



Over 40 Years Home Care & Hospice Experience

REFINING YOUR INTAKE PROCESS TO IMPROVE BILLING

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Many accounts receivable collections problems can be avoided through proper gathering of information during the intake process. Most home health providers have a clinician responsible for collecting initial referral information. This is appropriate to obtain critical medical information to make a determination about the provider's ability to accept the patient and coordinate initial services. While the intake clinician obtains pay source information, it is vital that the provider designate responsibility for follow-up verification of coverage and eligibility.

The Common Working File (CWF) is the source of eligibility and entitlement information for Medicare Beneficiaries. This is accessed online through the logon procedure into the Direct Data Entry (DDE) and the Fiscal Intermediary Standard System (FISS). On the screen where you would normally type FSS0, type HIQH (Health Insurance Query Access for Home Health and Hospice). The provider should verify coverage and eligibility for every start of care (SOC). Home Health and Hospice providers should access the HIQH detail inquiry screens by entering the Health Insurance Claim Number (HICN), first 6 letters of the last name, first initial, sex, and date of birth information obtained upon referral. We recommend the verification pages be printed and retained. The number of pages is shown in the upper right corner of the page.

The **first page** will verify the Health Insurance Claim Number (HICN), the correct spelling of the beneficiary name, date of birth, date of death (if applicable) and sex. It also contains information on the dates of entitlement as well as any termination dates of the Part A and/or Part B ben-



efits. Any incorrect data keyed will be shown in red.

Page two contains information on the most current Home Health benefit period. It will show the dates of the earliest and latest billing action for the benefit period. It will also give the number of Part A visits remaining and number of Part B visits applied.

Page three will show the two most recent PPS episodes (based on the date entered on the Part A Inquiry screen). It will show the start and end dates, intermediary and provider numbers and the patient status. This page is particularly important to review to ensure that you will not be in an overlap situation with either your agency or another provider when you submit you Request for Anticipated Payment (RAP). It should be noted that home health providers who are not timely in submitting RAPs and

final claims have a negative effect on the reliability of information obtained in HIQH.

Page four contains information on Medicare Secondary Payer (MSP) periods. It will give the type of MSP coverage with effective and termination dates. (If there are any open MSP periods, more definitive information can be found by logging out of HIQH and going into HIQA).

Page five lists any Health Maintenance Organization (HMO) coverage and effective dates. It shows the number that identifies the HMO plan (Call a correspondence specialist for more information about identifying the HMO plan). The option code identifies who will process the bills. If the SOC falls in an open HMO period, contact the HMO for primary payer information.

Page six shows preventive services and the next date the beneficiary is eligible for that service. It should be noted that these dates change as billing is processed.

Finally, **pages seven** and eight contain the Hospice period information. There is space on each of these pages for two separate hospice periods. It will show the start and termination date of each period, the provider number, earliest and latest billing activity and number of days used. There is a revocation indicator (1) indicates that the patient has revoked their hospice benefit. Looking at this indicator will alleviate the problem of an overlap with a hospice benefit period.

Although HIQH is used most frequently for Home Health and Hospice verification you will find that HIQA contains valuable information that HIQH

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SO YOU WANT TO START A PRIVATE DUTY AGENCY?

Carol Conrad, *Senior Manager*

The aging of the US population has been well-documented in the media. Both in absolute numbers and as a percent of the total population, the number of people age 65 and older will increase steadily over the next decade and then more dramatically for about two decades after that. This should provide a basis for growth for all types of services along the long term care continuum.

Critical to the successful development of a private agency by a certified home health agency is entrepreneurial leadership of the private agency, demand side thinking, and a well developed business sense. A critical mind shift is necessary. Certified home care and private home care are different and distinct business lines across the long term care continuum. Both are equal in strategic importance for the organization.

The Planning Process

A Market Assessment should be part of the initial planning process for private services. You want to find out the following:

- Current services offered by competitors and pricing
- Services not offered
- Client & community “wants” and unmet needs
- Business turned away by your certified agency
- Potential payers

The business and legal organizational structure is a key planning item. Will the private agency be for-profit or non-profit? A separate corporation? An affiliate? Will the agency be staffed separate from the certified agency or utilize administrative and direct care staff of the certified organization?

Additional key planning points include decisions regarding the following:

- Accreditation
- Information system
- Financial management
- Staffing model: part time versus full time; contracted staff versus employees
- Recruitment and retention strategies

- Policies, procedures, and forms
- Marketing plan
- Pricing of services
- Billing and collection policies: credit cards, deposits, billing frequency

Customer Service

The “customers” of the certified home care business are the federal, state, and insurance entities. The consumer accepts what care that the payers determine is appropriate for their current medical status. Patients must be “skilled,” “homebound,” and require care that is “medically necessary” for their medical condition.

