MAXIMIZING REIMBURSEMENT FOR COMPLEX BILLING SCENARIOS:

THE POWER OF PURPOSE-BUILT BILLING AND FINANCIAL ANALYTICS SOLUTIONS

XiFin | THE POWER TO DO GOOD™

Speakers

Clarisa Blattner

Senior Director of Revenue and Payor Optimizations
XiFin, Inc.

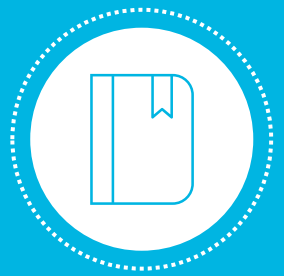
Clarisa Blattner, Sr. Director of Revenue and Payor Optimization at XiFin, Inc., is a renowned subject matter expert in revenue cycle management (RCM). With a keen focus on operational efficiency and revenue maximization, she brings over 20 years of invaluable experience in the healthcare sector. Additionally, she serves on the Economic Affairs Committee for the Association for Molecular Pathology (AMP), contributing her expertise to shaping policies in molecular diagnostics.

Atabek Yucel

Vice President, Customer Technology
XiFin, Inc.

Atabek Yucel is VP of Customer Technology at XiFin, where he drives product strategy for provider and patient portals and manages technology partnerships. With 10+ years of product management experience at companies like Aetna/CVS Health and Siemens Healthineers, he holds an MBA from Montclair State University, an M.S. in Biomedical Engineering from NJIT, and a B.S. in Electronics Engineering from Dokuz Eylul University.

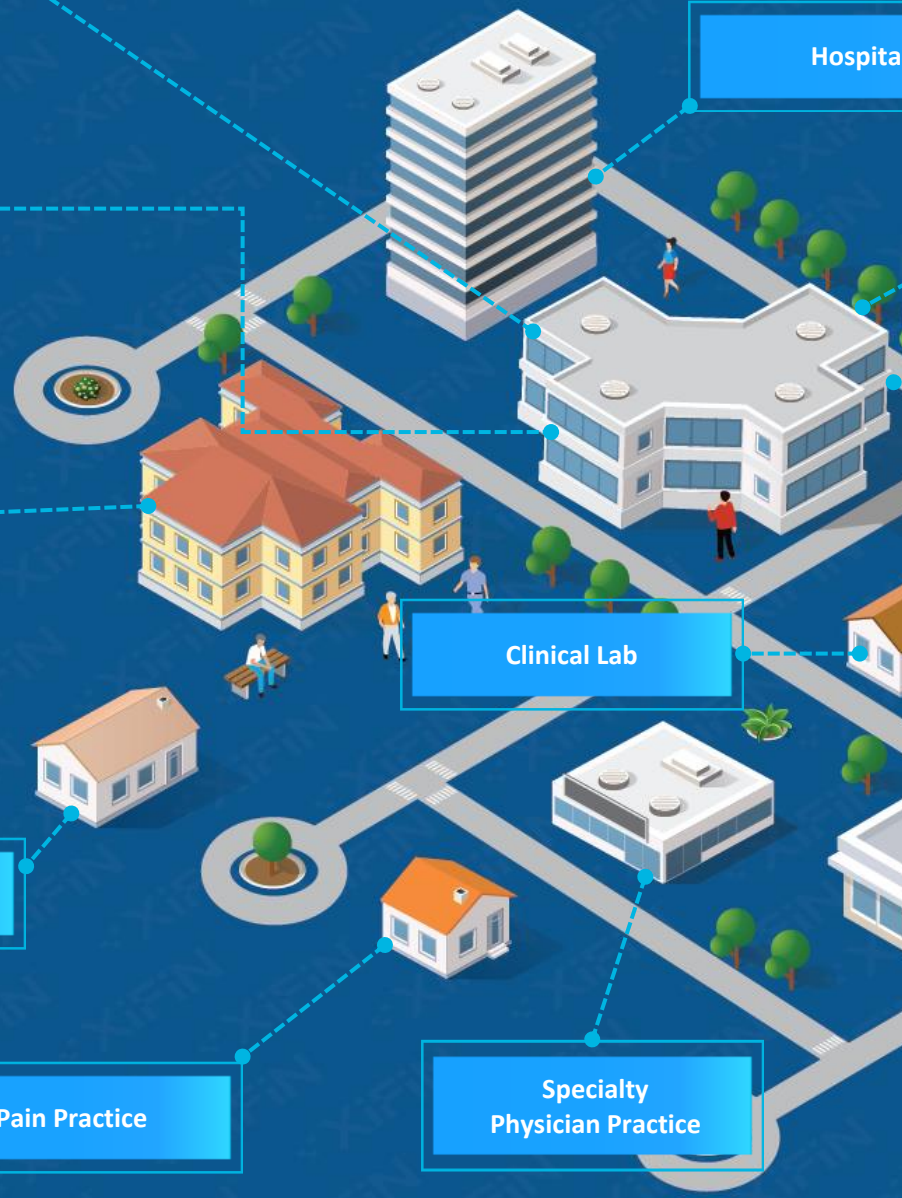
Agenda



- DME – Telehealth and MedTech in a distributed healthcare ecosystem
- Common or impactful billing challenges and payor behavior
- The link between patient experience touchpoints and billing challenges
- Denial and strategic appeals management
- People, process, and technology that can help
- Strategies for tomorrow

Beyond the Health System

Toward a Distributed Healthcare Ecosystem



- Outpatient Radiology
- Outpatient Pathology
- Nursing Home
- Retail Pharmacy
- Pain Practice
- Hospital
- Clinical Lab
- Specialty Physician Practice
- Outpatient Laboratory
- Outpatient Pharmacy
- Home Health
- Pathology Practice
- Molecular Diagnostic Provider
- Medical Device & Remote Patient Monitoring Facility

