The Ultimate eBook for Urgent Care Billing and Operations

eBook

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Contents

Introduction

In this industry, getting patients in and out fast is your biggest priority. But to be successful, it's just as important to manage your billing and operations accurately and efficiently. This eBook will provide essential tips for billing non-credentialed and non-contracted providers, best practices, and KPIs you should be watching.

Chapter One

Billing for Non-credentialed and Non-contracted Providers

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Billing for Non-credentialed and Non-contracted Providers

A frequently asked question in the urgent care industry is whether a practice can bill and receive payment as an in-network provider for a clinician (physician or mid-level) who is new to the practice but not credentialed or contracted with the clinic's health plans.

This question occurs most commonly for the following situations:

- Employed Full-time or Part-time Hire: As a practice grows rapidly, new providers are needed quickly. This is especially true in urgent care. Sometimes this need is unexpected, and a clinic owner may not have the four to six months advance notice needed to fully credential a new clinician.
- Temporary or Substitute Hire: Another reason is unexpected loss of a provider (e.g., termination or leave without notice). A clinic may also have a clinician who is absent due to illness, pregnancy, vacation, or other situations where that person will be returning to work, and they need a short-term substitute provider.

For these situations, practices often ask their billing company if they can bill for the new provider under the clinic name or under another doctor's name. The answer is: it depends on the situation. Commercial insurance carriers will each have their own individual requirements, and Medicare also has its own policy regarding non-credentialed providers.

Billing For Employed Non-Credentialed Providers

Pay close attention to your payer contracts to know if you can bill for non-credentialed providers. If the health plan requires providers to be credentialed before providing services or if your new provider is not replacing anyone, you cannot bill for services rendered by that provider.

A practice would potentially be in violation of their health plan contract if they billed for services not provided by a credentialed provider. Some health plans require only physicians to be credentialed and tied to the contract. It is becoming more common for health plans to require all providers including mid-levels (CNPs, PAs, and other APs) to be credentialed.

On the other hand, if the health plan does not require individual credentialing, you can bill under the clinic name for new providers. In these cases, most health plans just need an updated roster of providers offering services under the clinic agreement. Medicare requires that all employed (permanent full-time or part-time) providers be credentialed with Medicare in order to bill for the services provided.

Billing For Temporary or Substitute Non-Credentialed Providers

The answer is more complicated in this type of situation. Let's look at the two billing options available for non-credentialed providers in this circumstance—locum tenens (fee-for-time compensation agreements) and reciprocal billing arrangements.

Locum Tenens (Fee-for-Time) Arrangements

LOCUM TENENS DEFINITION: A locum tenens is a substitute physician, who fills in for a regular physician (the provider that is normally scheduled to see the patient) who is absent but does not plan to permanently join the practice. Locum tenens usually have no practice of their own and move from area to area as needed.

Locum tenens is now officially called fee-for-time compensation by the Centers for Medicare and Medicaid (CMS), although many people still refer to this arrangement as locum tenens.

Medicare Rule for Locum Tenens

Medicare allows a regular physician to bill and receive payment (when assignment is accepted) for a substitute physician's services as long as the following criteria are met:

- The regular physician is absent and unavailable to provide the services
- The Medicare beneficiary has an appointment or seeks an appointment with the regular physician
- The regular physician pays the locum tenens for their services on a per diem or similar fee-for-time basis
- The locum tenens does not provide services for more than 60 consecutive days (even if a provider does not have a full-time schedule)
- The regular physician identifies the services as locum tenens services meeting the above criteria by applying the Q6 modifier on each procedure (CPT) code billed

Medicare's policy does not allow advanced practice providers (mid-levels) to be locum tenens. If a provider or group practice requires a substitute physician for longer than 60 consecutive days, it is a good idea to enroll that locum tenens provider with payers. After the 60-day limit expires, a practice may no longer bill for that locum tenens physician.

The practice must also keep a record of services performed by the locum tenens along with the NPI number.

Newly employed physicians that are not enrolled with Medicare cannot be considered locum tenens physicians.

Commercial Insurance Carriers

Verify with your payers what the terms of your contract are or what their billing policies are regarding the use of locum tenens physicians. Some health plans require locum tenens to still be listed as the rendering/billing provider and others may follow Medicare's policy.

If you do not know the specifics of a health plan contract, a good rule of thumb is to follow the Medicare policy for locum tenens physicians until you have clear guidance.

