Clinical Explanation of Benefits Training (EOB)

Produced by the Alabama Department of Public Health
Video Communications and Distance Learning Division

Faculty

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Why Is "Recovery" Important?

- Reductions in State and Federal funding
- Escalating operating costs
- We are not a free clinic
  - We are a confidential, non-profit entity

What's in It For Me?

- Maintains your facility
- Provides services to everyone who needs them
- Pays staff
- Purchases medical supplies / contraceptives
- Educates others

The Mission vs. The Business

Let's Start at the Very Beginning

Annie Plan

- Client completes application
- Clerk / CC will check application for completion
- Clerk will date stamp application
- Clerk will copy the application
- Clerk will obtain original signature, preferably in blue ink, on original and copy

Annie Plan

- Social Security Number must be on application
  - Will need to provide proof of citizenship and identity if SSA cannot verify citizenship
    - Same process we use to do

Completed Application

- Clerk keeps copy of application
- Clerk mails original application
- Copy should be kept in a "pending file"
- Applications only good for 45 days

Pending File

- Check file within 30 days to see if awarded
- Check MedWeb site to determine award status
- If awarded, make sure it is the month of the date stamp
  - If incorrect notify Annie Vosel

Pending File

- If no decision after 30 days, notify Annie Vosel
- If award is correct, make a copy showing award, place in record, shred application
- If client is denied, document that and bill according to sliding fee scale

Incomplete Application

- Keep both copies of the application in a "hold file"
- Put a sticky note on the application identifying what information is needed
- Put a note in the progress report regarding what information is needed

Hold File

- Check the file weekly and follow-up with client about needed information
- Once information is obtained, send original application to Medicaid
- Keep copy of application in the pending file

Can't Obtain Missing Information

- Application lasts for 45 days
- After 45 days, document in progress note that the needed information was not provided
- Bill client according to the sliding fee scale

Can't Obtain Missing Information

- Shred the application
  - Keep a copy of the birth certificate if you have it

Challenges with the Paper Application

- Applications are incomplete
  - Date stamp missing (bottom left hand corner)
  - Missing SS#, birth information (#2, 3, 4)
  - Sterilization question blank or they say yes (#6)

Challenges with the Paper Application

- Address missing (#9)
- Insurance information (#11)
- Don't check that they have no income (#12)
- Can't calculate salary (#13)
- Fails to sign and date

Challenges with the Paper Application

- Award date is incorrect
- Medicaid never receives the application

Electronic Plan First Application

- Pilot with Kiosk
  - Lavender application
- Made available July 2010 all clinics for staff
- Completed application sent electronically every night

Electronic Plan First Application

- Eliminates the need to date stamp and make copies
- Will need to keep 1 page which has a "P" number
- Incomplete application available for 30 days

Electronic Plan First Application

- Application report available to show all completed and incomplete or redirected applications

Electronic Plan First Application

- Kiosks should now be available at all sites
  - Combined ALL KIDS / SOBRA (blue application)
  - Plan First (lavender application)
  - WIC education modules

Benefits of Electronic Application

- Re-certifications made easier
- Paperless
  - Less lost applications, accuracy of applications
- Date stamp issues gone
- Reduce staff time processing paperwork

Challenges of Electronic Application

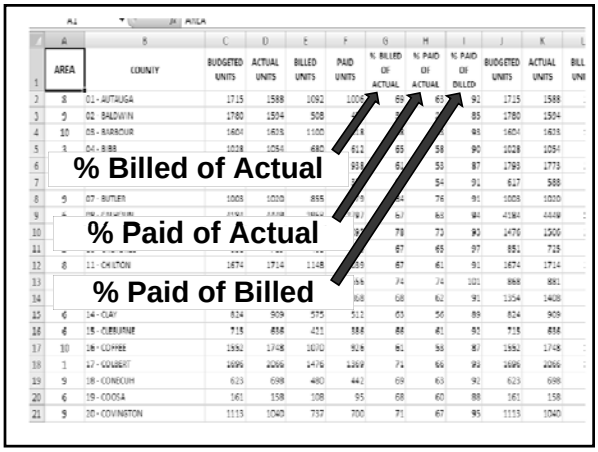
- The date stamp is when the application is submitted
- Once submitted, it is difficult to change
- Need to remember your password to have access to an incomplete application

Challenges of Electronic Application

- Kiosk applications need to be closely monitored for completion
- Redirected applications

Performance Measures

- Need to monitor Plan First enrollment
  - Particularly with kiosk use
- What % of your visits are to Medicaid clients?
- Are you getting paid for what you bill?