In a private pay agency services are often of a “non-medical” nature and provided at the request of the consumer who is also the “customer.” The customer/consumer is also the payer and determines what care is provided; how much is provided; and what price they are willing to pay.

This can be a difficult mind shift in customer service for home care staff in a certified agency to accomplish. Rather than external regulatory bodies and insurance entities driving the amount and length of services, the consumers are in control of what services they want.

Customers have more options than ever before. That means that the competitive advantage is now in your agency's ability to keep customers and build repeat business. Good customer service is no longer enough. It has to be superior, unexpected service. It means doing what you say you will; when you say you will; how you say you will; at the price you promised; plus a little extra tossed in to say “I appreciate your business.”

We recommend using several criteria as your scorecard.

- Decrease in written customer complaints
- Decrease in oral complaints
- Increase in referrals generated from your current customers
- Increase in the repeat business of your current customers

- Faster response time/turnaround time on orders
- Increased productivity and less rework on customer projects.

This self-evaluation costs time and money, but it is well worth it to see how you score.

Inquiry Management

A telephone call to a certified agency generally results in accepting a referral for services. Taking a referral request requires obtaining information from the referral source on the telephone, stating capacity limits, and screening for eligibility criteria. One of the most important processes within a private duty office is Inquiry Management, *i.e.*, the process by which you convert calls for information into actual client cases. Inquiry and referral for private services must focus on the needs of the caller or potential client and ask what we can do to meet the caller's needs. Private services are consumer driven. Families and clients research agency services and rates prior to choosing an agency. Many people will choose an agency based on how connected they feel to the agency, as long as the rates are in a competitive range.

We recommend that designated Inquiry Management staff be assigned to handle inquiries regarding pricing and service packages. These individuals will require training on how to convert family/client inquiries into cases for the agency. We recommend establishing an agency-specific conversion rate target using the following formula:

Conversion rate =

$$\text{Total \# Admissions} \div \text{Total \# Inquires}$$

For example, select a target conversion rate of 40%. The conversion rate scores should be tracked and reviewed on a monthly basis. If the conversion rate is below the target goal, an action plan should be developed and implemented to improve it. If the conversion rate is above the target, a higher rate should be chosen.

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does not (*i.e.* identifying information on insurances in MSP periods).

HIQH provides the PPS provider number and patient status for PPS periods and HIQA does not. It is important to be familiar with both to have as much information as possible on patient eligibility.

Verifying commercial insurance is generally more complicated than verifying Medicare coverage. Upon referral, the provider should obtain:

- name of the insurance company
- telephone number
- name of the insured and relationship to patient
- group name and identification number
- employer name, address and telephone number.

A telephone call is then made to the insurance company to verify that the information is correct, and to obtain eligibility and coverage specifics. Key questions to follow up on include :

- determining if this pay source is primary
- if there is a home care benefit
- if there are any limitations on the home care benefit, (*i.e.* a maximum number of visits, skilled nursing only, etc.)

- what claim form is required
- the correct billing address
- any clinical documentation must accompany the claim.

Providers should also inquire about deductible and co-insurance amounts that are the patient's responsibility, and whether there is a preferred vendor for medical supplies.

The insurance verification process should include an inquiry about authorization requirements and case management. The home care provider should obtain all authorizations directly from the pay source case manager and not rely upon authorizations obtained by the referral source. In most cases, the person you verify coverage and eligibility with will not be the same person who provides authorization for services. It will often require a home care clinician speaking directly to the insurance case manager to obtain appropriate authorization based on the clinical needs of the patient. Be sure to obtain the name and direct phone number of the individual providing the authorization, document any authorization numbers received, and determine if a confirmation will be mailed or faxed to the provider.

Once authorization is received, the provider must be careful about scheduling visits according to the terms of the authorization. If services are authorized for specific dates, those dates must be adhered to in order to bill and collect payment successfully. If a visit needs to be rescheduled, addi-

tional authorization should be obtained to cover additional dates.

While state Medicaid programs vary, many states have automated phone verification systems or intranet access to confirm eligibility. In addition, many states have coverage under several different programs, some of which may require authorization. It is important to check Medicaid eligibility upon admission and at every billing cycle to confirm continuing benefits as states have varying requirements for maintaining eligibility. Some states have provisions that require Medicaid recipients to spend down assets on medical services or products to maintain financial eligibility for Medicaid benefits.