Reciprocal Billing Arrangements

RECIPROCAL BILLING DEFINITION: A reciprocal billing arrangement is an agreement between physicians to cover each other's practice when the regular physician is absent. This is usually an informal arrangement and is not required to be in writing.

Medicare

Services may be submitted under a reciprocal arrangement if all of the following criteria are met:

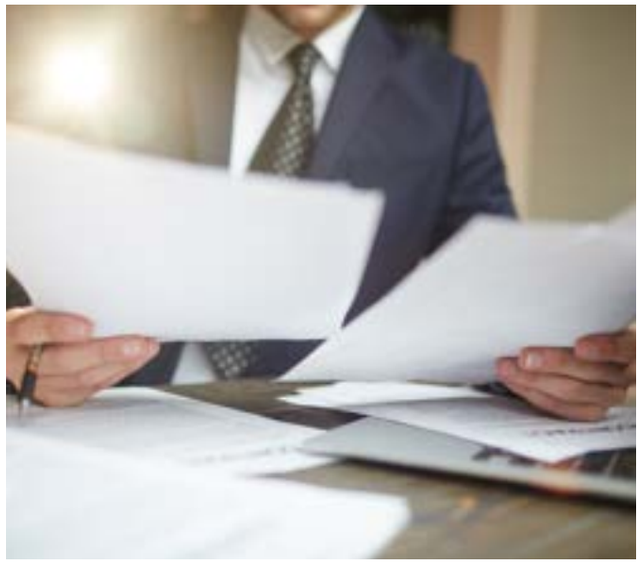
- The regular physician is unavailable to provide the services
- The patient has arranged or seeks to receive care from the regular physician
- The substitute physician does not provide services to the beneficiary over a continuous period of more than 60 days
- The regular physician submits the claim with a Q5 modifier with each service (CPT) code

Reciprocal billing is another option for urgent cares if locum tenens arrangements are unavailable or are no longer an option. Similar to locum tenens, reciprocal billing arrangements cannot extend past 60 days.

These stop-gap measures are meant to be a temporary solution, and Medicare assumes your clinic is working toward employing regular credentialed and contracted physicians to provide services.

Commercial Insurance Carriers

Verify with your contracted health plans to make sure you are following your contract and billing policies for reciprocal billing. If you do not know what is required by a specific payer, again, it is a good rule of thumb to follow Medicare policy.



Tips for Utilizing Non-Credentialed Providers

If neither locum tenens nor reciprocal billing arrangements are a solution for your practice's billing needs, don't lose heart.

There are some options to help fill the gaps as your providers gain their proper credentials. Here are a few quick ideas that might help your urgent care:

- Always, always know your health plan contracts well and understand the best way to bill for non-credentialed physicians (so no violation and potential lost contract occurs)
- Have non-credentialed providers see only self-pay patients
- Have non-credentialed providers do sports physicals, OccMed services, and other types of services that do not require credentialing
- If commercial insurance allows some levels of staff to be non-credentialed, schedule more visits to those non-credentialed staff to help with workload until they receive their credentials
- Work with patients who see a non-credentialed provider (out of network) so a payment plan or some other option can be utilized
- Start credentialing providers right away (even while in the interview phase) so by hire date their credentialing is in motion and ideally completed

A Last Word on Non-Credentialed Provider Billing In Urgent Care

Non-credentialed provider billing will continue to grow as a topic and come under scrutiny. Due to the quick growth urgent care practices experience and turnover of physicians, it is important you know how to bill for non-credentialed providers when the need arises.

You must understand your contracts with health plans and what their billing policies are regarding non-credentialed providers to avoid any potential violations. Work closely with billers and credentialing teams to ensure your urgent care knows exactly how to bill claims for non-credentialed physician services.

When using non-credentialed providers, be fully transparent with patients. Let them know that while the clinic is credentialed, they may (or will) be seen by a provider outside of their network to prevent any unexpected billing surprises.

Chapter Two

7 Common Missteps in Urgent Care Coding and Billing

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Medical coding and billing are often viewed as separate from the practice of treating patients. But nothing could be further from the truth.

Patient care and billing are intimately connected, and consequently, so is claim reimbursement. Even though a patient's insurance coverage or lack of coverage may complicate reimbursement, it should never impact medical decisions. Every person in the claim creation process impacts revenue and the overall financial success of your practice.

