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BEHAVIORAL HEALTH BILLING

CLAIM PROCESSING: ENSURING EFFICIENT MANAGEMENT OF YOUR REVENUE CYCLE

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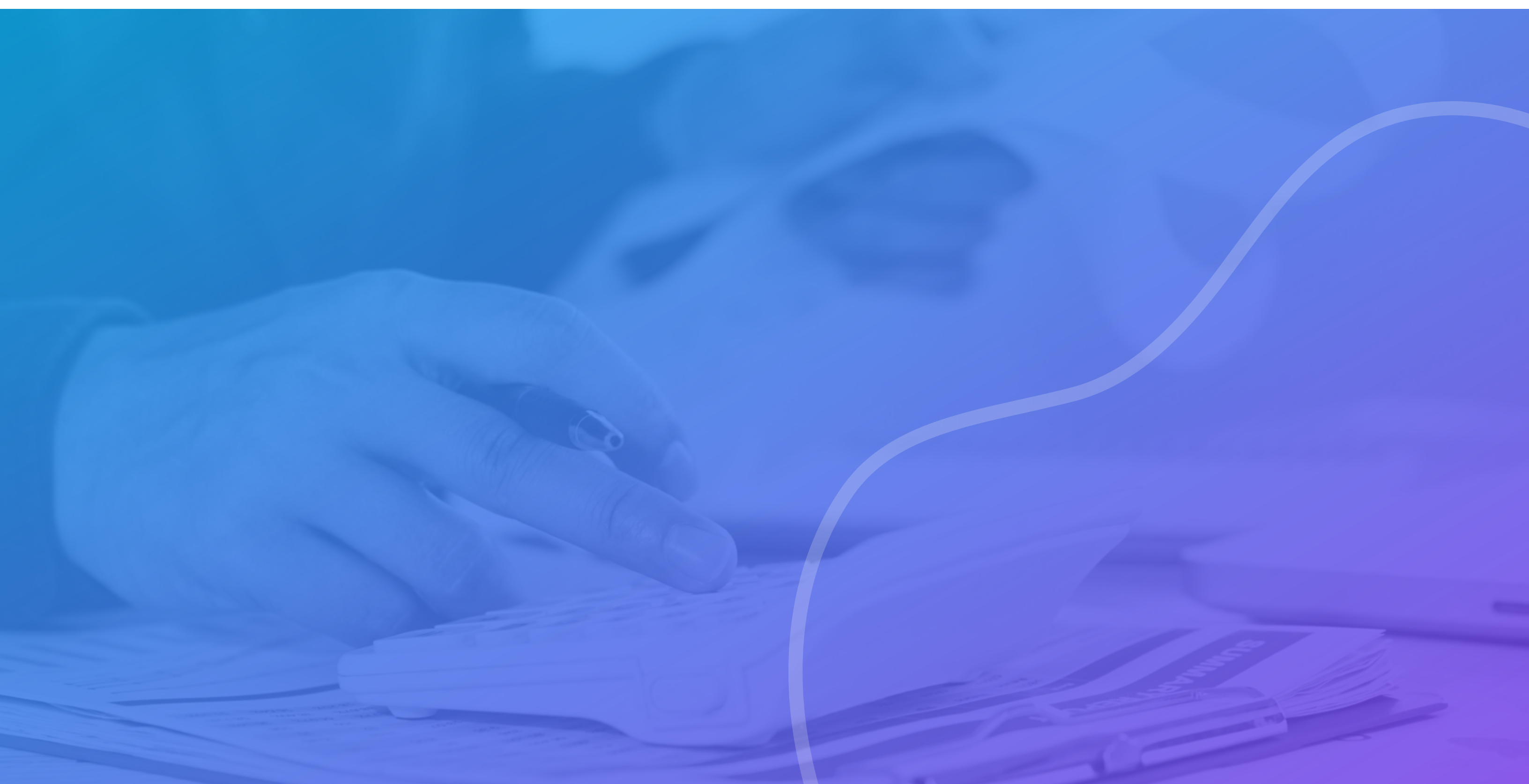
Claim Processing: Ensuring Efficient Management of Your Revenue Cycle

Mastering behavioral health billing claims processing is what will set you apart from others in the market. This process is integral to the financial success of your organization. Providers learning and understanding the ins and outs of this process, what resources to utilize, and how to streamline each step will help them tackle issues in their revenue cycle and optimize their bottom line.

The behavioral health revenue cycle involves every financial process from when a client or patient schedules an appointment to when they pay their bill in full. Here, we will cover the central component of the revenue cycle and the initial component of the back-end process.

UNDERSTANDING CLAIMS

The middle section of the revenue cycle is the claims process. Efficient management of behavioral health claim processing enables providers to get payments in hand more quickly and with fewer obstacles.