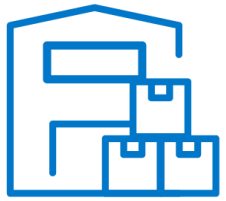
Reimbursement & Payment Pathways

- Medical Insurance
- Pharmacy Benefit Pathway
- Patient Self Pay

Device Specific Functions and Implications

Patient Intake

Order processing and fulfillment

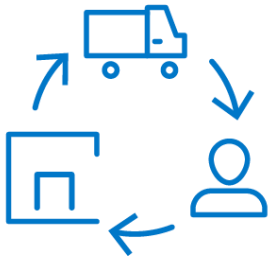


Inventory Management

Outbound Transportation and delivery

Patient Engagement

Billing and revenue cycle management

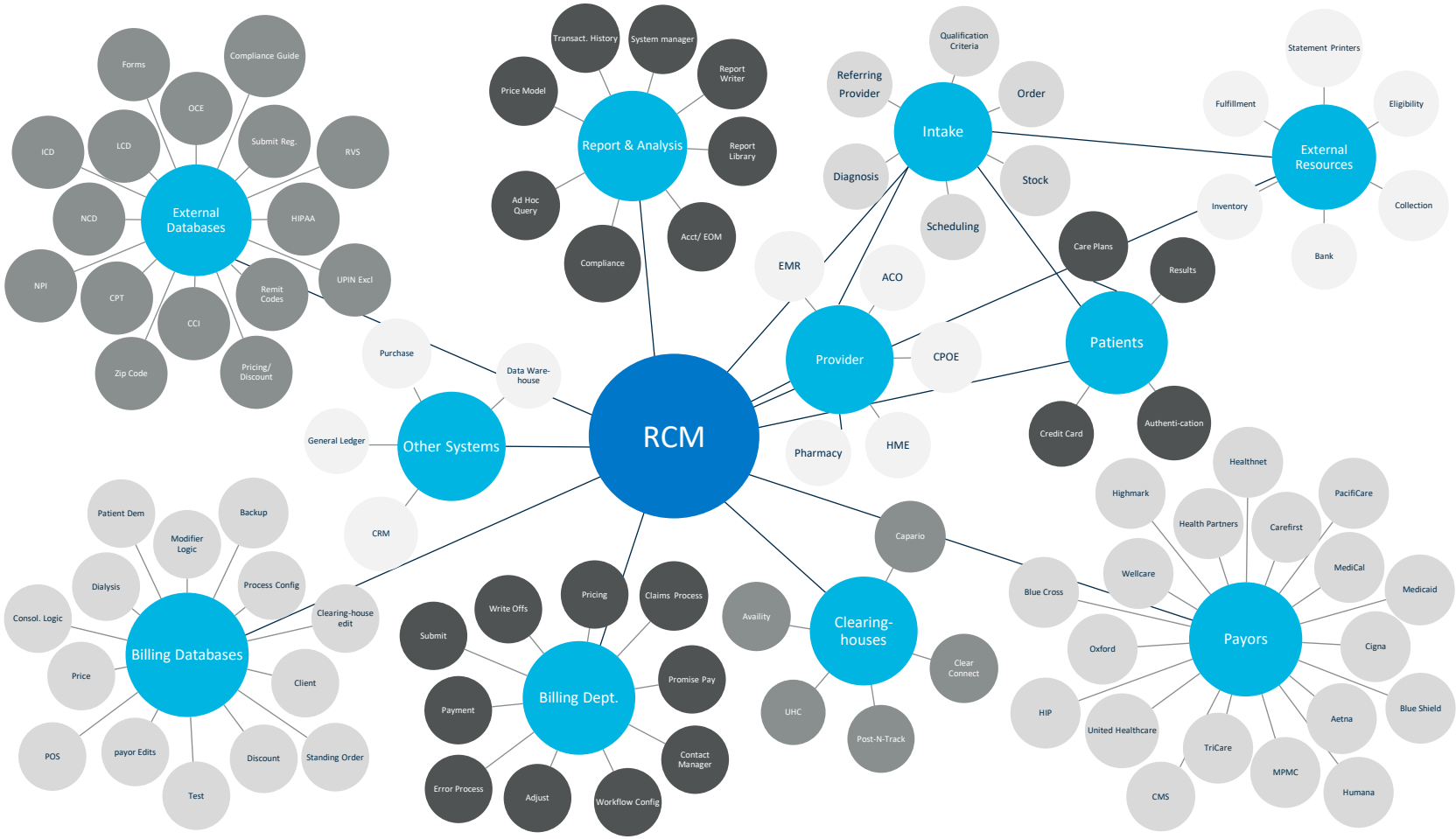


Returns and customer service

Business Intelligence

Referrals, Fulfillment & Billing Continues to Grow in Complexity

Connecting & Automating Your Ecosystem

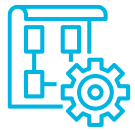


Common Medical Billing Challenges for Medical Device and DME

- Often not the treating physician; requires coordination with other parties
- Intake processes, prior authorizations and qualification criteria
- Siloed systems; need real-time bi-directional connectivity
- Split billing (Technical Component (TC) / Professional Component (PC)

- Need granular edits by product/service type and payor (at the plan level)
- Lack of visibility into payor trends and profitability
- Patient and provider engagement
- Managing denials and appeals

Payor Policies



Medicare LCD Updates

- Frequent updates to Local Coverage Determinations (LCDs) by Medicare are making certain diagnosis codes obsolete.

Medical Records Requirement

- UHC is increasingly requiring medical records for many claims, leading to high rates of N706 (Missing Documentation) and M127 (Missing/Invalid Patient Medical Record) denials.

Diagnosis Code Challenges Across Payors

- Many payors, including UHC, Aetna, Cigna, Medicare, and Priority Health, have specific medical policies that create challenges with diagnosis codes.

Challenges Thru Pharmacy Medical Benefit Pathway

Top denial codes occur when BGM claims are billed alongside non-adjunctive CGM, leading to denials by Durable Medical Equipment Medicare Administrative Contractors (DMEMACs).

Common denial codes for this situation include

Product/Service	DMEMAC	Claim Adjustment Reason Code (CARC)	Description	Remark Code	Description
BGM or BGM Supplies (but Medicare has record of patient on CGM therapy)	Noridian	CO-16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication	M124	Missing/incomplete/invalid information
	CGS	CO-B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated	<null>	No associated remark code provided (null).
CGM or CGM Supplies (but Medicare has record of patient on BGM therapy)	Noridian	CO-119	Benefit maximum for this time period or occurrence has been reached	M86	service denied because payment already made for the same/similar procedure within a set time frame

Overcoming Billing Challenges

Technology Plays a Role but the right expertise and optimal process are key

Patient Engagement

Use patient communication tools to improve transparency and reduce confusion about billing

Improved Connectivity

Real-time data exchange with payors and seamless integration with prescribing physicians' systems.