Unfortunately, claims are often plagued by missteps because of the number of steps and people involved in the claim creation process. Reimbursement is the lifeblood of your clinic, so don't wait for problems to happen. Be proactive and look out for these common missteps in billing and coding to help your clinic receive the reimbursements you've earned.

MISSTEP

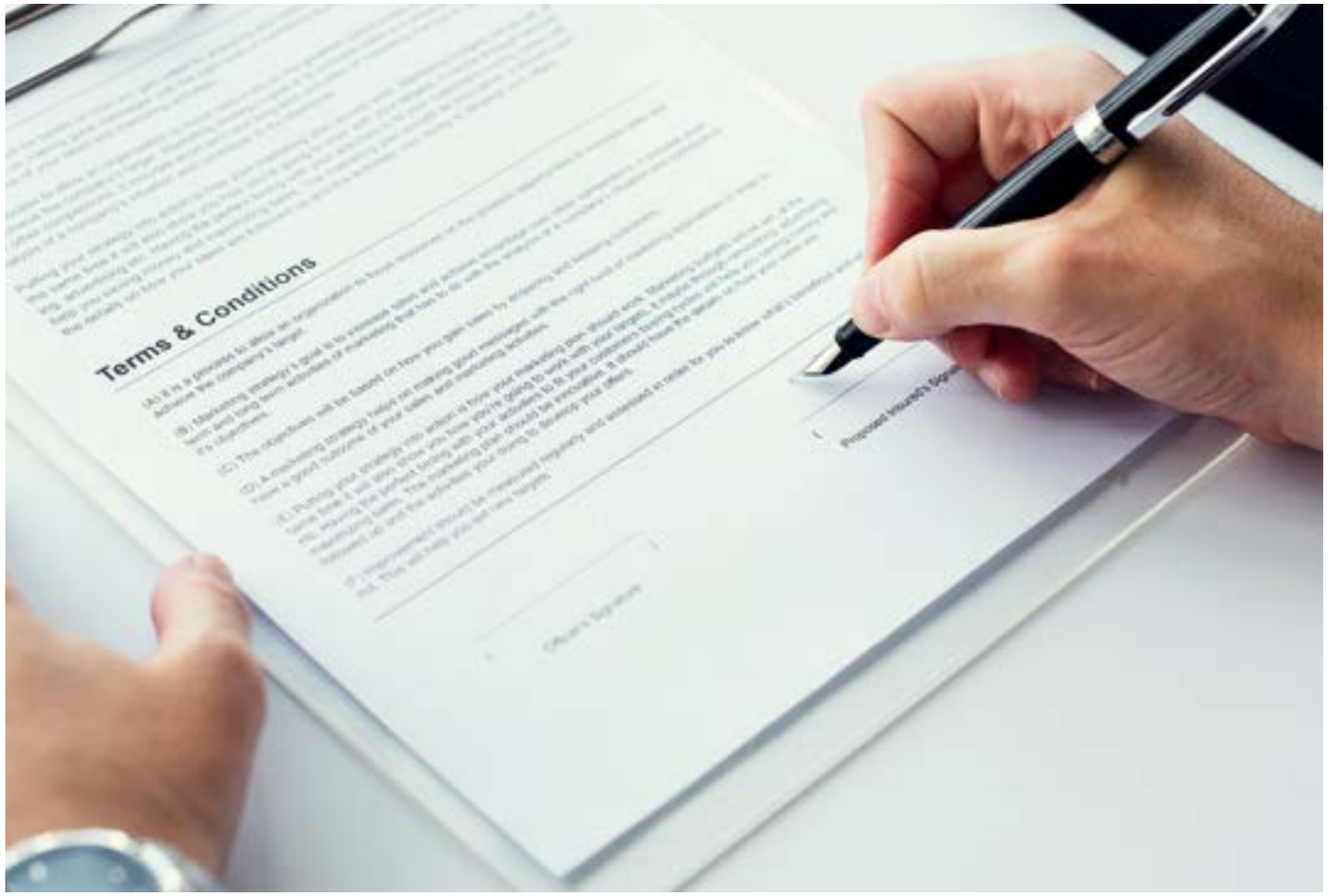
1

Bad *(or No)* Payer Contracts

Before workflow even begins, contracting is where issues can arise. If your clinic has poor or no payer contracts, this will be directly reflected in your clinic's reimbursement.