When verifying all pay source information, it is critical that attention to detail is preserved into the next step of registering the patient in your information system (IS). If numbers are transposed or names are misspelled, claims may be rejected, resulting in the need to research and resubmit. If your IS contains both clinical and back office components, it is important to make sure that the data in both is consistent. If Intake has registered the patient as Mary Ann and the clinician entering the initial assessment enters the patient as Mary, chances are the IS will not be able to generate a clean claim. Taking extra care on the front end can result in the ability to submit clean claims timely and reduce the amount of re-work on the back end to research and correct the claim.

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Pricing of Services

For services in the non-certified home health agency, pricing and billing of services is often most difficult, yet it is most critical that they are accurately calculated. Precise pricing of services ensures a good basis for employee recruitment, client acceptance and satisfaction, and should provide a reasonable profit.

Each year the MetLife Mature Market Institute conducts a market survey of nursing home and home care costs in the United States. In

2005 the survey included hourly rates for homemaker/companion services. The average national billing rate for Home Health Aide was \$19.00 or 5.5% higher than 2004. The average national billing rate for Homemaker was \$17.00. Home-maker rates were not surveyed in 2004.

We recommend that personal care services and homemaker/companion care have individual bill rates to reflect the level of skill required to provide the requested service. Following a cost analysis, we recommend that an agency strive to develop bill rates that are in the mid-range of its competitors' rates.

Many assisted living facilities support the philosophy of "aging in place" so residents are allowed to stay at the residence as long as their physical and mental impairments can be supervised and maintained either by direct care staff at the facility or by contracted services.

In addition to external marketing for the private duty agency, we recommend that the leadership of the private agency develop an action plan to educate staff in the certified agency of the features and benefits of the services of the private duty agency. We recommend that the educational information include how to use the OASIS questions to determine a need for private duty services.

Strategic Opportunities

Schedule of Events

Northern New England Home Care and Hospice Conference

South Portland, ME 5/4 - 5/5/2006
The Future of Hospice: The Road Ahead
Robert J. Simone, Principal

Power Home Health Referrals Advanced Marketing Strategies Conference

Orlando, FL 5/10 - 5/12/2006
Anodyne Therapy: New Technology Speeds Healing while Growing HHA Referrals
Lucy Andrews, Senior Manager

Home Care Alliance of Massachusetts

Annual Spring Conference
Westford, MA 5/11 - 5/12/2006
Is Home Care Ready for Medicare Managed Care?
Betty Gordon, Principal
Bob Simone, Principal

LTC 100 Executive Management Conference

Las Colinas, TX 5/21 - 5/23/2006
The Opportunity in Hospice
Bill Simone, III, Principal

New York Association of Homes and Services for the Aging

Saratoga Springs, NY 5/22 - 5/25/2006
Is Home Care Ready For Managed Care
Robert J. Simone, Principal

Pennsylvania Home Care Association

State College, PA 5/31 - 6/2/2006
Keeping Your Business Plan off the Shelf
Bob J. Simone, Principal

THE SIMIONE ADVISOR

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New York State Health Care Providers Exploring Private Pay Opportunities

Albany, NY 6/6 - 6/7/2006
Calculating Breakeven in a Private Pay Business
David Berman, Principal

Decision Health

Audio conference 6/13/2006
Marketing to the Hospitalist
Lucy Andrews, Senior Manager
Audio Conference 7/11/2006
Non Traditional Marketing Sources for Private Duty
Lucy Andrews, Senior Manager

Home Care Association of New Hampshire Annual Meeting

Meredith, NH 6/14/2006
Panel Participant: Trends and Key Challenges Facing Home Care and Hospice
Robert J. Simone, Principal

National Association for HomeCare and Hospice

Financial Managers Conference
Chicago, IL 7/19 - 7/21/2006
Facilitator for the Leadership Panel
William J. Simone, Managing Principal
Medicare Managed Care
Robert J. Simone, Principal

Private Duty Advanced Training Conference

Las Vegas, NV 11/13 - 11/17/2006
Medicare to Private Duty: Your Plan for Success
David Berman, Principal
Lucy Andrews, Senior Manager

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NEWS FLASH

New Information Technology Division

In response to requests from clients for help in getting the most from their IT investments, Simone Consultants, LLC created a dedicated IT Division.

Division Director, Suzanne B. Sblendorio, unites her years of experience, unique perspective and practical strategies with the strong consulting teams from the operational and financial divisions. From new system searches to implementation support and utilization analyses, the division delivers unmatched value and outcomes.

IT Division 973.667.9485

West Coast Services Expanded

With its desire to offer needed services to home care and hospice agencies in California and the southwest region, Simone Consultants, LLC has expanded its Washington State office.

Senior Manager, Lucy Andrews RN, MS, CHCA, will coordinate new client and consulting activities. With 25 years experience in the home health, hospice and private duty industries, and a regional presence, she will bring her proven strategies to her clients.

California - 707.538.3675
Washington - 360.258.0224