CLAIMS PROCESSING TERMINOLOGY

- **Claim** - A claim is a request for payment made to an insurance company for a service rendered by a provider. They can be sent electronically if they follow the required HIPAA-secured format (837i/837p). These claims can be sent manually (claim form CMS-1500). Most providers are highly familiar with this term and its purpose.

- **Claims Reconciliation** - Claims that are sent daily or weekly must be reconciled with what was received or rejected from the clearinghouse or the payer. A practice management system should come equipped with billing reconciliation reports that enable you to track your claims through the entire behavioral health billing claim process. (Claims can sometimes get lost, and reconciliation helps you pinpoint those losses for resubmission. A rejection is pre-billing, and denial is post-billing)

- **Denial Avoidance** - This is the process/effort of avoiding denials by assessing for errors/potential causes before submission. To avoid a denial, the provider must include the authorization number for services on the claim (if necessary), the required documentation (complete and accurate), adhere to the payer filing/appeal deadlines, and code the claim with the correct CPT Code, Modifier, and Diagnosis.

- **DSM-5** - The American Psychiatric Association (APA) published The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) manual. It Is used to define and classify mental disorders, improving overall diagnoses, treatment, and research.

- **ICD-10** - The International Classification of Diseases (tenth revision) is a system that contains codes for various diseases, signs, symptoms, and abnormal findings. ICD-10 codes are used primarily for insurance purposes. They also provide valuable data for improving healthcare and understanding complex diseases/symptoms.

- **Location Code** - These are the standardized codes used to identify the place where services were rendered. (e.g., 03 for school-rendered services, 11 for in-office services, etc.). These are also known as place-of-service codes.

- **CPT/HCPCS** - Healthcare Common Procedure Coding System (HCPCS) involves two levels of codes. Level 1 consists of Current Procedural Terminology (CPT) codes, which are made up of 5-digit numbers and are managed by the American Medical Association (AMA). These identify the type of service and procedures ordered by the licensed professional or physician. Level 2 consists of alphanumeric codes that primarily include non-physician products, supplies, and procedures that are not included in the CPT set.

- **Billing Provider** - The individual or organization that rendered and billed for a service.

- **Modifier** - This is a 2-character code appended to a CPT code that provides additional claim details to the payer.

- **Rendering Provider** - The provider who rendered the services to the patient. The rendering provider is usually face-to-face with the patient. It is critical to know the payer policy for rendering providers.

- **Clearinghouses** - This company functions as a middleman between a healthcare provider/organization and an insurance payer. They receive claim information from the provider and assess it for errors, verifying that it is compatible with the payer software/requirements. Some payers require a clearinghouse in order for an organization to bill them. Clearinghouses will be reviewed in greater detail later on.

THE CLAIMS CYCLE

In order to master behavioral health claim processing, providers need a firm grasp of the claim cycle and what it entails. While the revenue cycle starts when the patient schedules a visit, the claim cycle starts after services are rendered. Once you have rendered services to a client/patient, it is time to file a claim for reimbursement. There are many steps and procedures that go into filing claims, but the main steps are as follows:

- **STEP 1:** The first step is to file the claim with the insurance payer. Once you have verified the client/patient's coverage and demographic information, you can submit a claim to the payer. Before submission, your review process should be thorough to reduce your chance of denial. Providers should edit for errors before submitting the claim.

- **STEP 2:** Remember, there is a middleman between providers/organizations and the payer. If the claim is sent electronically, it should pass through a clearinghouse. They will review the claim, assessing it for errors or potential causes for denials. At this time, the claim is either accepted and sent on to the payer or rejected at the clearinghouse level. The claim will never show on an EOB or be in the payer system if rejected. The clearinghouse must clear the claim for it to be passed on to the payer. Providers are responsible for resolving the causes for the rejection before resubmission can happen.

- **STEP 3:** The claim is accepted by insurance for processing and processed by the payer. This is referred to as the adjudication process.

- **STEP 4:** Next, Payers will issue either remittance (if the claim was approved) or denial information to the provider. If a patient is covered for services and the submitted claim includes all of the necessary and accurate information, it should be approved. If the payer finds cause to deny your claim, they will. If their claim were approved, then payment would be delivered to the provider at this time. Once a claim has been approved or denied by the payer, the client/patient would receive an Explanation of Benefits (EOB).

- **STEP 5:** Once the claim has been processed, clients/patients are then responsible for any applicable balances. There are methods for billing insurance claims and patient responsibility balances concurrently that providers might want to consider to jumpstart that patient payment process.