Plan First Visits

- Initial – one per lifetime per provider
- Annual – allowed 1 per calendar year (Jan- Dec)
- Periodic / Revisit (supply visit)
  - Allowed 4 per calendar year

Plan First Limitations

- Only for women ages 19 through 55
- Must be living currently in Alabama

Allowable Charges Plan First

- Allows for up to 2 HIV counseling sessions per year
  - Can be either pre-test or post-test
- Allows for 16 packs of pills in 1 year
- Depo injection is limited to every 70 days
  - No age restriction

IUDS

- Pays for 1 Mirena IUD every 5 years
  - Exceptions
    - Spontaneous expulsion during the first 6 months
    - Has removed, gets pregnant, wants another after delivery
      - All within a 5 year period

IUDS

- Has removed and develops medical complications that allow for a progestin only method
- ParaGard has no limitations

Family Planning / Plan First

- Initial and annual visits must include the physical exam
- Medicaid reimburses for one initial visit per patient, per provider, per lifetime

Family Planning / Plan First

- Each county HD is considered an individual provider so a patient can get an initial at each site
  - However, counties can transfer medical records seamlessly and not require the patient to get another exam before it is due

Family Planning / Plan First

- Annual visits paid by Medicaid based on one per calendar year, not 365 days
- If outside provider already has been reimbursed for annual for the year, the HD will get a denial
  - In this case, visit may be changed to Periodic Revisit in order to get reimbursed for services provided

Family Planning

- Deferred physical visits:
  - The basis for these visits is to allow a patient to get started or continue on a method while deferring the physical exam and lab work for a specific reason
    - The reason must be documented in the chart

Family Planning

- These visits are billed to Medicaid as a Periodic Revisit

Family Planning

- We can utilize deferred physical visits under 2 circumstances:
  1. To defer the exam of a postpartum patient
  2. To defer the initial or annual visit

Family Planning

- If postpartum, we must receive the "Deferral of Postpartum Exam form" and can supply the patient until her annual exam is due
- To defer the initial or annual visit, we can provide a method up to 6 months before a physical exam must be done

Family Planning

- Use it for days when the nurse or NP is out, patient is on menses, to coincide a repeat smear with her annual exam, etc.

Family Planning

- Billing of exam visits are not contingent on the Pap smear being done

Family Planning

- Which visit is <u>not</u> billable to Medicaid and why?
  - 36 GYN Problem / Lab / Couns Visit was established based on Title X criteria, not Medicaid

Family Planning

- These visits allow us to count encounters for Title X that we ordinarily would not be able to capture based on Medicaid requirements alone
  - Examples include counseling only visits (Pap results), pregnancy test only visits, etc.

Family Planning

- What are some of the Medicaid billing and coding issues?
  - Contraceptive methods issued but the visit is coded as a non-billable visit (36 GYN Problem Visit)
    - This includes ECPs
  - Methods such as Implant or Depo not getting entered into PHALCON correctly

Family Planning

- Changes made in PHALCON to assist with Medicaid coding issues
  - System will not allow the following methods to be entered if gender is male:
    - Implant, OCs, IUD, diaphragm, Nat/Rhy, injection, contraceptive patch, vaginal ring, female condom, rely on male method (vasectomy)

Family Planning

- The system will not allow the following services to be entered if the gender is male:
  - IUD insertion, IUD (Mirena), IUD (Paragard), IUD removal, Pap smear, pregnancy test (urine), or wet prep

Blue Cross / Blue Shield Reminders

- Check eligibility of patient through the BCBS website to be sure the plan is still active, spelling of the name on the policy is correct, etc.
- No BCBS card and no other way to check eligibility = Charge Patient
- Incorrect data in PHALCON = No Payment!!

Blue Cross / Blue Shield Reminders

- DO NOT mark encounter as complete until all the fields are entered
- Policy Number:
  - There must be a policy number in PHALCON in order to bill!!!

Blue Cross / Blue Shield Reminders

- PHALCON – Required fields are now in place for insurance information when "Bill Insurance" is marked

Bill Insurance Tab

- Check Bill Insurance when:
  - The client has BC/BS even if they have Medicaid
  - They do not need confidentiality
  - The client has a billable BC/BS visit

Bill Insurance Tab

- Check Do Not Bill when:
  - They have BC/BS coverage and they DO NOT want the EOP going to their home
    - They request confidentiality

Bill Insurance Tab

- Check N/A:
  - When they have Medicaid only
  - When they present with PEEHIP (EDU) insurance
    - ADPH is not eligible as a provider
  - When they have no insurance coverage

BC/BS Billing Criteria

- NP Visits
  - Initial
  - Annual
  - * GYN problem
  - * Periodic Revisit / Deferred PE visit
- * Should include a diagnosis code
  - May not be necessary if procedure driven visit (Implant insertion)

BC/BS Billing Criteria

- RN only visits
  - Periodic Revisit / Deferred PE Visit when Depo is administered
    - * Must include 4 digit NP provider number