Evolving Payor Requirements

Future Focus: Continuous adaptation to evolving payor requirements and leveraging data analytics for proactive adjustments

Automation and AI

Utilize technology to automate prior authorizations, manage denials, and optimize workflows

Business Intelligence

Business Intelligence and analytics including Provider Profitability

The Patient Experience

Evolving the Patient Experience

Access/sharing results

Financial payment options

Easy to understand and access invoices

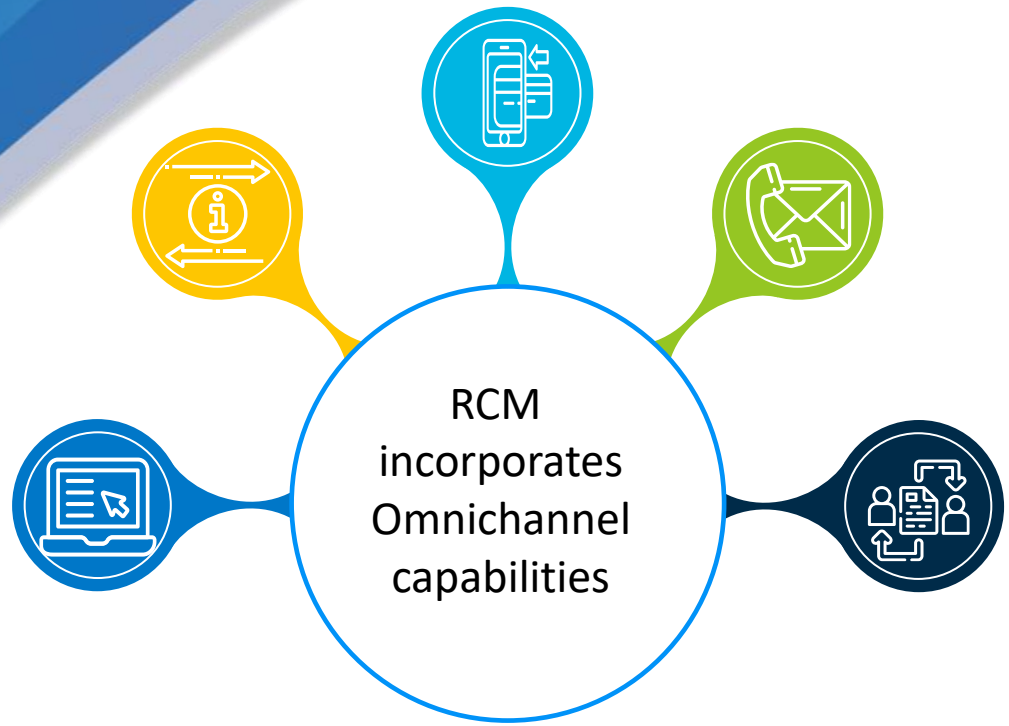
Multi-channel patient journey follow-up

Out-of-pocket estimation & payor accountability

Patient preferences

Facilitate access to care (prior auth, qualification, benefit coverage and insurance discovery)

Delivering a consumer-inspired and ***expected*** patient experience



The Patient Journey

Sample considerations related to DME, Telehealth, Remote Patient Monitoring and Digital Health

Meet Susie

Before Visiting their Provider

- *Trigger Event: injury, illness, or desire for proactive care*
- *Patient searches for right provider*
- *Patient schedules the visit*

Encounter of Care Leading to Referral

- *Experience depends on the 'type of provider'*
- *Patient encounter with the provider*
- *Discussion of care options*
- *Out-of-pocket expense estimation*
- *Agreement on care plan*
- *Treating or Referring provider orders for patient and the appropriate care setting*

Order Receipt and Patient Intake

- *Capture of requisition/script/order within intake system*
- *Omnichannel touch point with the patient confirming receipt from the referring/ordering provider and communication next steps*
- *Patient and physician engagement to capture all required information, documentation for patient qualification, insurance/benefit verification, eligibility*
- *Financial discussions including estimated patient responsibility, prepayment, payment plans, or other options*
- *Coordination of logistics, delivery and other providers in care setting*

DME, Telehealth, RPM delivery and ongoing care

- *Patient communication of next steps (order status and delivery, confirmation of receipt, login information, scheduling)*
- *Coordination of care with provider(s) and appropriate to the setting*
- *Patient and provider engagement to assist with medical adherence*

Ongoing treatment/monitoring and follow-up

- *Forward thinking to resupply/reorder scheduling, prior auth expiry, etc.*
- *Ongoing monitoring and coordination of care*
- *Patient and provider engagement to assist with medical adherence*
- *Patient satisfaction feedback surveys*
- *Clinical follow-up*
- *Financial follow-up*

Importance of Patient and Provider Communications

Audience specific portals and use of APIs for two-way real-time data exchange

Provide 24-hour, convenient access to results, statements, and bill payment capabilities.

Payments are automatically applied in real-time to the account, which increases customer satisfaction and reduces errors.

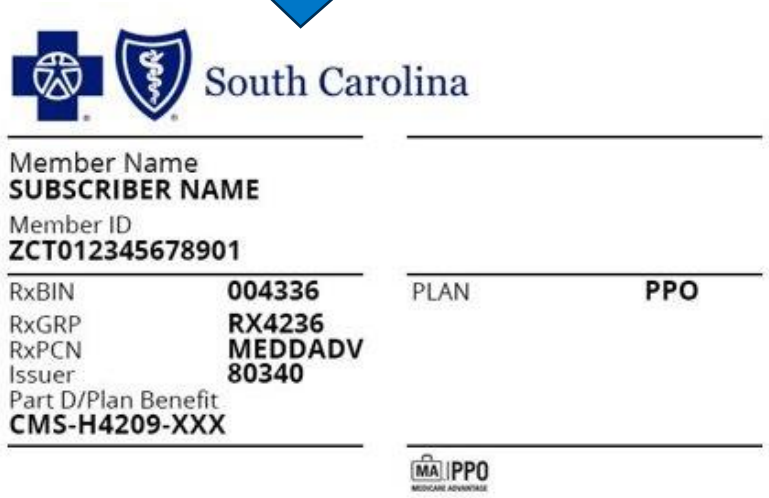
Support a better patient experience by calculating the expected patient responsibility and enabling pre-payments before services or products are dispensed to patients.

