Managing Family Planning Revenue Cycles

Solutions from the Field

LIFE AFTER 40

COMPANION WORKBOOK

National Family Planning & Reproductive Health Association

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& Reproductive Health Association

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Introduction

The National Family Planning & Reproductive Health Association (NFPRHA) is working to assist publicly funded family planning providers adapt to the changes created by the Affordable Care Act (ACA). Grant funding supports the *Life After 40: The Family Planning Network and the ACA* project, which focuses on the sustainability of the family planning service delivery network in the years following the fortieth anniversary of Title X, the federal family planning program, in 2010.

Managing Family Planning Revenue Cycles: Solutions from the Field, the third case study of the *Life After 40* project, focuses on the billing, coding, and collections processes of family planning providers. The case study presents different models and methods for structuring the tasks and activities of the revenue cycle process learned from the participating provider agencies.

This companion workbook presents actual tools and resources utilized by the three participating agencies. The goal of the workbook is to provide examples of materials that can be adapted for use in an agency's revenue cycle process. The materials are divided into the following topics:

- Organizational revenue cycle design
- Insurance contracting
- Billing processes during a patient visit
- Billing processes after a patient visit

Each topic area includes an overview of the tools and resources to aid in identifying possible opportunities to adapt these tools for use within an agency.

Organizational Revenue Cycle Design

Billing Systems and Staffing

Ensuring effective and efficient revenue cycle processes requires that an agency have appropriate staffing patterns. Agencies may utilize different staffing models for the revenue cycle process. Dedicated staff can be organized on a functional basis or general staff in the health center can be assigned specific billing responsibilities and activities. Each of the participating agencies developed a cadre of staff responsible for the management of the revenue cycle. The following job descriptions reflect the variety of staffing models established in each of the agencies:

- Insurance Verification Specialist (PPAZ)
- Medical Reimbursement Specialist (PPAZ)
- Medical Billing Specialist (PPAZ)
- Business Analyst (PPAZ)
- Clinic Coordinator (BRIDGER)
- Office Manager (BRIDGER)

PPAZ Insurance Verification Specialist Job Description

Job Title: Insurance Verification Specialist

Division: Customer Service & Admin Services

Reports To: Revenue Cycle A/R Manager

FLSA Status: Non-exempt

SUMMARY

Our services include an emphasis on family planning and reproductive health care, including the provision of birth control and comprehensive contraceptive counseling, testing and treatment of sexually transmitted infections, pregnancy testing, counseling and referral, HIV testing, annual exams, abortion care, and more. In addition, we focus on providing medically accurate sexuality education and training services throughout the state.

This position provides insurance verification for insured patients; informing them of financial obligation at time of service and when prior authorization or referrals are required; responds to all internal and external phone calls regarding patients' insurance verification inquiries.

The employee, whose signature appears above, agrees to be accountable for the JOB SPECIFIC DUTIES AND RESPONSIBILITIES, which include the following; other duties may be assigned:

- Responsible for ensuring external and internal telephone calls are answered in a professional and timely manner in accordance with department policies, procedures and performance goals.
- Verifies Commercial and Medicaid insurance for eligibility and benefit utilizing one of the following methods as appropriate: RTS, payer's website, and phone.
- Patients are called to inform them of their financial obligation at the time of service for any amount beyond the copay.
- Same day, walk in, and future insurance appointments are verified for eligibility and benefits.
- Maintains all passwords for the Managed Care/Third Party carriers who allow claims status via provider websites.
- Works closely with health center and call center staff to assist in identification of patient responsibility. Identifies accurate patient portions in order to collect money at the time of service (including past due account balances).
- Ensures that collection of all Managed Care and Third Party claims are followed up in accordance with department policies, procedures, and performance goals.
- Processes and posts patient payments (credit card) in an accurate and timely manner in accordance with department policies, procedures and performance goals.
- Corresponds with and assists vendors involved with patient accounts. Reviews and prepares check requests for patient and insurance refunds.
- Maintains confidentiality of all information; adheres to all HIPAA guidelines/regulations.

SUPERVISORY RESPONSIBILITIES

None required.

QUALIFICATIONS

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE

High School diploma or General Education Degree (GED) and one year work experience; Medical Coding Certification and knowledge of Current Procedural Terminology (CPT), International Classification of Diseases and Health Care Procedure Coding System (ICD-9) knowledge.

LANGUAGE SKILLS

Ability to read and interpret documents such as safety rules, operating and maintenance instructions, and procedure manuals. Ability to write routine reports and correspondence. Ability to speak effectively with customers or employees of organization.

