Billing for Services: Key Considerations for Providers

Your organization may be required to change billing practices upon contracting, or entering into an agreement, with a health plan. Submitting a formal medical billing claim form may be a new experience for your organization. Your organization may be used to sending invoices directly to the state or a county agency for long-term services and supports (LTSS) you provided to Medicaid enrollees. While billing practices and requirements will vary between health plans, there is some basic information that will be common across all plans. This brief outlines key issues for LTSS providers to consider when billing or submitting claims to health plans.

Key Considerations

What does my organization need to know about getting paid?

- Each contract will specify payment terms. The payment structure may vary between health plans; your organization should carefully review this section to understand the arrangement with each health plan, including:
  - **Claims processing.** This section will define the timeframe in which your organization is obligated to submit your claims (or bills) to the health plan. It will also define how quickly the health plan will process your claim. Check to see if there is any penalty for the plan if it fails to process your claim in the specified time frame.
  - **Form of payment.** Some health plans may only offer electronic deposits instead of paper checks. This may require your organization to modify your accounting processes to ensure that you can accept electronic deposits. Communicate with the health plan to determine whether there are any technological constraints that will affect how you need to be paid.
  - **Frequency of payment.** You may need to work with the plan to ensure timely payments (e.g. every two weeks or monthly). Based on your cash flow requirements, you may need more frequent payments or your organization may need to adjust internal accounting procedures to match the frequency of payments.
- Each contract will specify the fee that the health plan will pay for each service and the billing codes that should be used. Your organization should carefully review this section to understand the arrangement with each health plan, including:
  - **Billing units.** The contract should establish the billing units and corresponding rates. *Is the billing unit per person? Per ride? Per day? Hourly*?
  - **Billing codes for services.** Each service that you provide is going to be identified by a unique code. For example, your organization will need to use different codes depending on whether a service is provided by a home health aide or registered nurse. Health plans may use state-defined services and codes or opt to define their own list. Your organization should pay special attention to code “modifiers.” Modifiers allow you to provide additional information to the health plan to ensure that you are paid correctly.

- **Service definitions.** A particular billing code may code for bundled services. The contract should establish the service definition for each billing code, detailing what is included. *Does assisted living include room and board? Does the billing code for adult day services include transportation, meals and baths?*
- **Service pre-authorization.** Some services will only be paid for if they are pre-authorized. What are the health plan's policies regarding pre-authorization of services?

What will prevent the denial of claims?

- Health plans are responsible for offering provider manuals and many will offer training sessions on billing for LTSS providers. Please refer to any billing training materials to review your health plan's billing specifications.
- Your organization should review how the health plan defines "clean claim." These are generally claims that are complete, do not contain errors, and are able to be processed by the health plan. When filling out the billing claim form:
  - Make sure that you are using the correct billing form.
  - Type or write legibly. Claims that are difficult to read may cause delays in processing.
  - Verify that all information on the claim form is accurate and complete.
  - Consider exploring electronic billing if it is offered by your health plan. Electronic submission can be faster and more accurate resulting in a reduction in claims processing time and faster payment. Electronic billing can also point to missing or incomplete information when attempting to submit the claim. If you don't have electronic billing capabilities now, ask the health plans what they may be able to do to help you.
- Don't hesitate to speak up if you encounter any problems. Contact your health plan to make sure that they know of any operational limitations that your organization is facing.

What to do if your claim is denied?

- Try to understand why the claim was denied. Make sure that you thoroughly review the claim that was denied for any missing or incomplete information.
- Contact the health plan help desk or a designated claim dispute hotline if assistance is required.

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