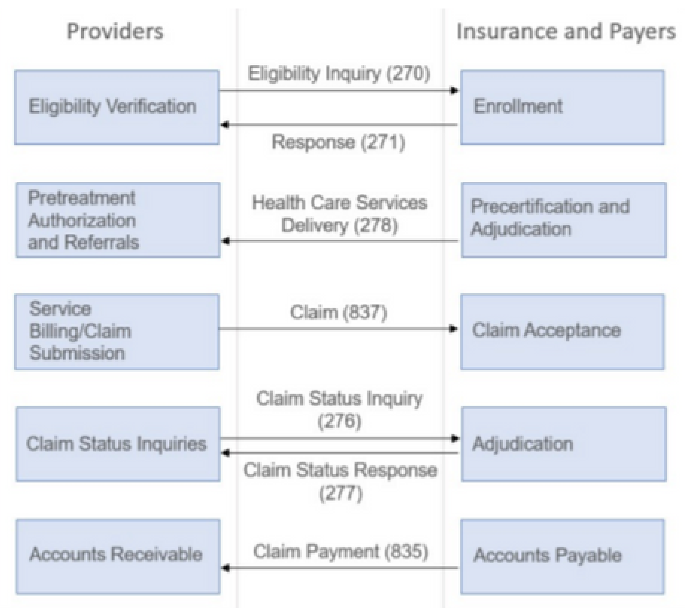
HIPAA TRANSACTION SET

The Healthcare Insurance Portability and Accountability Act (HIPAA) of 1996 required that the Department of Health and Human Services (HHS) establish national standards for electronic transactions to improve the efficiency and effectiveness of the nation's health system. These standards apply to all HIPAA-covered entities, including health plans, clearinghouses, and covered healthcare providers. These ultimately determine the level of privacy and security necessary to protect a client/patient's protected health information from falling into the wrong hands.

The Patient Protection and Affordable Care (PPACA) of 2010 expanded on the HIPAA provisions requiring that operating rules be developed for adopted transactions. Together, they are referred to as Administrative Simplification due to their purpose being to simplify the business of healthcare.

ADOPTED TRANSACTION STANDARDS AND OPERATING RULES:

Transaction	Standard
Health Care Claim (Institutional, Professional, and Dental)	X12N 837 Version 5010
Health Care Eligibility Benefit Inquiry/Response	X12N 270/271 Version 5010
Health Care Services Review Request for Review/Response	X12N 278 Version 5010
Health Care Claim Status Request/Response	X12N 276/277 Version 5010
Health Care Claim Payment/Advice	X12N 835 Version 5010



FOUR WAYS TO FILE A CLAIM:

- **Mail** - Some providers still choose this method despite it being the least efficient and least optimal for submitting claims to a payer. The process of mail-in claims involves sending a completed CMS 1500 form to the claims mailing address of the payer. Providers would need to use this method should the payer specifically not accept electronic claims directly or through a clearinghouse. Providers need to ensure that they have the receipt for the mailed claim in hand for tracking purposes. This way, if the claim is lost in the mail, you are aware and can resend it. Providers also need to send any attachments that are required for reimbursements, such as client/patient history, documentation/notes, or client/patient records—sending claims by mail delays behavioral health claims processing quite a bit.

- **Online** - Most (although not all) payers will allow providers to complete and submit claims electronically. This is done with an electronic version of the CMS 1500 or UB04 form through their secure payer portal. Form 837p is the HIPAA secure claims format for professional claims, and form 837i is the HIPAA secure claim format for institutional claims. This method is both faster and optimal. However, it requires manual tracking by the payer for follow-up purposes.

- **PMS/EHR/ClearingHouse** - You can submit claims using a Practice Management System (PMS), an Electronic Health Record (EHR), or a clearinghouse. Claim submission using a PMS or EHR is the leading practice for providers/organizations that submit claims electronically. Claims sent via these methods are created in the system, then submitted through a clearinghouse for editing. These are referred to as “pre-bill edits,” and they ensure that a claim is clean upon payer receipt. A clean claim is one that is completely free of errors, inaccuracies, or any other potential cause for denial. If a claim is clean, then the only likely cause for denial would be that the client/patient lacks coverage for the services they received.

A clearinghouse will complete your pre-bill edits to verify that your claims are clean before they are sent to the payer. This cuts down on rejections/denials so that you are on track for a timely payment.

Electronic Remittance Advice (ERA) can be retrieved back from the clearinghouse for claims’ payments and denial information. There are some that provide denial information based on type, the payer, or based on the denial codes. This information can be incredibly helpful for helping facilities get a firm grasp on why their claims are being denied and how they can prevent this from happening in the future.

- **Third-Party Vendor** - A third-party vendor can be responsible for processing claims for your institution so that you do not have to. Providers will need to supply them with pertinent claim information in order for them to do this. These third-party services are often referred to as “managed billing services” and, with the right partner, can be an incredible resource for helping providers optimize behavioral health claim processing.