MATHEMATICAL SKILLS

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs.

REASONING ABILITY

Ability to apply common sense understanding to carry out instructions furnished in written, oral, or diagram form. Ability to deal with problems involving several concrete variables in standardized situations.

CERTIFICATES, LICENSES, REGISTRATIONS

Coding Certification preferred.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to sit and use hands to finger, handle, or feel. The employee frequently is required to reach with hands and arms and talk or hear. The employee is occasionally required to stand and walk. Specific vision abilities required by this job include close vision, depth perception, and ability to adjust focus.

WORK ENVIRONMENT

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate. This is not necessarily an exhaustive list of all responsibilities, skills, duties, requirements, efforts or working conditions associated with this job. While this is intended to be an accurate reflection of the current job, management reserves the right to revise the job or to require that other or different tasks be performed when circumstances change.

PPAZ Medical Reimbursement Specialist Job Description

Job Title: Medical Reimbursement Specialist

Division: Finance

Reports To: Revenue Cycle/Accounts Receivable Manager

FLSA Status: Non-exempt

SUMMARY

Our services include an emphasis on family planning and reproductive health care, including the provision of birth control and comprehensive contraceptive counseling, testing and treatment of sexually transmitted infections, pregnancy testing, counseling and referral, HIV testing, annual exams, abortion care, and more. In addition, we focus on providing medically accurate sexuality education and training services throughout the state.

This position provides patient and medical billing support by researching and resubmitting open Managed Care, Third Party and Medicaid claims. Responds to all internal and external phone calls regarding patient and insurance billing inquiries. Processes credit card payments and handling internal and external client calls regarding billing inquiries. Maintains provider websites to monitor outstanding claims, by ensuring passwords are current. Utilizes CPT and ICD-9 coding for paper and electronic submission of Insurance, Managed Care, Third Party, and Medicaid claims.

The employee, whose signature appears above, agrees to be accountable for the JOB SPECIFIC DUTIES AND RESPONSIBILITIES listed below; other duties may be assigned:

- Responsible for ensuring external and internal telephone calls are answered in a professional and timely manner in accordance with department policies, procedures and performance goals.
- Reconciles and post ERA/EOB to NextGen EPM.
- Ensures that collection of all Managed Care and Third Party claims are followed up in accordance with department policies, procedures and all applicable laws and regulations.
- Processes and posts patient payments (credit card) in an accurate and timely manner in accordance with department policies, procedures and performance goals.
- Corresponds with and assists vendors involved with patient accounts. Reviews and prepares check requests for patient and insurance refunds.
- Responsible for ensuring all Managed Care and patient correspondence is resolved and a response is given to the patient in a timely manner (24 hours) in accordance with department policies, procedures and performance goals.
- Maintains all passwords for the Managed Care/Third Party carriers who allow claims status via provider websites.
- Responsible for the verification of insurance benefits and obtaining referrals and prior authorization for future office visits.
- Provides professional, accurate, and timely insurance verification and notification of benefits to patients and clinic staff.
- Prescreens all accounts to ensure required information has been received and recorded in database.
- Works closely with health center staff to assist in identification of patient responsibility. Identifies accurate patient portions in order to collect money at the time of service (including past due account balances).
- Coordinates with insurance providers and health centers to obtain referrals and prior authorizations. Documents the findings and notifies patient and health center staff.
- Verifies medical necessity and coordinates with health centers to obtain necessary documentation.
- Maintains confidentiality of all information.

SUPERVISORY RESPONSIBILITIES

None.

QUALIFICATIONS

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE

High School diploma or General Education Degree (GED) and one year relevant work experience; Medical Coding Certification and knowledge of Current Procedural Terminology (CPT), International Classification of Diseases and Health Care Procedure Coding System (ICD-9) knowledge preferred. Bi-lingual (English/Spanish) preferred.

LANGUAGE SKILLS

Ability to read and interpret documents such as safety rules, operating and maintenance instructions, and procedure manuals. Ability to write routine reports and correspondence. Ability to speak effectively with customers or employees of organization.

MATHEMATICAL SKILLS

Ability to add, subtract, multiply, and divide in all units of measure, using whole numbers, common fractions, and decimals. Ability to compute rate, ratio, and percent and to draw and interpret bar graphs.

REASONING ABILITY

Ability to apply common sense understanding to carry out instructions furnished in written, oral, or diagram form. Ability to deal with problems involving several concrete variables in standardized situations.