Provide online access for patients and ordering physicians' offices to securely view pricing, fix errors, and upload documents in real-time.

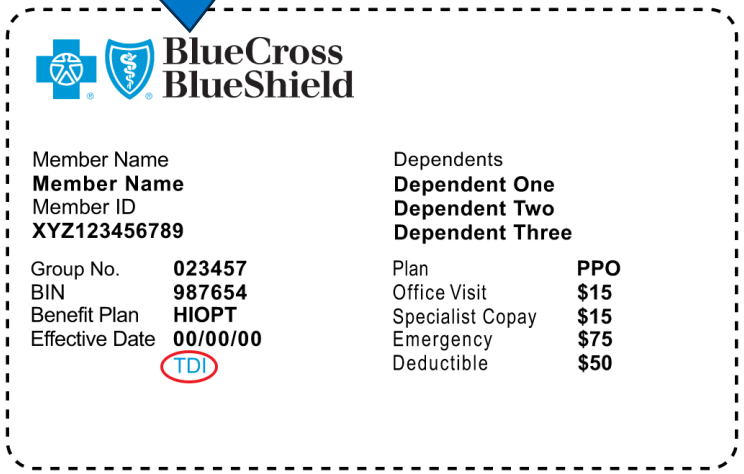
Deciphering Health Plan Insurance Cards Is Challenging