Only when this is corrected will claims be processed and paid correctly.

Make sure you're contracted with the payers in your area— preferably prior to opening your urgent care. If you wait to negotiate contracts, your clinic will not be able to accept insurance from patients in your area. While you can accept only cash-pay patients, your patient visits may stay low until more contracts are in place.



Advice: Hire a professional contracting expert who knows payers in your region. They will negotiate on your behalf, understand the fine print details, and know the best contracted rates for your region. Having a versed professional on your side will help you negotiate better rates—especially if you are a new urgent care.

MISSTEP

2

Poor Front-desk Processes

Patient registration has many steps, and errors can easily happen during this process. If a patient's demographics, insurance numbers, and claim addresses aren't entered correctly (or at all), submission will be delayed, or the claim will need to be resubmitted. An incorrect payer will often be selected by the front desk based on past patient records. A patient can unknowingly give incorrect insurance information if they are covered under multiple insurance plans.

Poor front-desk policies can contribute to failures too. Have personnel ask, "What's your current insurance?" rather than the more general, "Has anything changed since your last visit?" to avoid missed information.

One common error is claiming charges incorrectly under the wrong patient with a similar name or a minor linked to the wrong guarantor account. This is often discovered when the patient gets a bill. This could be a HIPAA violation and may need to be reported to the Office of Civil Rights (OCR) and could carry significant fines.

Advice: Train front desk staff to check insurance and periodically audit denied claims to see if you have a trend in incorrect information being entered during the registration process. Invest in a practice management solution with integrated real-time insurance verification.

MISSTEP

3

Missing Valuable Charges

Incomplete documentation causes missed charges. This misstep can easily happen in the busyness of a patient visit, especially when instructions are communicated verbally. Common missed charges include labs, blood draws, administration of an injection, and x-rays. Be sure providers and coders know which services are separately billable. Coders should review guidelines regularly (at least annually) to be sure they are following the current billing guidelines for services performed.

In addition, providers can fail to document units of service (or drug dosage amounts). Quantity of dispensed drugs need to be noted accurately so the correct charge can be stated on the claim. Poor documentation for procedures will cause delayed claim submission or missed reimbursement.

Advice: Teach providers to document commonly missed charges like labs and injections. If your EMR has smart alerts, set these up to remind providers of incomplete procedure documentation when locking charts. Have an easily reviewable list and common conversion table for drug dosage. Keep a log of all requested labs and drugs dispensed and double check these against claim charges.

MISSTEP 4

4

Using Wrong Codes and Ignoring Code Changes

Providers tend to get comfortable with their E/M code selection. Choosing a “just-right” Level 2 or 3 code is seen as a more prudent coding choice than choosing higher level codes—even if documentation supports a higher code level. If providers consistently select lower code levels than services performed, your practice could be losing hundreds of dollars a day.

Incorrect or incomplete documentation habits lead to poor coding, both under-coding and up-coding (which often initiates audits). Providers will regularly focus directly on patient care, leaving code selection entirely in the hands of the coder.

While not incorrect in their focus, this mindset can contribute to loss of revenue and incomplete documentation.

In light of the new E/M coding guidelines that went into effect in January of 2021, providers need a working knowledge of definitions more than ever. With this knowledge, they can more accurately select the appropriate level of risk which is primarily a clinical decision.

The American Medical Association updates CPT codes annually. It’s not uncommon for a code number to stay the same while the description changes. Be sure the code you choose accurately describes the service you provide, and make sure a “new” or different code is not more appropriate.

If your coding team isn’t up on code changes and isn’t re-certifying for updates—your claims could be submitted with dated information, and you could be losing money.

Advice: Audit claim levels in your practice over several years and compare them to the industry norm. See if you’re potentially under- or up-coding based on benchmark patterns. If using an EMR, see if providers regularly select a code other than what the system suggests or are selecting a single code level frequently. Make sure your coders are up to date on code changes.

MISSTEP

5

Choosing Incorrect *(or forgetting!)* Code Modifiers

Code modifiers are an addendum to a selected CPT code, which help accurately describe to the insurance payer the type of services provided to the patient. Often, services don't fit nicely into one CPT code, so modifiers can make the difference with explaining what exactly was provided to the patient. For example, if an office visit results in the decision to perform a separate, unrelated procedure, indicate this by applying a 25 modifier to the E/M code.