CERTIFICATES, LICENSES, REGISTRATIONS

Coding Certification preferred.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to sit and use hands to finger, handle, or feel. The employee frequently is required to reach with hands and arms and talk or hear. The employee is occasionally required to stand and walk. Specific vision abilities required by this job include close vision, depth perception, and ability to adjust focus.

WORK ENVIRONMENT

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate.

This is not necessarily an exhaustive list of all responsibilities, skills, duties, requirements, efforts or working conditions associated with this job. While this is intended to be an accurate reflection of the current job, management reserves the right to revise the job or to require that other or different tasks be performed when circumstances change.

PPAZ Medical Billing Specialist Job Description

Job Title: Medical Billing Specialist

Division: Billing

Reports To: Revenue Cycle A/R Manager

FLSA Status: Non-Exempt

SUMMARY

Our services include an emphasis on family planning and reproductive health care, including the provision of birth control and comprehensive contraceptive counseling, testing and treatment of sexually transmitted infections, pregnancy testing, counseling and referral, HIV testing, annual exams, abortion care, and more. In addition, we focus on providing medically accurate sexuality education and training services throughout the state.

This position facilitates all billing to third parties and patients. Credentials and maintains relationships with contracted insurance companies and providers. Audits patients' accounts for accuracy in transaction and collection and communicates with the health centers.

The employee, whose signature appears above, agrees to be accountable for the ESSENTIAL DUTIES AND RESPONSIBILITIES, which include the following; other duties may be assigned:

- Performs and maintains provider credentialing necessary with each insurance plan.
- Corrects, edits and manages denied claims via NextGen open tasks: Invalid CPT, Invalid DX, Missing Modifier, Bill another Carrier, Invalid Eligibility, Authorization/Referral, Documentation Required or Other open tasks requiring intervention.
- Audits, generates, and uploads insurance claims to clearinghouse and submits claim by paper as appropriate.
- Reviews and make corrections to rejected claims and resubmits to payers.
- Daily audit of self-pay encounters to ensure integrity of the patients' account.
- Handles internal communications with the health centers related to insurance billing and collections.
- Requests medical records from health centers as requested by the contracted insurance plans.
- Corresponds with and assists vendors involved with patient accounts. Reviews and prepares check requests for patient and insurance refunds.
- Processes and posts patient payments (credit card) in an accurate and timely manner in accordance with department policies, procedures and performance goals.
- Coordinates with the Network Administrator II to ensure accurate billing information flow. Updates CPT codes and ICD-9 codes, as needed, at least on an annual basis. Works with Billing Manager to maximize revenue potential based on our unique services and providers.
- Maintains confidentiality of all department, patient, and billing matters.

SUPERVISORY RESPONSIBILITIES

None.

QUALIFICATIONS

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE

High School diploma or General Education Degree (GED) and 1 year work experience, or an equivalent combination of education and experience. Medical Coding Certification and knowledge of Current Procedural Terminology (CPT), International Classification of Diseases and Health Care Procedure Coding System (ICD-9) knowledge preferred.

Ability to type 50 WPM, including statistical/financial typing with accuracy. NextGen software experience highly desirable. Excel, MS Word with Windows based computer experience skills required.

LANGUAGE SKILLS

Ability to read and write simple instructions, short correspondence, and memos. Ability to communicate clear instructions to enact policy decisions. Ability to effectively present information in one-on-one and small group situations with employees of the organization.

REASONING ABILITY

Ability to apply common sense understanding to carry out instructions furnished in written, oral, or diagram form. Ability to deal with problems involving several concrete variables in standardized situations.

CERTIFICATES, LICENSES, REGISTRATIONS

CPT Coding Certificate helpful.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to sit and use hands to finger, handle, or feel. The employee frequently is required to reach with hands and arms. The employee is occasionally required to stand, walk, and talk or hear. Specific vision abilities required by this job include close vision, and ability to adjust focus.

WORK ENVIRONMENT

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate.

This is not necessarily an exhaustive list of all responsibilities, skills, duties, requirements, efforts or working conditions associated with this job. While this is intended to be an accurate reflection of the current job, management reserves the right to revise the job or to require that other or different tasks be performed when circumstances change.

PPAZ Business Analyst Job Description

Job Title: Business Analyst

Division: Customer & Administrative Services

Reports To: Director of Operational Standards

FLSA Status: Exempt

SUMMARY

The Business Analyst assumes primary responsibility for generating and maintaining all routine agency performance metrics, integrating both programmatic and financial data into useful dashboards. S/he is also responsible for creating analytics that address strategic business concerns and decisions.

