Understanding Reimbursements

Janet Bozzone, DMD, MPH, FAGD
Maggie Drozdowski Maule, DMD, MBA

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Part of NNOHA’s developing Practice Management Resources

Current chapters in development for the Operations Manual for Health Center Oral Health Programs include:

- Financials – Published!
- Risk Management – Published!
- Workforce and Staffing – Coming Soon!
- Quality – Coming Soon!

“Understanding Reimbursements” will be available as a chapter next year.
Learning Objectives

• After attending this session, the participants should be able to:
  ▪ Understand the different payment systems;
  ▪ Understand how Health Center fees are generated and how the money is recouped;
  ▪ Know the different organizations that are involved;
  ▪ Recognize the differences between private practice and Health Center billing practices; and
  ▪ Understand sliding fee schedules and nominal fee charges
“Health Center dentists don’t need to worry so much about productivity because the costs of the oral health program get paid for through a federal grant.”
Setting Your Financial Structure

- “Health Center dentists don’t need to worry so much about productivity because the costs of the oral health program get paid for through a federal grant.”
  - Typically, Health Center grants pay for about 17% of costs
  - The majority of costs must be paid through 3rd party payments (primarily Medicaid and commercial insurance)
Prospective Payment System

- The PPS establishes a per visit payment rate for each Health Center. [PL 106-554]
  - Replaced “cost-based” reimbursement in 2001
  - Is generally paid for each visit to the Health Center, regardless of number of departments involved.
  - Is often defined differently by states.
  - Is generally defined as a face-to-face dental visit between a patient and a dentist or a licensed dental hygienist.
  - Is a floor, not a ceiling on reimbursement for Health Center services.
  - Is not restricted by Federal law. Nothing prevents, prohibits, or precludes a state from paying Health Centers above the PPS rate.
Future Rates

- Starting fiscal year 2002 rates modified by
  - Medicare Economic Index (MEI)
  - Change in scope for the FQHC (increase or decrease)
  - Capital expenses
    - New sites
    - Expansion
    - New equipment

- Can appeal for review
PPS for New FQHCs

- Entities that qualify as FQHCs after fiscal year 2000
  - The rates established for the fiscal year for other centers or clinics located in the same or adjacent area with a similar case load or
  - In the absence of such a center, in accordance with Medicare FQHC regulations and methodology, or based on other tests of reasonableness as the Secretary may specify

*NACHC presentation*
Capitation

• Capitation
  ▪ is a fixed amount of money per patient per unit of time. Generally, a fixed fee per member, per month
  ▪ Used by managed care organizations to control health care costs.

• Wrap-around
  ▪ is a payment mechanism where states reimburse Health Centers if there is a difference between the PPS payment rate and the amount they received under their Medicaid managed care contracts
New Concepts

• Ambulatory Payment Groups (APG)
  ▪ Ambulatory patient groups form the basis of a prospective payment system for reimbursing outpatient services that was developed through funding from HCFA for use in the Federal Medicare program.
### Sample Table of revenue for a single dentist Health Center practice

<table>
<thead>
<tr>
<th>Payor</th>
<th>Encounters</th>
<th>Avg Charge</th>
<th>Total Charges</th>
<th>Adjustment Rate</th>
<th>Expected Amount</th>
<th>Collection Rate</th>
<th>Projected Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>1000</td>
<td>$150</td>
<td>$150,000</td>
<td>100%</td>
<td>$150,000</td>
<td>100%</td>
<td>$150,000</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>500</td>
<td>$150</td>
<td>$75,000</td>
<td>80%</td>
<td>$60,000</td>
<td>90%</td>
<td>$54,000</td>
</tr>
<tr>
<td>Self Pay</td>
<td>1000</td>
<td>$150</td>
<td>$150,000</td>
<td>15%</td>
<td>$22,500</td>
<td>80%</td>
<td>$18,000</td>
</tr>
<tr>
<td>Total</td>
<td>2500</td>
<td></td>
<td>$375,000</td>
<td></td>
<td>$232,500</td>
<td></td>
<td>$222,000</td>
</tr>
</tbody>
</table>
Factors Affecting Your Financial Structure

- Encounter rates
- Fee Schedules
  - Full fee schedules used at Health Centers should be comparable to those employed in the surrounding private sector.
- Sliding Fee Scale
  - A sliding fee scale must be applied to the charges of any patient whose income is below 200% of the poverty level if Medicaid, commercial insurance or other forms of payment do not apply.
Factors Affecting Your Financial Structure (Cont’d)

• Nominal Fees
  - HRSA Sliding fee regulations require that all patients whose income is at or below 100% of the FPL be charged only a nominal amount for each visit (typically $25 or less, though there is no set standard).

• Relative Value Units
  - Help measure provider productivity and compensation
  - Assist in the development of fee schedules and reimbursement models
### Using RVUs to Generate a Fee Schedule

