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Utilizing Third Party Billing Companies

8/29/2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

Our objective for this webinar is to assist with providing education and knowledge related to using third party billers for your Medicare Part B claims. We'll identify vulnerabilities, how to reduce costs and assist in identifying inappropriate third-party activities.

Today's Presenters

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Agenda

- What are Third Party Companies?
- Legal Responsibilities
- Common Trends and Provider Impact
- Questions for Your Third Party
- Training to Share
- Resources

What Are Third Party Companies?

What Are Third Party Companies?

- A third party company or individual outside of your organization with whom the provider of service contracts to perform certain duties
- Common examples include
  - Billing agencies
  - Clearinghouses
  - Software vendors
  - Auditing firms

Legal Responsibilities

Legal Responsibilities

- Providers are legally responsible for all actions taken by their employees and companies with whom they contract
  - Any legal action falls on the provider of service, not the third-party vendor
- Providers sign Medicare contracts and accept full responsibility of their claims and handling of PHI
  - Enrollment forms
  - Claims submission
  - EDI

Legal Responsibilities

- There are many reputable and knowledgeable third party companies
  - Network Service Vendors
  - HETS 270 271 Approved Vendor List (cms.gov)
  - Compliance Review Program | CMS
- Three steps to ensure you and your billing parties are following Medicare guidelines
  - Step 1 – Identify how your third party entities protect your data
  - Step 2 – Understand how they will ensure accurate and timely claim, appeal, etc., submission
  - Step 3 – Determine your contractual charge structure
- Note: CMS does not make distinctions between provider and third party biller agencies

Common Trends and Provider Impact

MACs Initiatives

- Track high-volume callers
- Contact the billing provider when identifying inappropriate trends
- Take an active approach to high-volume callers to reduce costs to the Medicare Trust Fund
- Utilize data available by provider NPI, PTAN, and call-in phone numbers
- Report to CMS specific providers not in compliance after education

No Direct Line Of Communication

- Cannot contact via number called from
- Provider business office is not familiar
  - Phone numbers used to contact Medicare
  - Name of individuals contacting Medicare
  - Person knowing patient's PHI
  - Person knowing provider financial information
- Concern that provider is unaware
  - Person knowing patient's PHI
  - Person knowing provider financial information

Lack of Access to Self-Service

- MACs receive numerous calls asking for information already available
- Third party vendors express they do not have access
  - Many use spreadsheets of claim information
    - They do not contain all needed information
    - They are unaware of the claim status
- Use of self-service tools is required in accordance with CMS
  - CMS IOM Publication 100-09, *Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual*, Chapter 6, Section 50 – 50.1

Increase in Common Errors

- Duplicate Billing
  - Many claims are repeatedly billed with the same error
  - Verifying claim was already partially/fully paid before resubmitting
- Clerical Errors
  - Incorrect spellings of provider or ordering/referring names
  - Incorrect forms used

Scripted Calls

- Increase in inquiries from third party vendors asking for claim status information
  - Remittance Advice
  - Self-service portals
    - Example: Asking for denial reason on claim submitted with GA or GZ modifier. These modifiers indicate the provider anticipated denials from Medicare
- Many calls include scripted questions that don't relate to claims and information already available
  - Provider's mailing address
  - MACs mailing address even though provider bills electronically
  - Providers submitter ID when the provider has weekly claims on file

Provider Impact

- Increases risk of
  - PHI breaches
  - Abusive billing practices
- Held accountable for all actions taken on their behalf by their third party contracts
- Missing Medicare timeliness guidelines
  - Initial claim submission
  - Appeals
  - Recoupments

Provider Impact

- Delayed or lack of payments for Medicare claims
- Higher risk of failing reviews and audits
- Charges from third party vendors for additional
  - Phone calls
  - Claim submission
  - Appeals request

Provider Impact

- Reduced time for legitimate requests for assistance
- Not cost effective for the Medicare program or providers
- Call center privileges revoked
- MACs monitor calls
  - Noncompliance
  - Non-use of self-service technology
  - Abusive to MAC staff
- MACs report to CMS for possible revocation of privileges
  - CMS IOM, Publication 100-09, *Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual*, Chapter 6, Section 30.4

Questions for Your Third Party

Who Has Access to Patients PHI?

