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Maneuvering Through the Medicaid Billing Maze



Thursday, 01 July 2010 19:26

It's a maze! It's a puzzle! It's a high risk and potentially fatal bureaucratic challenge for resource-strapped nonprofits! It is the billing preparation and submission process to get paid by Medicaid.

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Medicaid is the largest single funding source for many nonprofit providers of community mental health services, alcoholism and substance abuse treatment, and programs for the developmentally disabled. Yet billing for Medicaid payments – at least submitting bills so you actually get paid – is largely considered to be a nightmare by most nonprofit CEOs and CFOs. It seems to many observers that the system is designed with the ultimate aim of rejecting claims for payment rather than actually processing them.

"I estimate that Medicaid has 650 denial codes," says one CFO who declined to comment for the record – not an uncommon request by agencies leery of drawing the ire or even the attention of the Medicaid payment staff – or worse yet, the Office of the Medicaid Inspector General (OMIG).

Even large and highly sophisticated service providers routinely experience denial rates of 10-12% on initial Medicaid billings. Those kinds of outstanding receivables add up in a hurry and can quickly create serious cash flow problems for any nonprofit. Take an agency doing approximately \$15 million a year in Medicaid services, which translates into roughly \$300,000 per week in Medicaid billings. At a 10% initial denial rate, that means \$30,000 per week and a total of almost \$400,000 after just three months.

Sure, agencies work to correct problems and resubmit billings for payment, but that takes time and effort. And, while you are cleaning up old payment denials, new ones are piling up.

So, what is the problem? Why aren't you getting paid?

The key to successful Medicaid billing is having good information – at least a dozen or so key pieces of information, including, client name, Medicaid number, date of birth, sex, zip code for the client, date of service, provider name, National Provider Identification (NPI) number for the clinician providing the service, license number for the clinician, service code, rate code, diagnosis code, etc. That doesn't sound too hard, does it?

"The 12 different elements have to be perfect," says one CFO. And, perfect doesn't mean correct; it means accurate in the sense that it matches data as recorded in the Medicaid system. "You can't have a patient name with a dash in it," says the provider. "You may be serving a male client, but the Medicaid system will have them recorded as female. New therapists have to be registered with an NPI number that matches the facility's provider code. The service codes, rate codes and diagnosis codes all have to be consistent. It goes on and on."

Then, of course, the client has to be Medicaid eligible. That, too, is much more complicated than it sounds.

"Medicaid is designed to provide services for the indigent public," says another CFO. "Sometimes people are more indigent than others." Clients can go on and off of Medicaid eligibility with unsettling frequency due to a variety of circumstances including having their Public Assistance case sanctioned.

And, since Medicaid must always be the payer of last resort, there is a requirement that providers bill all other third-party payers – private insurance, Medicare, even Medicaid managed care organizations – before billing Medicaid directly for fee for service payment. In many cases, providers are forced to submit bills to these other payers knowing full well that they will be denied, only so they can show the denial as documentation for the Medicaid claim. Without having gone through that process, Medicaid billings will be denied.

"We don't always know that a patient has insurance," says one CFO. "Sometimes the patient



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doesn't know. Sometimes the system is wrong and the patient actually doesn't have private insurance."

None of these documentation and eligibility requirements are inappropriate, say providers. It's just that there are a lot of places where errors can be made – especially if your main mission is providing service to clients in need.

"Our primary goal is to give them care," says one provider. "It is not like we are Macy's. If we can't run your credit card, you don't walk out with a pair of pants."

Front desk and/or reception staff often get the blame for documentation errors. "It is not like our people are paid a lot of money," says a provider CFO. "These are folks in really difficult neighborhoods, dealing with really difficult people. If a client comes in, doesn't have their third party insurance card with them and says they'll bring it next time, it's not as if you aren't going to let them see a therapist."

Joan Vitiello, Comptroller at North Shore Child and Family Guidance Center, believes that some of this focus on faulty initial intake at the front desk is misplaced. "You need to expect that insurance eligibility is going to change, from the first phone call to the first visit or a few weeks down the pike," she says.

The key, says Vitiello and other CFOs, is to keep billing problems from getting out of hand. Each week's Medicaid billing generates a remittance with an Explanation of Benefits (EOB) the following week. EOBs on rejected claims will feature one of Medicaid's various denial codes. "You have to work those EOBs," says Vitiello. "You have to find out why the claim was rejected and get people on the phone fixing the problems."

"It is a process you have to stay on top of," agrees Kenneth Klum, CFO at New York Foundling.

In some cases, providers look for outside help to address billing problems that have gotten out of control, resulting in accounts receivable balances due from Medicaid in the hundreds of thousands, or even millions, of dollars.

Millin Associates, based in Cedarhurst, is one Medicaid billing specialist which has developed an impressive track record in winning substantial recoveries on stalled Medicaid billings for community mental health programs, substance abuse treatment programs, MRDD facilities, foster care agencies and community health centers.

"We come in and look at all your billings for the past two years," says Millin President Sol Weiss. "We have an ability to take all your data – no matter how you currently maintain it – and quickly determine which claims were actually paid, which claims weren't paid and why they weren't paid." Millin then cleans up errors and resubmits unpaid bills, always staying within Medicaid's time constraints and billing regulations.

The results can be astounding. Weiss cites a long list of Medicaid billing recoveries in the hundreds of thousands of dollars -- \$415,000 here, \$250,000 there, as much as \$800,000 or more in other agencies. While Millin has a packet full of recommendation letters, not all clients were anxious to have the size of their recoveries published. Nevertheless, Millin's client list reads like a "who's who" of leading nonprofit human service agencies throughout New York State.

Millin's real selling point is that its recovery work is basically free – or at least feels that way to CFOs frustrated with an inability to get paid on outstanding Medicaid billings. The company works on a contingency basis, taking a percentage fee on the total recoveries. No Medicaid payments recovered; no charge. (In case you're interested, Millin is at 516-374-4530.)

The key to Millin's success, says Weiss, is three decades of Medicaid billing experience in the state of New York and a sophisticated series of computer programs that allow the company to quickly process vast amounts of billing data, pre-screening many elements for

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conformance with Medicaid's own system information.

In many cases, Millin expands its relationship with clients beyond the initial recovery effort to provide ongoing billing services.

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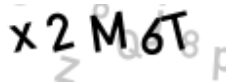
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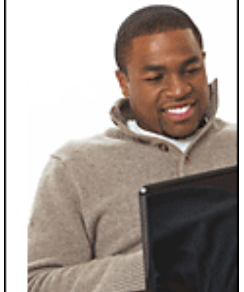
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