Code modifiers can easily be missed, used incorrectly, or abused. It's also important to understand each payer's requirements. Individual payers have varying levels of acceptance of certain modifiers, and the misuse of modifiers will cause claim denials.

Understanding HCPCS levels is key to accurate reimbursement. HCPCS Level 1 codes refer to CPT code charges. HCPCS Level 2 codes are included for injectable drugs, medical equipment, or supplies provided in addition to treatment—such as splints or crutches. If you supply medical equipment, ensure you use correct code modifiers to prevent denials.

Advice: Ensure coders understand the proper use of modifiers. Run a report on your most used CPT codes and corresponding modifiers and include these for easier selection on your superbill or in your EMR.

Use code scrubbing software to automate repetitive modifier and code selections. Audit periodically to ensure modifiers are correctly correlated to provided services.

Communication can go a long way to cleaning up claims. Be sure your billing team is sharing coding denials with coders, so they are aware of common mistakes.

MISSTEP

6

Having Wrong Diagnosis to Procedure Mapping

A fast way to increase claim denials is to have a wrong diagnosis to procedure correlation. For example, if a patient has a laceration, you shouldn't pair that procedure with a diagnosis of acute asthma. Each procedure should correspond directly with the diagnosis of the patient and be considered "reasonable and necessary" for treatment or preventative care. Each line item should be linked to the correct ICD for accurate reimbursement.

It's a coder's responsibility to map the correct procedures with the relevant diagnosis code as documented. Knowing payer limitations and requirements (which change frequently) is essential to receive correct reimbursement—such as using NCDs or LCDs for Medicare patients.

Advice: Look at the correlation between diagnoses and procedures at your urgent care. Do they line up? Make a list of the top diagnoses in your clinic and corresponding procedures to help educate your billers. Always know your payer's requirements before claim submission. Utilize an automated coding tool to assign common diagnoses and procedure pairings.

MISSTEP

7

Not Following Up on Denied Claims or Writing Off Unpaid Charges too Quickly

Many practices don't have enough time or enough information to find a consistent pattern in claim denials. Sometimes billers don't have time to audit work — let alone look at problems with denials.

Looking at trends of denials with specific payers, providers, and similar diagnoses can give your clinic a more transparent, proactive approach to claim cleanliness.

After receiving claim payment, accurate payment posting is essential to reducing bad debt. Clinics often make the mistake of automatically writing off unpaid charges that can be appealed or corrected and then resubmitted.

If charges can be received from a payer with a few corrections, it's worthwhile to take this additional step to ensure accurate revenue intake.

Advice: Avoid writing off bad debt for your practice by following up on denied claims. Find a pattern in your rejections and use them to help train staff on how to improve documentation.

Conclusion

While some urgent cares have adopted a fee-for-service only model, most still rely on insurance payment.

As long as clinics depend on payers more than patient responsibility for reimbursement, claim coding and billing will be important for financial health. Consequently, making sure each step in the claim creation process is accurate and complete is vital to receiving timely and full reimbursement.

Chapter Three

10 KPIs to Watch in Your Urgent Care

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KPIs are the vital signs of your clinic. Similar to a patient exam, these metrics help tell the story of your urgent care's overall financial health.

Poor KPIs serve as warning signs of business issues that need to be addressed. With this data, owners are empowered to make wiser decisions regarding staffing, services offered, and process improvements.

While owners traditionally track KPIs in an urgent care, all staff should understand why and how the KPIs are measured, and what actions affect each metric.

Here are ten of the most important KPIs to watch in your urgent care.

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KPI 1

Average Revenue Per Visit

What it is and why it's important:

The average revenue per visit is the total amount received per visit from both the patient and the payer. Average revenue shows actual payments received per visit. It also helps determine projected cash amounts.

What can affect it:

This number can be difficult to calculate accurately because it needs to be averaged over a set period of time, usually six months to one year (rolling average). Incomplete visits in A/R should be removed from this metric, along with bad debt write-offs.

Occupational medicine and workers' compensation visits should be segmented and averaged separately, so they don't skew the average revenue per visit for general urgent care visits. The mix of payer types and contracted rates affect this number.

CALCULATION

$$\frac{\text{Total Payments Collected} - \text{Total Refunds}}{\text{Total Visits}}$$

Recommendation

Calculate this over a set period of time.

KPI 2

E/M Code Distribution

What it is and why it's important:

E/M code distribution shows the use of code levels by staff. E/M codes directly affect reimbursement amounts. Code levels 2 through 5 tell payers the level of visit complexity, and accordingly charges rendered.