- Verify specifically who has their patients PHI information
- Who specifically do they grant access to your claims?
  - Subcontractors
- What steps do they have to protect you and your patient's data?
- Are they sending information overseas (offshore)?

Direct Line of Contact

- Who does the provider contact if they have concerns with how the third party vendor handles their claim and patient information?
- How is the third party vendor notifying you of
  - Claim denials
  - Claim rejections
  - Requests for documentation
  - Appeal activities and results
  - Recoupment requests

What Fees Do They Charge?

- Do they only change a percentage of the provider's Medicare reimbursement, or are there other fees?
- Are they upcoding claims?
  - Adding charges
  - Inappropriate diagnosis codes
- Do they refund if Medicare recoups a payment?
- What are other fees?
  - Hourly amounts
  - Piece work
    - Phone calls
    - Individual questions
    - Appeals
    - Refunds such as phone calls or appeals

Do They Thoroughly Review Claims?

- Does their staff work the claims thoroughly by reviewing each claim that denies, or are they just resubmitting and calling Medicare on every claim?
  - Example: If a claim is rejected up front via NCE edits, are the provider's coding staff being notified of the rejection so they can correct the claim, or is the billing company just resubmitting it without correction?
  - Example: If a claim denies for duplicate or patient having another insurance, are they logging into the portal to verify the denial?

Do They Have the Proper Tools?

- Does vendor staff have access to the tools they need?
  - Remittance advice
  - Self-service technology
- Each user must have a separate account
  - Medicare does not allow sharing of passwords
  - Deleting accounts when staff leave

Is Their Staff Properly Trained?

- Are the staff members properly trained on the following
  - Medicare rules and regulations
  - Self-service technology
  - Website
  - Education offerings
  - YouTube channel
  - Reading remittance advice
  - Understanding common denials messages
  - Use of IVR

How is Compliance Enforced?

- What are your expectations?
- What are consequences when expectations are not met?
- Who is fiscally responsible for recoupments?
- Do they understand your legal responsibilities?
  - HIPAA
  - Understanding Medicare guidelines
  - Repayment to Medicare
  - Revocation from the Medicare program

Training to Share

Appropriate Versus Inappropriate Calls

- Contact Centers are only to be utilized for complex issues that providers cannot answer via any self-service tool (E.g., MAC portal, IVR, remit, MAC/CMS website)
- All inquires that can be resolved via self-service tools must be referred to those respective tools
- MACs are to refer all inquiries to self-service technology when appropriate
  - Patient eligibility
  - Patient deductible
  - Patient eligible for frequency-controlled services
  - Medicare Secondary Payer
  - Claim status including explanation of denials codes
  - Duplicate denial information
  - Financials

Resources

Resources

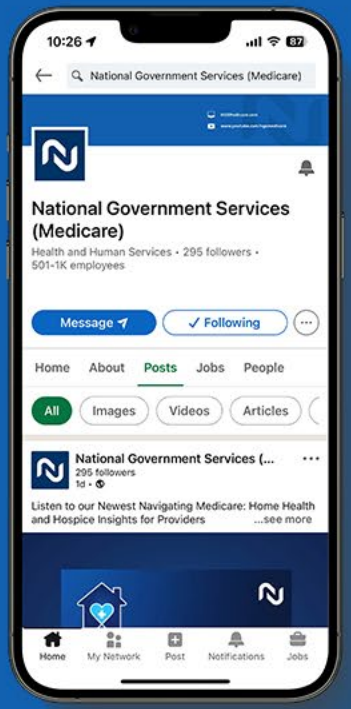
- U.S. Department of Health and Human Services
  - HIPAA Privacy Rule Business Associates Guidance
- Compliance Program Guidance for Third-Party Medical Billing Companies: Federal Register, Volume 63
- MLN® Fact Sheet *Checking Medicare Eligibility*
- Security Rule at 45 Code of Federal Regulations (CFR) 164.308(a)(1)(ii)(A) and (a)(1)(ii)(B)
- Medicare National Correct Coding Initiative (NCCI) Edits
- MBI resources
  - Providers and Office Managers