This position is a central support for the Program Managers, Center Administrators and Division Heads in investigating financial queries. This position has the authority to act with regard to day-to-day problem solving and exercises judgment within these functional relationships.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned.

- Analyzes proposed programmatic plans for completeness, accuracy, and long-range impact against business objectives.
- Assists, as needed, in the preparation of monthly financial statements and annual budgets.
- Compiles required financial and budgetary reports and submits to external parties on behalf of the COO.
- Develops and performs analysis on profitability and productivity trends. Conducts regular Relative Value Unit cost and pricing analyses.
- Develops projections to assess impact of proposed changes to operations.
- Conducts statistical analysis and applies principles of accounting to analyze past and present health center operations and estimate future revenues and expenditures.
- Analyzes past and present financial data and estimates future revenues and expenditures, applying principles of finance.
- Makes recommendations to maximize the effective use of resources throughout the organization.

SUPERVISORY RESPONSIBILITIES

None

QUALIFICATIONS

To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. The requirements listed below are representative of the knowledge, skill, and/or ability required. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

EDUCATION and/or EXPERIENCE

Bachelor's degree in Accounting, Finance or related field and four years relevant work experience or equivalent combination of education and experience.

Minimum of four years of accounting, and financial or budget analysis experience. High level proficiency in Microsoft Office Suite specifically Excel and Access is required. Healthcare experience a plus.

Proficiency in EPM/EMR databases, preferably NextGen.
Ability to work well with people, meet deadlines, work under pressure, and work with minimal supervision in a professional manner. Organizational skills and attention to detail is essential. High integrity with excellent communication skills.

LANGUAGE SKILLS

Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, or governmental regulations. Ability to write reports, business correspondence, and procedure manuals. Ability to effectively present information and respond to questions from groups of managers, clients, or customers.

MATHEMATICAL SKILLS

Ability to work with mathematical concepts such as probability and statistical inference. Ability to apply concepts such as fractions, percentages, ratios, and proportions to practical situations.

REASONING ABILITY

Ability to define problems, collect data, establish facts, and draw valid conclusions. Ability to interpret an extensive variety of technical instructions in mathematical or diagram form and deal with several abstract and concrete variables.

CERTIFICATES, LICENSES, REGISTRATIONS

None required.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

While performing the duties of this job, the employee is regularly required to sit and use hands to finger, handle, or feel. The employee frequently is required to reach with hands and arms. The employee is occasionally required to stand, walk, and talk or hear. Specific vision abilities required by this job include close vision, and ability to adjust focus.

WORK ENVIRONMENT

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions.

The noise level in the work environment is usually moderate.

This is not necessarily an exhaustive list of all responsibilities, skills, duties, requirements, efforts or working conditions associated with this job. While this is intended to be an accurate reflection of the current job, management reserves the right to revise the job or to require that other or different tasks be performed when circumstances change.

BRIDGER Clinic Coordinator Job Description

Title: Clinic Coordinator

Status: 0.7 FTE or greater

DEFINITION

The Clinic Coordinator will carry out responsibilities which insure high quality, well-coordinated patient care in the clinic according to Title X guidelines and Bridgercare's mission. The Clinic Coordinator will work closely with the Nurse – Quality Assurance Coordinator to insure that supplies, documentation, follow up activities related to patient care, and support staffing are optimized for efficient, compliant provision of high quality patient care.

QUALIFICATIONS

The Clinic Coordinator will have a Bachelor's Degree in a field with relevance to health care operations. Candidates with relevant work experience or advanced education in public health, business, or another relevant field will be considered with preference. The Clinic Coordinator must have highly developed verbal and written communication skills and the ability to work effectively with administrative, clinical and support staff to accomplish the goals of the program. The Clinic Coordinator must be able to carry out the Clinical Assistant role at Bridgercare, in order to supplement clinic staffing, when necessary, and assist in training this sector of the clinic workforce.

SUPERVISION

The Clinic Coordinator will be supervised by the Executive Director who may seek feedback from the administrative team and Nurse Quality Assurance Coordinator with respect to the Clinic Coordinator's performance review.