Getting the payor's name correct can be challenging

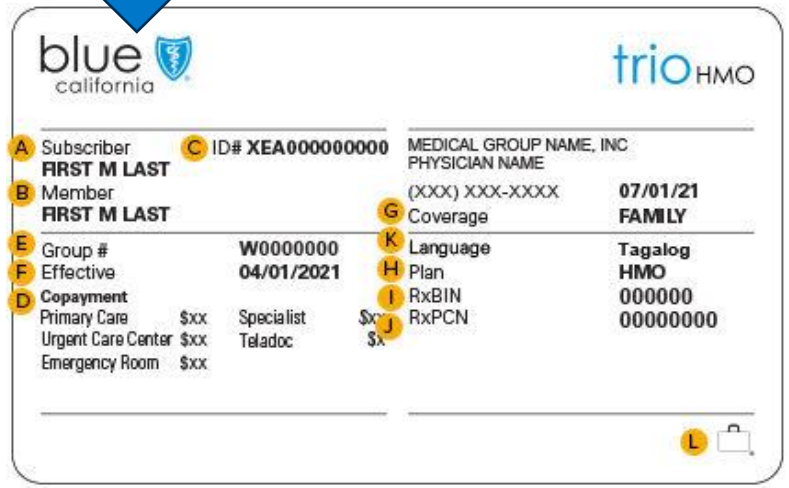
No Payor Name Text



Incomplete Name Text

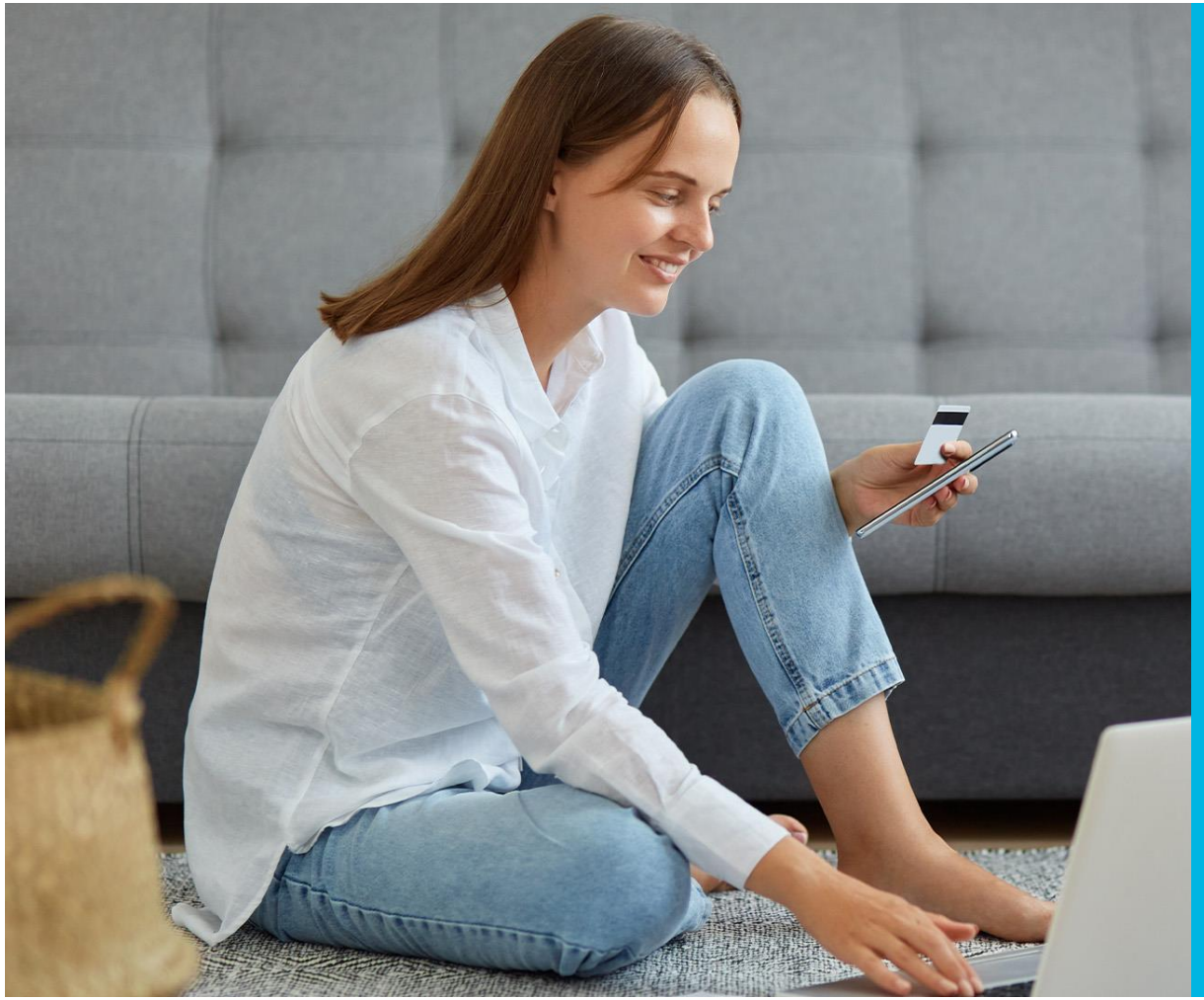


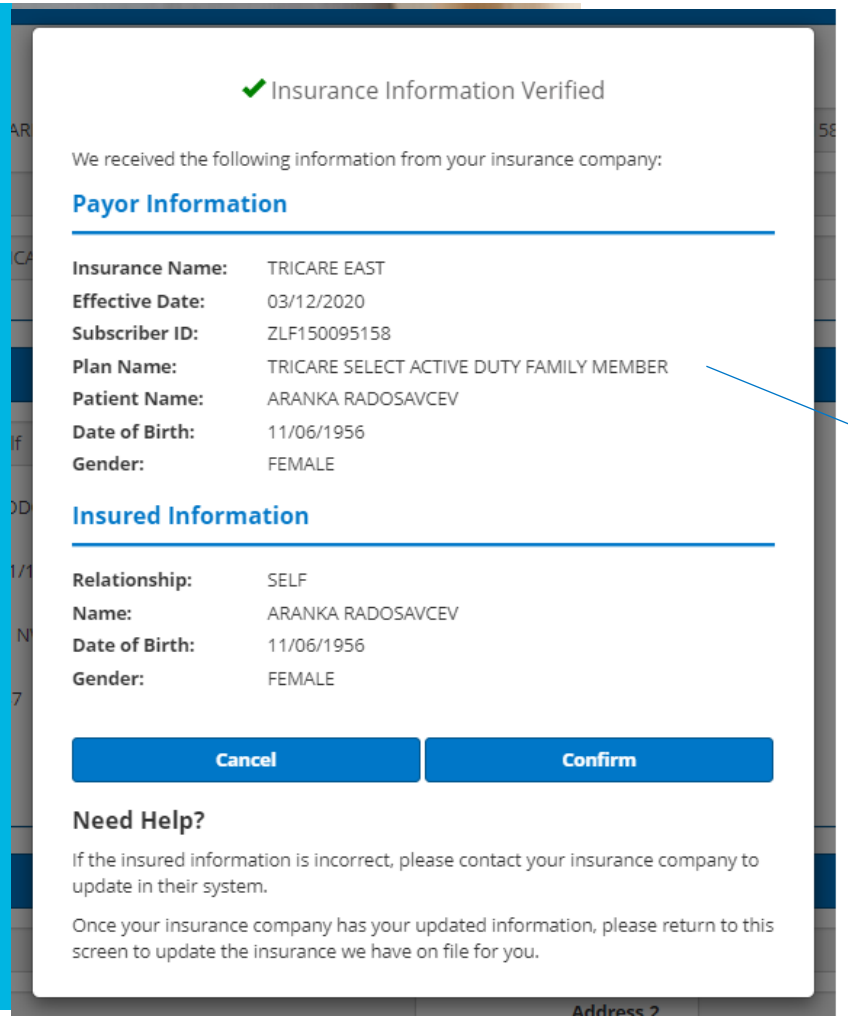
Partial Payor Name Text



AI uncovers the insurance information

Minimal information capture or card image upload completes the process.





AI maps the payor eligibility response data to the appropriate RCM payer plan/fee schedule.

Patient Estimation: Why Eligibility Info Isn't Enough

Provider network status is not determined

Generalized to Service Type:

- Very few procedure-/service-level responders
- Coverage Limitations not considered

Multiple and conflicting/overlapping service type benefit descriptions.

- 43 different potentially applicable coinsurance benefit loops
- 3 different potentially applicable values

Rules are complex, differ from payor to payor, and don't always get to a unique result that will match adjudication

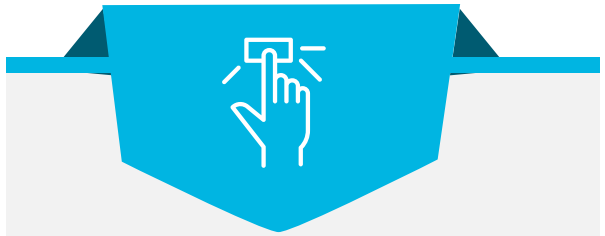
Machine Learning Models trained on recently adjudicated claims can overcome these challenges and provide accurate:

- Estimated Copay
- Estimated Coinsurance
- Risk of coverage limitations

Patient Experience Has Started
NOW WHAT?

Prior Authorization

Programmatic Approach is Essential



Market Access

- Monitoring on payor policy by plan and service
- Successful coverage tied to appeals strategy
- Gold Card status
- Negotiate away requirements

Commercial

- Educated and engaged sales team
- Referring entity's existing PA process (potential to leverage)
- Drive adoption of portals/other methods of info collection
- Referring provider education program

RCM

- Visibility to payor plan/service-specific requirements
- Measure outcomes by payor, service, and referring provider
- Cross-departmental feedback loop – Market Access, Commercial, and Finance

Finance

- Continuous process improvement
- Provider profitability analysis
- Overall strategic decisions

Golden Rule of Medical Billing

Report Documentation: ***If it wasn't documented, it wasn't performed***

Report documentation should clearly outline the services provided and the medical necessity of those services

- Ordered
- Performed
- Medically Necessary

The Golden Rule

Of Medical Billing

Example: Understanding Medical Record Documentation Requirements

Who?
Ordering/referring provider

What?
What product(s) or service(s)/are being ordered?

Where?
Where is the service performed?