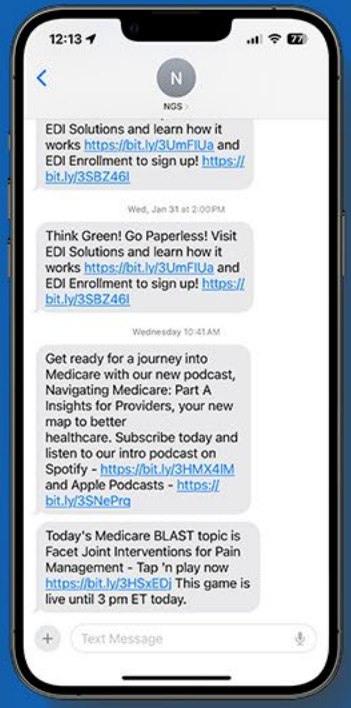
Resources

- Additional Resources
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15 – Covered Medical and Other Health Services
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 17 – Drugs and Biologicals
  - CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3 – Verifying Potential Errors and Taking Corrective Action
  - CMS IOM Publication 100-09, *Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual*, Chapter 6, Section 50 - PSS Technology

Questions?

Thank you!





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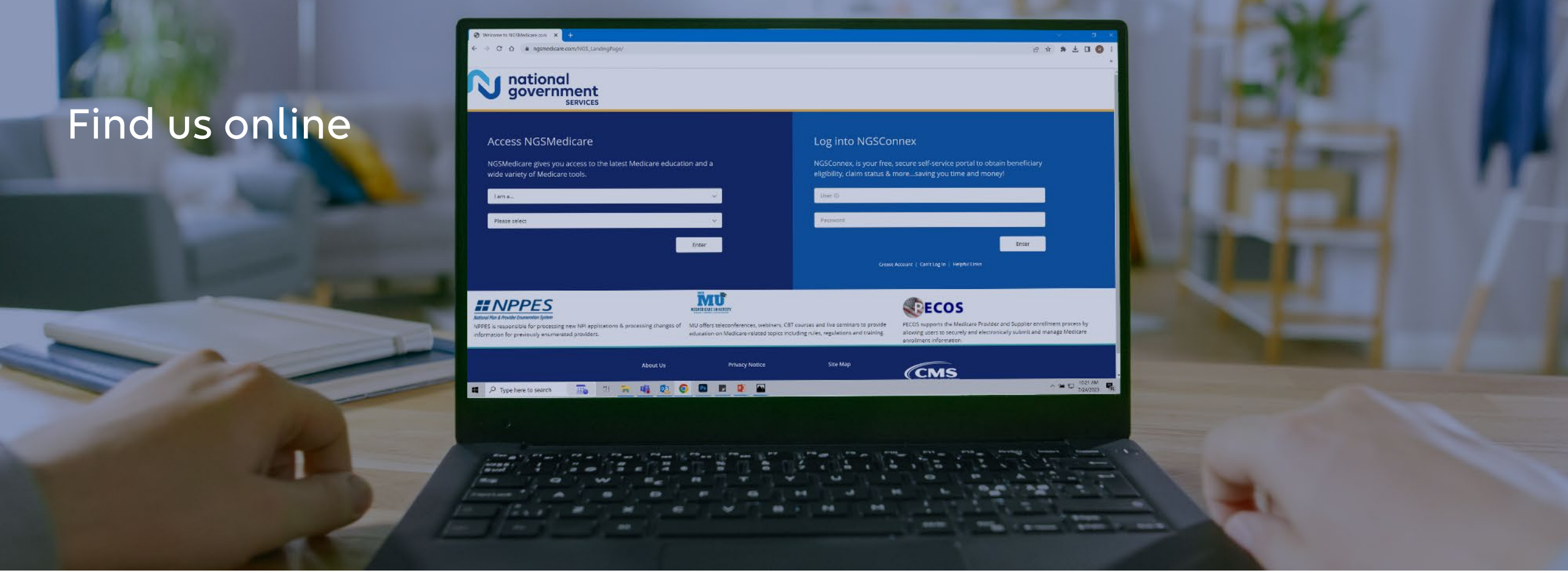

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Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

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