  With a managed billing partner, there is less RCM burden, allowing providers to focus on the level of care they are delivering to their clients/patients. Instead, expert billers manage the entire RCM cycle, perfecting the behavioral health claim process along the way.

  Providers should make sure that the third-party vendor is up to date on HIPAA regulations and guidelines to protect your practice and business from violating those standards. You should also execute a Business Associate Agreement (BAA) with them. Teams should be clearly defined, and third-party roles/responsibilities should be included in the signed agreement. Key Performance Indicators should also be discussed and reviewed on a weekly or monthly basis.

  The vendor you choose to work with should also be ready to offer automation capabilities for billing such as automatic claim submission, ERA, and workflow automation.

BENEFITS OF UTILIZING A QUALITY BILLING PARTNER:

- Increase Clean Claims - With a team of experts taking over the process, an organization's percentage of clean claims rises. They pinpoint errors in behavioral health claim processing to help you have your best odds at approval. A good vendor or third-party billing service will have a good track record for increasing clean claims.

- Streamline the Process - more clean claims along with fully-automated processes means that your organization gets paid as quickly as possible. Those looking to increase the efficiency of their claims process can do it with an excellent third-party resource.

- Worry Less - As was mentioned before, RCM burden decreases when the grunt of the work is removed from your plate. Instead, focus on client care and worry less about whether or not your revenue cycle is on track.

For a free consultation with a quality managed billing partner, click here.

KEY TAKEAWAYS:

- **Understanding The Terms** - Making sure you understand the most-used terms regarding behavioral health claim processing is a great place to start. While most providers have a good understanding of what a claim is, there is much more to know if an organization wants to optimize the efficiency and result of the processes overall. From knowing what forms are used and where to what denial avoidance refers to, a better grasp of these terms has an impact on your ability to master each process.

- **The Claims Cycle** - While we could discuss every detail of the claims process for days, there are 5 main steps that go into it. Providers edit/submit the claim to the clearinghouse, the clearinghouse reviews it and sends it to the payer, the adjudication process takes place, the payer approves/denies the claim and pays the provider if applicable, and then the remaining balance is sent to the patient. There are a number of different digital tools and resources providers can use to automate and streamline each of these steps to make sure they are achieving the best outcomes in the shortest amount of time.

- **Administrative Simplification Standards** - There are several rules and regulations that must be adhered to through the entire billing process. Compliance is necessary for providers that wish to bill insurance.

- **The Different Methods For Filing** - There are several different methods that providers can choose from to file their claims with a payer. The most recommended option is to utilize a clearinghouse and submit claims electronically. Only use manual claim processing when absolutely necessary or if they are required by the payer.

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HOW THERAPY BRANDS/LOGIK SOLUTIONS CAN HELP:

In-house behavioral health claims processing can be complicated, time-consuming, confusing, and unfruitful. Utilizing every resource that is available is how organizations can add efficiency where it is needed and reach their KPIs.

Therapy brands can handle the process for providers by focusing on Denial Avoidance. While many are familiar with the term “denial management,” it is a thing of the past. Providers should not be trying to manage the denials they receive, they should be avoiding denials altogether. Therapy brands want to help you maximize clean claims, helping your organization get paid in a timely manner. We truly have the best interest of your organization in mind as we only do well if you do well.

Therapy brands will also help you run your practice more efficiently by providing a focus for strategic planning and decision-making through KPIs.

On average, therapy brands help our customers collect 95% or more of their expected net revenue while keeping accounts receivable over 90 days old under 20% of the total insurance accounts receivable.

Therapy Brands will manage your revenue cycle to truly optimize your bottom line.

SOURCES:

- Stall, D., Thompson, L. A., & Logik by Therapy Brands. (2021, October). Behavioral Health Billing 101: Claims Processing [Ensuring Efficient Management of Your Revenue Cycle]. Retrieved 2021, from https://f.hubspotusercontent30.net/hubfs/6854285/BILL/LGK/Logik%20Claim%20Processing%20Oct%2021%20webinar%20PPT.pdf

About Logik Solutions

As a pioneer in the industry, Logik has been partnering with behavioral health organizations for over 30 years. Behavioral health practitioners across the country trust and use our products and services to help their practices and facilities thrive. We are dedicated to elevating the behavioral health industry by providing powerful software, custom solutions, and an exceptional commitment for our customers.

Our signature billing software, built for enterprise-level behavioral health practices, streamlines billing and patient management and helps organizations maximize revenue and create efficiency. We also offer custom software, integrations and outsourced IT solutions to manage your practice in addition to consulting services that improve your operations.

Logik's passionate team of technologists and healthcare experts are dedicated to making a difference in behavioral health by advancing industry-leading technologies and solutions.

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