What can affect it:

Documentation supports E/M code selection, so it's essential for providers to enter all correct information for the appropriate code selection. Up-coding and under-coding can explain unnatural variations in E/M codes—leading to wider clinic revenue fluctuations. Chart audits (on a per provider basis) can pinpoint coding and documentation performance needs.

The percentage of new versus established patient visits should be evaluated when reviewing E/M code distribution, as reimbursement per visit varies per patient type. Established patients traditionally have a higher code level, due to past documentation records.

CALCULATION

$$\frac{\text{Expected Code Value of all Visits}}{\text{Total \# of Visits}}$$

Example

CODE	NUMBER OF VISITS	EXPECTED CODE VALUE
99202	1	2
99203	1	3
99204	1	4
99205	1	5

Sum of expected code value of all visits = 14
Number of visits = 4

14/4 = 3.5

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KPI 3

Ancillary Revenue Per Visit

WHAT IT IS AND WHY IT'S IMPORTANT:

Ancillary revenue per visit is how much revenue you receive per visit for procedures and services. Urgent cares often have a contracted amount for an office visit E/M code with payers—so ancillaries are in addition to that amount. Ancillary charges can be labs, injections, x-rays, or medical equipment.

WHAT CAN AFFECT IT:

Incomplete documentation of procedures cost an industry average of $25 per visit. Providers can forget to include procedure documentation and codes when tied to an ancillary service (such as a rapid strep test plus the charge for processing the lab result). Only visits with an E/M code should be considered, as these visits have procedures tied to the visit type.

CALCULATION

$$\frac{\text{Total Collections of CPT Code Range}}{\text{Total Visits with CPT Code}}$$

KPI 4

Front Desk Collection Average

WHAT IT IS AND WHY IT'S IMPORTANT:

Front desk collection rate is the percentage of collections gathered by the front desk from patients before they leave the clinic. A larger the percentage captured at the front desk is typically reflected in a higher percentage of overall collections per visit. Patient payments continue to increase.

WHAT CAN AFFECT IT:

Enforcing the correct collection of co-pays at patient intake ensures higher percentage of patient payments in full.

Traditionally in urgent care, the policy is to gather as much at time of service as possible since the patient is not as likely to be a repeat customer — or may not be insured.

Having real-time insurance verification in your software helps staff collect the correct amount. If patient is cash-pay, personnel should gather 100 percent at time of service.

CALCULATION

$$\frac{\text{Front Desk Collection Dollar Amount}}{\text{Total Visits}}$$

KPI 5

Days in Accounts Receivable (A/R)

WHAT IT IS AND WHY IT'S IMPORTANT:

Days in A/R is the amount of time your charges are sitting in accounts receivable. This is the revenue you have yet to get paid for, divided by the average daily charges at your clinic. The lower your days in A/R, the quicker the turnaround with realized revenue.

WHAT CAN AFFECT IT:

Payers and patient responsibility both affect this number. The cleanness of your claims during submission means a faster accepted claim and reimbursement. Fluctuations in days in A/R mean payer or claim issues are likely.

The goal for days in A/R is to keep day distribution steady and not to let more A/R slide to higher aging.

Days to bill (how long it takes to get your bills out) and days to pay (how long it takes a payer to pay) also affect this metric. Typical days in A/R for urgent care range from 20 to 40+ days. For the most accurate result, calculate this metric on a three-month average.

CALCULATION

$$\frac{\text{Total Outstanding Accounts Receivable}}{\text{Average Daily Charges*}}$$

*Average Daily Charges = Total gross charges/number of days

Recommendation

Use last 90 to 120 days of charges as an average to remove seasonal fluctuations. Also review total days in A/R versus insurance-only days in A/R.

KPI 6

Percentage of Accounts Receivable Over 120 Days

WHAT IT IS AND WHY IT'S IMPORTANT:

This metric is the percentage of A/R being held for over 120 days. The longer your A/R isn't collected (in 90 to 120+ days) the more likely it is you have serious collection issues—and lower overall reimbursement rates. The goal is to have the smallest percentage possible fall into this older aging bucket. Split your A/R into categories of insurance, patient, and employer—and set goals for how much A/R you'd like in each aging segment.

