- **Initial timely filing and follow-up timely filing timeframes vary vastly between states**
- **Follow up requirements are tedious, often require a phone call to the state, and are hard to track efficiently**



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QUESTIONS?

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THANK YOU!