RESPONSIBILITIES

1. Maintain patient care schedule in NextGen and keep Executive and Associate Directors apprised of schedule fluctuations related to patient demand or staffing levels.
2. Purchase medical, pharmaceutical and office supplies in accordance with Bridgercare purchasing policies, with ongoing monitoring of costs, availability of new or improved supply options, and awareness of current inventory levels. Communicate with Executive Director for budgeting purposes about price and supply fluctuations.
3. Collaborate with Administrative team in clinical program goal setting, progress evaluations, and ongoing problem solving.
4. Collaborate with Administrative and Education staff in obtaining grant funding and planning, accomplishing and evaluating grant funded activities and programs.
5. Participate in Clinical Conference calls, staff meetings and trainings, and assist in coordination or provision of continuing education for clinical or support staff.
6. Assist Associate Director in recruitment, orientation and training of students serving as lab volunteers at Bridgercare.
7. Serve as a resource to all staff about supply location, availability, storage requirements, and any additional pertinent information.
8. With training, conduct tasking of Medical and Pap Follow Up in the NextGen system to providers. Assist in completing written and phone notification to patients of follow up due or in obtaining documentation from other providers of referral or follow up outcomes.
9. Coordinate reportable STI follow up with Bridgercare providers, patients and Health Department. Document related patient communication in NextGen.
10. Oversee follow up documentation required from healthcare partners such as the MT Cancer Control Program Review.
11. With supervision or review from the Clinical QA Nurse, conduct or delegate semiannual internal medical and pap smear follow-up audits per Title X guidelines.
12. Maintain expertise in Bridgercare and third party billing practices, and the software systems used to accomplish these tasks. Work with the Office Manager to provide for backup staffing at the Front Desk. Assist in training identified staff in insurance coding, claims submission, and pay downs. Serve as a resource to clerical staff over all front office functions and assist in training new hires. Assist in the hiring process for clerical-clinical assistants.
13. Maintain excellent patient service relationships and represent Bridgercare professionally in all work related interactions with vendors, community members and healthcare and Title X colleagues.
14. Participate in ongoing NextGen training and assist the Administrative team in optimized development and use of this EMR system. Additional duties as assigned by the Executive or Associate Directors

BRIDGER Office Manager Job Description

Title: Office Manager

Status: 0.8 FTE or greater

DEFINITION

The Office Manager oversees the daily operations of patient accounts, third party billing, and financial bookkeeping. This individual assists in the analysis and organization of office systems and procedures to enhance clinic productivity. The Office Manager trains and supervises clerical job functions of clerical-clinical assistants and participates with the Associate Director in providing performance reviews of that staff. The Office Manager position is responsible for high quality clerical and financial operations that support Bridgercare's mission in compliance with Title X Guidelines.

QUALIFICATIONS

A minimum of a college degree in Business, Accounting or related field is preferred. At least two years of experience in billing, collections, CPT/ICD coding and accounting is required. An ability to handle multiple competing priorities is also required.

SUPERVISION

The Office Manager works under the supervision of the Executive and Associate Directors, who will conduct annual performance evaluations.

DUTIES AND RESPONSIBILITIES

A. Accounts

1. Oversee payment of bills that have been approved by Executive Director.
2. Develop and maintain banking relationships for the agency.
3. Pay expenses monthly expenses in coordination with contracted bookkeeper.
4. Maintain Quick Books' records in coordination with contracted bookkeeper.
5. Interface with accountant for the timely completion of the FAS, payroll, accounts payable, bank reconciliation, W2s, IRA contributions and other clinic accounts.
6. Monitor credit policies and collection procedures.
7. Meet with auditors as necessary.

B. Third Party Billing

1. Support the negotiation of third party contracts to ensure a productive and professional relationship with payers.
2. Oversee billing and respond to patients' questions regarding insurance.
3. Pay down patient accounts upon receiving EOB's.
4. Maintain accuracy of patient accounts.
5. Back bill insurance companies and Medicaid as indicated.
6. Maintain electronic claims submission process.

C. Management Responsibilities

1. Maintain office technical equipment support and update equipment and software as necessary.
2. Monitor ongoing currency of client data system.
3. Consult as member of Clinic Management Team regarding strategic planning.
4. Generate input to Executive Director to assist in the maintenance and implementation of a good system of management.
5. Hire, train, supervise and evaluate clerical functions performed by Clerical-Clinical Assistants with oversight from the Executive and Associate Directors.
6. Train and oversee accurate CVR (Clinic Visit Record) data collection, entry and reporting by clerical staff via the Ahlers Data Collection System according to Title X guidelines.