When?
Date of service or product was provided

Why?
Patient's signs/symptoms or what prompted the product or service to be ordered

How?
How are the results being used to manage the patient's medical condition?

RCM Business Intelligence: Understanding Payor Behavior

Linkage and alignment to RCM worklists is critical

Payor reimbursement behavior is complicated and constantly changing:

- New products and plans
- In and out-of-network providers
- Policy evolution
- Service-level limited coverages

These changes manifest in billing as:

- New denials
- Changes in denial rate
- Change in % reimbursement
- Change in time to payment

Failure to quickly recognize and adapt workflow to payor reimbursement changes can result in:

- Costly appeals projects
- Bulk write-offs
- Patient billing – audit prevention

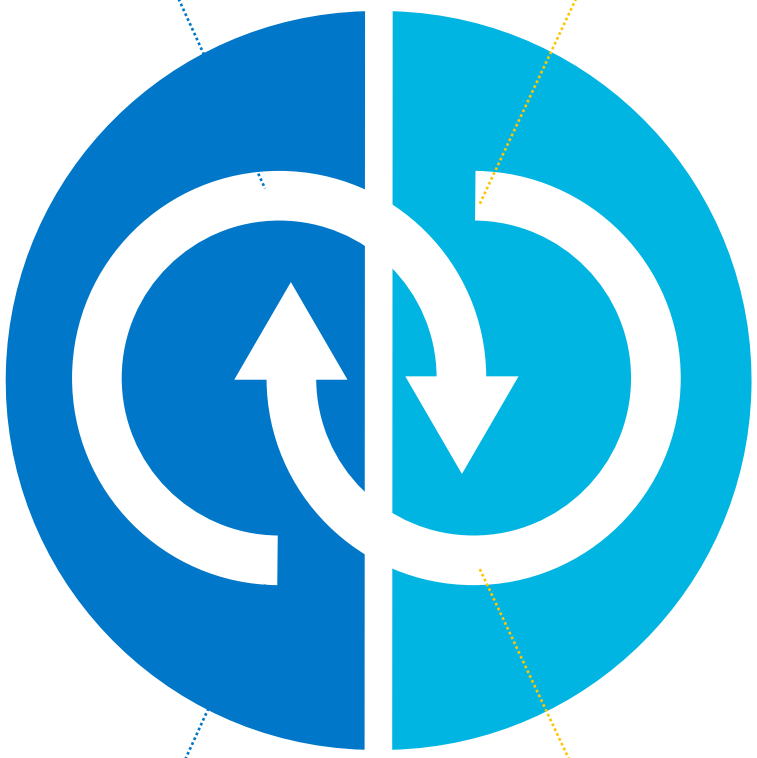
XiFin-Recommended Business Intelligence Best Practices

- Analyze your payor mix
- Understand the relevant medical policies
  - For Medicare or Medicaid billing, are there local coverage determinations (LCDs) or national coverage determinations (NCDs) that impact your products or services?
- Know your prior authorization (PA) requirements
- Work with your RCM partner to leverage their data resources and contacts
  - Your RCM partner can query their cross-customer data to understand average reimbursement for similar products, services, top denial reasons, and denial trends
  - Leverage your RCM partner's contacts and relationships with payors and policy advisors
- Meet regularly across teams to share data and trends to prioritize efforts

Understanding Common Denials Reasons

Front-End Denials

- Invalid/Missing Modifier
- Non-Covered Services
- Missing Prior Authorization
- Missing or Inaccurate Patient Data
- Delayed Claim Submission

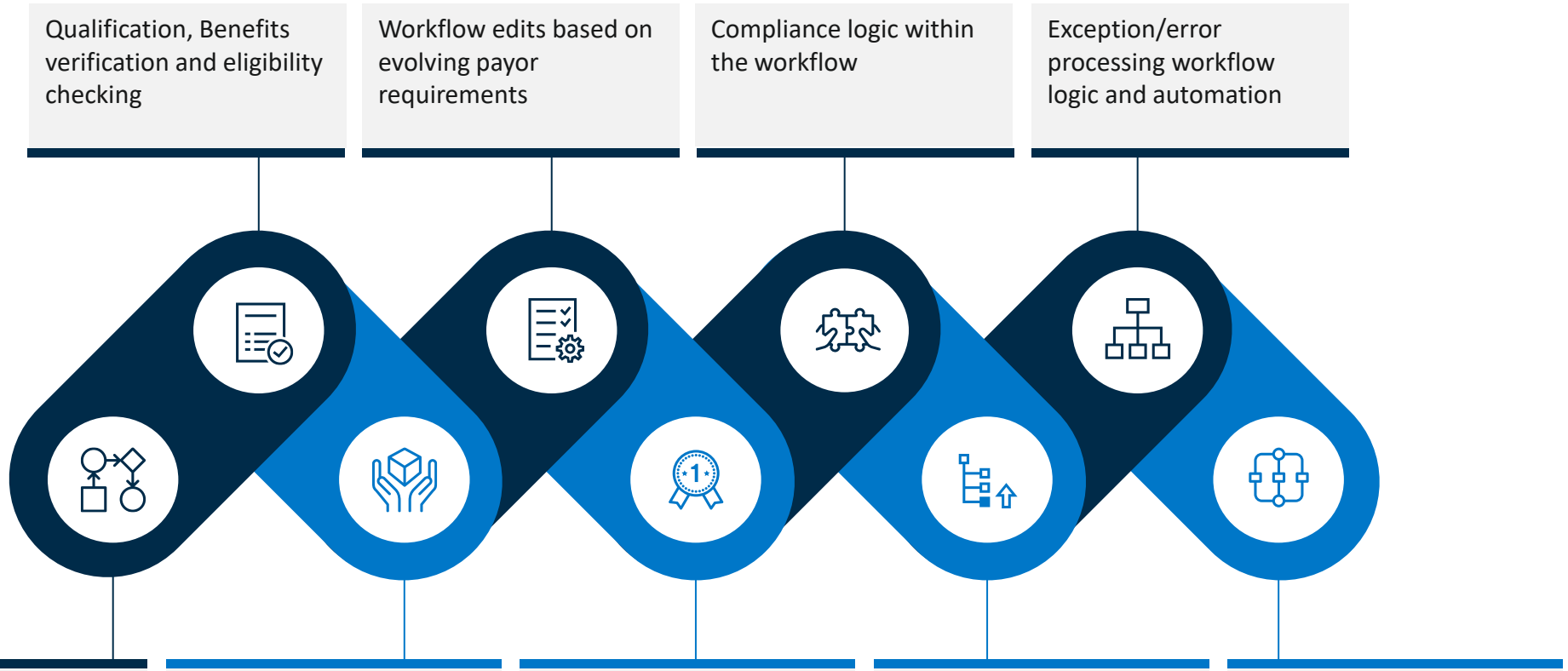


Back-End Denials

- Insurance Complexity
- Invalid CPT or Diagnosis Coding
- Unauthorized Services
- Medical Records Requirement