#### Fee Schedule for Anytown CHC

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>UDS</th>
<th>RVU</th>
<th>Supply/Lab Cost</th>
<th>Slide A</th>
<th>Slide B</th>
<th>Slide C</th>
<th>Slide D</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic Oral Exam</td>
<td>1</td>
<td>1.5</td>
<td>$3.00</td>
<td>$25.50</td>
<td>$36.75</td>
<td>$48.00</td>
<td>$78.00</td>
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<tr>
<td>D0140</td>
<td>Limited Oral Evaluation - Problem Focused</td>
<td>1</td>
<td>0.5</td>
<td>$7.50</td>
<td>$11.25</td>
<td>$15.00</td>
<td>$25.00</td>
<td></td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive Oral Evaluation</td>
<td>1</td>
<td>3.0</td>
<td>$5.00</td>
<td>$50.00</td>
<td>$72.50</td>
<td>$95.00</td>
<td>$155.00</td>
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<tr>
<td>D0272</td>
<td>Bitewings - Two Films</td>
<td>1</td>
<td>0.4</td>
<td>$2.00</td>
<td>$8.00</td>
<td>$11.00</td>
<td>$14.00</td>
<td>$22.00</td>
</tr>
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<td>D0274</td>
<td>Bitewings - Four Films</td>
<td>1</td>
<td>0.8</td>
<td>$4.00</td>
<td>$16.00</td>
<td>$22.00</td>
<td>$28.00</td>
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<td>D1110</td>
<td>Prophylaxis - Adult</td>
<td>2</td>
<td>1.5</td>
<td>$4.00</td>
<td>$26.50</td>
<td>$37.75</td>
<td>$49.00</td>
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<tr>
<td>D2750</td>
<td>Porcelain/Ceramic FM High Noble Metal</td>
<td>3</td>
<td>10.5</td>
<td>$130.00</td>
<td>$287.50</td>
<td>$366.25</td>
<td>$445.00</td>
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<tr>
<td>D2150</td>
<td>Amalgam - 2 Surface, Primary or Permanent</td>
<td>3</td>
<td>2.0</td>
<td>$4.00</td>
<td>$34.00</td>
<td>$49.00</td>
<td>$64.00</td>
<td>$104.00</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin - 1 Surface, ANTERIOR</td>
<td>3</td>
<td>2.0</td>
<td>$4.00</td>
<td>$30.00</td>
<td>$45.00</td>
<td>$60.00</td>
<td>$100.00</td>
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<tr>
<td>D2392</td>
<td>Resin - 2 Surface, POSTERIOR</td>
<td>3</td>
<td>2.5</td>
<td>$2.00</td>
<td>$39.50</td>
<td>$58.25</td>
<td>$77.00</td>
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<tr>
<td>D3320</td>
<td>Root Canal - Bicuspid</td>
<td>4</td>
<td>12.0</td>
<td>$4.00</td>
<td>$184.00</td>
<td>$274.00</td>
<td>$364.00</td>
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<td>D5110</td>
<td>Complete Denture - Maxillary</td>
<td>6</td>
<td>15.0</td>
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<td>$475.00</td>
<td>$587.50</td>
<td>$700.00</td>
<td>$1,000.00</td>
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</tbody>
</table>
Coding Accurately

- Maximizes revenue
- Adds to the basis of your PPS rate
- Captures productivity more precisely
- Provides billing compliance
Factors Affecting Your Financial Structure (Cont’d)

• Payor Mixes: Appropriate vs. Optimal Payor Mix
  ▪ Health Centers should know what percentage of full cost to expect from each of the payor sources before determining the range of services to be offered.

• Services provided/ Scope of practice
  ▪ Focus may range
    • Preventive, Diagnostic and Emergency Care*
    • “Essential” Oral Health Services**
    • Varying levels of services up to full “Comprehensive” care

• Outside Lab Work
Revenue

- Net Revenue = Gross Charges less
  - Contractual Adjustments
  - Sliding Fee Discounts
Different Revenue Sources

- Grants
- Self-Pay Patients
- Third Party Insurers
- Medicaid
- Medicare
- CHIP
- Fee-for-service (FFS) contractual agreements/Contractual allowances
- Capitation plans
Revenue Cycle Management: Front Desk to Operatory to Check Out

- Revenue Cycle begins
  - Patient entry into the practice management system
  - Clinical services delivery
  - Appropriate and timely coding and billing of the provided services
  - Submission of claims for reimbursement
  - Ultimate collection of outstanding charges
Documentation

- Appropriate Coding
- Electronic Health Records vs. Paper Charts
- Practice Management Software
- Financial Reports
Accounts Receivable (A/R)

- Accounts Receivable = "financing" the cost of services provided
- An account becomes “receivable” when a service is performed but for which no payment is received
Adjustments to A/R

- Contractual adjustments
  - Schedule of benefits that differ from center’s
  - Managed care contracts
- Allowances for doubtful accounts (bad debt)
  - Generally self pay patient accounts
  - The likelihood that an account will be paid in full is inversely proportional to the time that has elapsed from when the service was performed.
Important Financial Reports

- Aging Report = Days in Accounts Receivable
  - by payer source
  - days outstanding (0-30, 31-60, 61-90, 91-120 and 120+)
- Profit and Loss Statement
  - Revenue – Direct Expenses
- Cash Flow
  - Cash received and where dispersed
- Balance Sheet (Net Worth)
  - Assets – Liabilities
Other Important Financial Terms

- Expenses
  - Direct
  - Indirect
- Assets
- Liabilities
- Ratios
  - Current
  - Quick
- Days in A/R
- Days in A/P
- Days of Cash on Hand
- Cost per Encounter
- Cost per Patient
- General Ledger
- Trial Balance
Bottom Line

• Collect co-pays upfront!
• Collect balances due before patient is seated
• Submit third party claims on a timely basis
• Monitor “Days-in Receivables”
• Decide when to write off doubtful accounts
For More Information...

- Look for the release of the “Workforce and Staffing” chapter toward the end of 2011!
- Order a printed copy or download the PDF version of “Survey of Health Center Oral Health Providers: Dental Salaries, Provider Satisfaction, and Recruitment and Retention Strategies”: http://www.nnoha.org/generalpage.html
QUESTIONS?
THANK YOU

Janet Bozzone, DMD, MPH, FAGD
Director of Dental Services
Open Door Family Medical Centers

Margaret Drozdowski-Maule, DMD, MBA
Dental Director
Community Health Center, Inc

NNOHA
www.nnoha.org
303-957-0635
info@nnoha.org