WHAT CAN AFFECT IT:

Offenders for insurance delays could be payer contracts, provider credentialing, front desk procedures, or not completing A/R fast enough.

You can keep your patient A/R from aging to 120+ days by sending unpaid balances to collections at the 90-day mark.

CALCULATION

$$\frac{\text{Total A/R Aged Over 120 Days}}{\text{Total A/R}}$$

KPI 7

Days to Bill

WHAT IT IS AND WHY IT'S IMPORTANT:

Days to bill is how long it takes your billing team to get claims submitted. Faster days to bill means fewer days in A/R and faster reimbursement from insurance and patients. However, faster days to bill is not worth causing claim quality to suffer if you increase claim rejections and therefore, days in A/R.

WHAT CAN AFFECT IT:

Several items can slow days to bill. They include providers not locking patient charts, front desk errors, slow coding teams, EMR system not set-up to have claims prepared daily, or bad processes for following up on unsent claims.

CALCULATION

> Number of days between visit date and claim date to the first payer

Recommendation

Calculate only for visits with insurance claims.

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KPI 8

Days to Pay

WHAT IT IS AND WHY IT'S IMPORTANT:

Days to pay is the amount of time it takes a payer to pay a claim. Quicker reimbursement means fewer days in A/R and faster revenue realized.

WHAT CAN AFFECT IT:

This number will vary based on payer types and will be affected by how clean your claims are. Contracts with payers generally define days to pay—and appeals for claims can be submitted by billing teams if the claim is rejected or not submitted on time.

Ranges for days to pay depend on payer and claim practices, but typically fall in a seven-to-30-day range.

CALCULATION

> Number of days between the date when claim is sent and date of first payment received from insurance

Recommendation

Calculate only for visits with insurance claims. Break days to pay down by payer. This can identify payers that take longer to pay—so you can pinpoint delays and inquire about reasons why.

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KPI 9 Visits Per Clinic Per Day

WHAT IT IS AND WHY IT'S IMPORTANT:

Even with the best payer contract rates, it doesn't matter if you don't have any patients coming through the door. You won't reach a profit without adequate patient volume. An urgent care business plan should designate breakeven and profit points tied to visits per day.

WHAT CAN AFFECT IT:

The age and location of the clinic affects this number. Newer clinics slowly build a patient base, while established clinics have a solid base with repeat customers and a reputation of service to rely on. Marketing and community partnerships can also increase this metric. Seasonality will often increase or decrease visits.

CALCULATION

$$\frac{\text{Total Patient Visits}}{\text{Total \# of Business Days}}$$

Recommendation

Calculate over a set time period — generally a week or month. Segment numbers by clinic if you have multiple locations.

KPI 10 Door-to-door Time

WHAT IT IS AND WHY IT'S IMPORTANT:

This is the amount of time it takes from the moment a patient enters your clinic to when they leave. In urgent care, lower door-to-door times increase the number of patients you can see. The more efficient the visit time, the more revenue made.

WHAT CAN AFFECT IT:

Complexity of visit, staff response within the clinic, and poor work-flows can affect this number. Typical door-to-door times in urgent care range from 20 to 70 minutes, well under national emergency room averages.

CALCULATION

$$\frac{\text{Total Door-to-Door Time for All Visits}}{\text{Total Visits}}$$

Recommendation

Calculate over a set time period — generally a week or month. Segment numbers by clinic if you have multiple locations.

*

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Conclusion

Use KPIs to understand your organization's health. Having set goals for your clinic is essential for success, along with establishing a baseline of data for comparison. Examining data over periods of time gives your clinic a well-rounded picture of performance.

Consistent data review keeps you aware of trends and potential issues. An invaluable asset to your clinic is a reporting tool that lets you pull real-time reports, find clinic trends, and spot trouble areas quickly. Better yet is if this tool includes benchmarks that let you compare your results directly against other urgent cares, regionally and nationally.

Data interpretation requires looking at the entire scope of your clinic's performance to find correct cause and effect. Assumptions and incorrect comparisons can result in poor reactions and business decisions. KPIs empower better decision making for urgent care owners—but only if you know how to calculate them, track them, and adjust processes to improve results.

To be successful and compliant, urgent care clinics must count on the accuracy of every claim. Understanding the differences in coding for non-credentialed providers, watching for common errors with regular audits, instituting best practices, and staying on top of important key performance indicators are big factors in supporting your success.

What are you waiting for?

LET'S TALK

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