Configurable, Intelligent Workflow Automation

Key Components of Configurable and Intelligent RCM Workflow Automation



Payor Policies: Industry Edits

National Correct Coding Initiative (NCCI) Edits

- Example: CO97 - Procedure or Service Isn't Paid for Separately
- Unlikely Code Combinations
- Published CCI Edits as **Unbillable Errors**
- **Corrected Claims** with Modifiers for Denials

Local Coverage Determinations (LCD) / National Coverage Determinations (NCD)

- Procedure / Diagnosis Code Combinations, Frequency
- Maintained by XiFin – **Unbillable Errors**
- Advanced Beneficiary Notice (ABN) Required to Bill Patients

Medically Unlikely Edits (MUEs)

- Units of Service
- Updated Quarterly
- Two edit categories
  - Claim Line: Units evaluated on each line
    - **Consolidation Rules:** Separate Units and Append Modifier
  - Date of Service: Units evaluated for entire DOS
    - Some cannot be overturned through appeal
    - **Automated Appeals** with medical records

Approaches for Exception/Error Processing

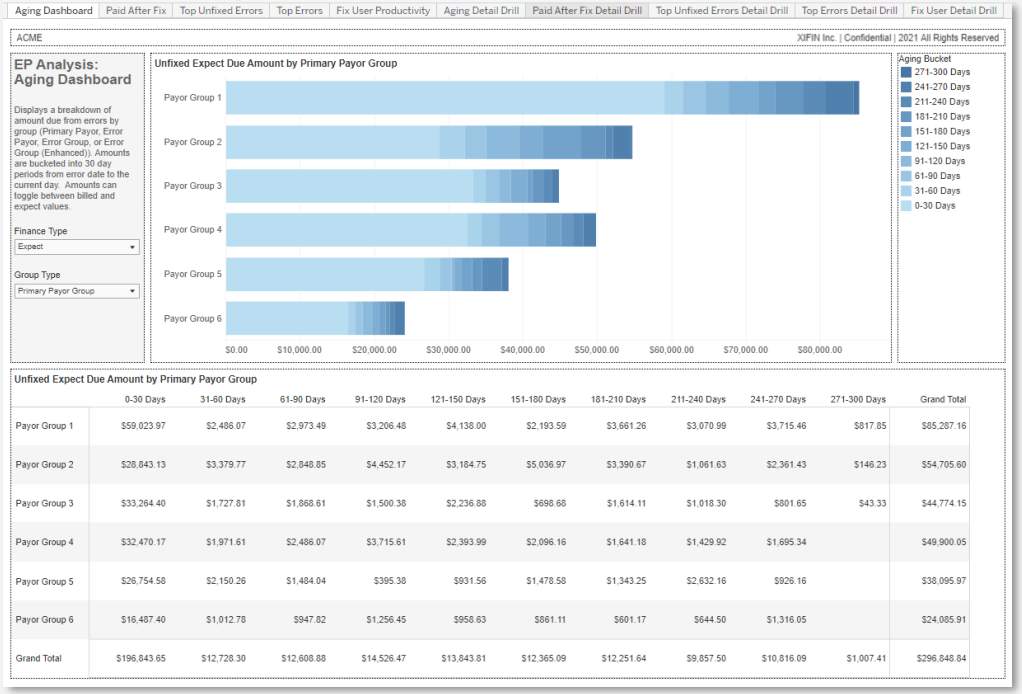
Error processing (EP) analytics help streamline revenue cycle management (RCM) and faster cash collection and improved productivity

Business intelligence (BI) reports vs. Error Processing (EP) analytics

Monitoring trends over time

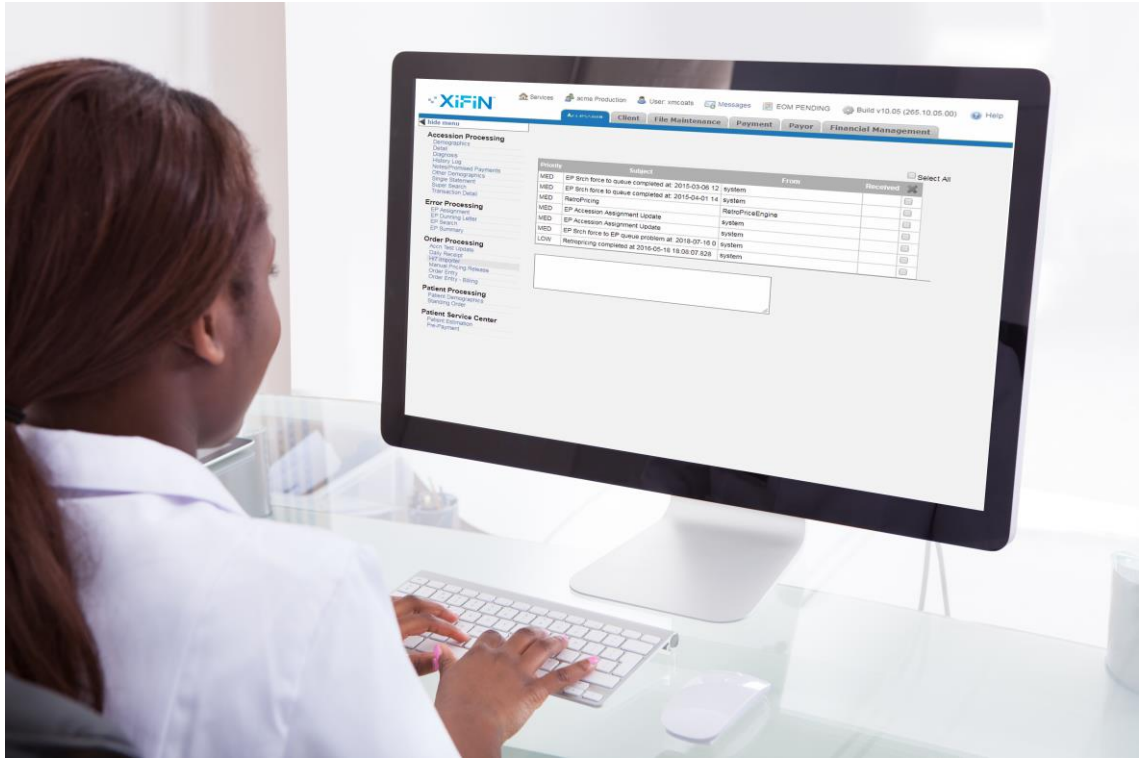
- Recognize emerging changes early
- Automate interventions
- Improve accuracy of forecasting

Focus reason code automation or dedicate staffing where resources are most needed and uncover root cause of errors efficiently



AI-Driven Workflow Example: Error Processing (EP) Work Assignment

- Claims prioritized by payment risk
- Claims routed to best user to fix
- Error Processing (EP) Assignment
- Prioritized Error Processing (EP) List by user



Choosing an Appeal Strategy = Automation and Reporting

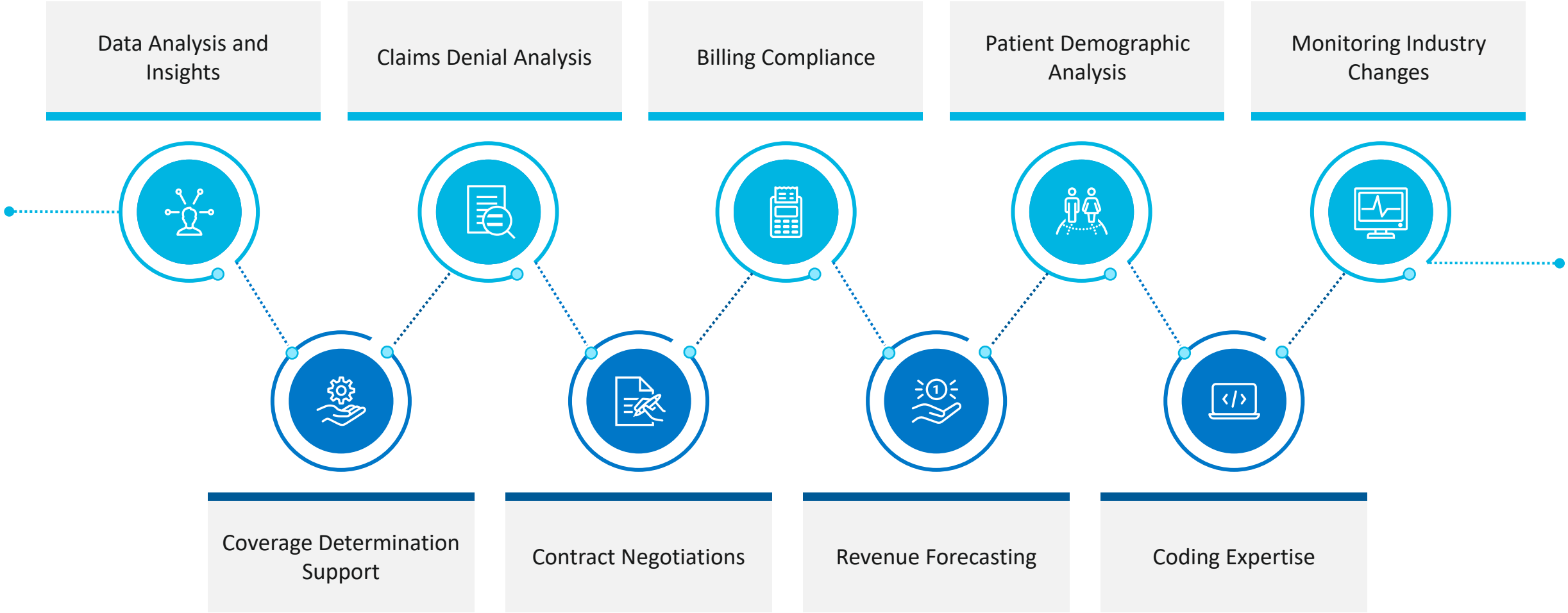
Identifying Appeal Codes, Error Processing Summary & Prioritized Actions of Appeal

Facilitates the ability to see appeal override codes in the various system dropdowns, the appeal related reason codes must be defined by checking the “Appeal Code” box in Reason Code File Maintenance

Error Processing Summary will reflect a new area within the EP Internal error group of “Appeal”

Reason Code File Maintenance now includes a prioritized action of “Appeal”

RCM Data and Expertise Supports Access and Coverage



How Teams Support Other

Expanding Payor Coverage

A primary objective of the collaboration is to secure and broaden payor coverage. Teams must work in tandem to define the scope and necessity of products or monitoring services in precise coverage determinations, which involves thoroughly evaluating the landscape to ensure patients have access to reasonable and medically necessary services.

Accurate Medical Coding

Ensuring accurate coding is vital for seamless interactions with payors. Collaboration ensures reports are documented using the appropriate medical terminology, which promotes efficient communication and reduces the likelihood of disputes and claim denials, as payors receive clear and comprehensive information about the services provided.

Payment and Reimbursement Assurance

Collaboration is critical in aligning payment and reimbursement with the products or services offered. By adhering to coverage determinations and accurately coding the services, the teams mitigate the risk of payment discrepancies. This benefits providers financially and ensures that patients receive necessary care without undue financial burdens.

Billing Compliance and Reform

Upholding billing compliance standards is a cornerstone of this collaboration. Teams must collaborate to stay updated on the ever-evolving regulations and billing guidelines. Continuous monitoring and active participation in discussions related to billing reform enable teams to adapt to changes while maintaining effective billing practices.