Organizational Revenue Cycle Design

System Needs and Requirements

Family planning health centers are implementing electronic health records (EHR) to leverage technology for both the documentation of services provided and improving patient outcomes. An agency can utilize a timeline to assist in the EHR implementation process, as well as to communicate with staff about the implementation. Tools are used to examine the workflow around the EHR to ensure the health center operates efficiently. System training with opportunities to practice helps to ensure staff members are comfortable with the new system. The following EHR implementation tools from BRIDGER are included:

- EHR timeline for implementation;
- EPM go live process timeline and responsibilities; and
- homework to prepare clinicians for using new systems.

BRIDGER EHR Five Month Implementation Timeline

** Identifying details have been changed*

June and July

- [IT Consultant] to order Server. Will load software and ship.
- [Associate Director] will order hardware and have shipped. Replace outdated desktops.
- [Business Manager] will work with Navicure to setup payers.
- Superusers and a few additional Staff will train on eLearning.
- [IT Consultant, Associate Director, and Volunteer IT Consultant] will network new desktop computers and setup VPN tunnel.
- [IT Consultant] and NextGen will perform software install
- [IT Consultant] will create database copy and test database copy

August

- Schedule and execute a phone call with [Staff] at MT State Lab, [NextGen Project Manager], and [Associate Director] to discuss interface
- Schedule and execute a phone call with [Staff] at MidWest Cancer Screening, [NextGen Project Manager], and [Associate Director] to discuss interface
- [Family Planning Agency Consultant] and team to begin System Administration and File Maintenance Build
- [IT Consultant] and [Family Planning Agency Consultant] will transfer templates to Bridger server and begin converting to Bridger specifications
- [Associate Director] will train with [Staff] at [Family Planning Agency Consultant] on the scheduler
- [Family Planning Agency Consultant] will send screenshots of templates and pick lists to [Associate Director]. [Associate Director] will work with Bridger staff to review and send changes to [Family Planning Agency Consultant].
- Demographic conversion ASAP so we can enter payers and schedule an insurance build and test. [NextGen Project Manager] to communicate with [Associate Director] on this.
- Bridger will fill out payer enrollment forms with Navicure.
- Phone call with [Associate Director] and NextGen claims analyst to perform Discover Document and billing info.

September

- [Associate Director] & tech support setup wireless and network laptops.
- [Associate Director] & tech support will create 2 computers to have hard copy of Ahlers.

October

- NextGen to perform system check
- Demographic conversion done so [Family Planning Agency Consultant] can enter payers and build billing
- [Family Planning Agency Consultant] to build insurance template
- NextGen to perform Insurance test (Claims scrubbing and testing)
- Bridger staff will do a webinar training on templates with [Family Planning Agency]

End of October

- [Family Planning Agency Consultant] comes to Bridger to train superusers on file maintenance, financial reporting, front desk, and providers.
- NextGen to perform pre GoLive audit
- Perform final extraction and conversion

October 31 – EPM GoLive

November 14 – EHR GoLive

BRIDGER EPM One Month Implementation Timeline

** Identifying details have been changed*

	Providers	**Front Desk**
Thurs, Oct. 13th	Rx labels Refill orders Alerts from Ahlers Superbill Signature pads, Consents	Tracking Rx for next 2 weeks Labels, scanners GL prep
Mon, Oct. 17th	**EPM Go Live**	**EPM Go Live**
Thurs, Oct. 20th	Phone calls Alerts, Follow-up, Recommendations	Phone calls Labs, scanning in EHR Tickler box, Alerts
Thurs, Oct. 27th	ePrescribe Labs, Referrals	Records Requests, incoming records Records Releases
Mon, Oct. 31st	EHR Go Live	EHR Go Live
Thurs, Nov. 3rd	Post Go Live trouble-shooting Follow-up reports	Post Go Live trouble-shooting Labs, missed encounter report

Tasks for [Family Planning Agency Consultant]:

- Scanning in EHR:
  - Labs, records, etc
  - Do you scan mammogram orders, records release forms, etc?
  - Printing records to send (do you keep records release form?)
  - Where to save incoming records/labs?
  - ePrescribe
  - Follow-ups
  - Return equipment

EHR GoLive:

- Missed encounter report – delete all encounters since EPM Go Live
- Tracking Provider activity
- Missed labs report
- Follow-up report
- ePads on Clinicians computers

BRIDGER Provider EHR Homework Log

PROVIDER EHR HOMEWORK Oct 17-23

Practice what you learned in training last Thursday. Practice e-signature pads, consents, tasks, and prescriptions.

You will get training on Thursday, 9-11 a.m., that will introduce Phone calls, Alerts, and Follow-up.

Enter 5 visits start to finish this week. Use patient charts from the purged files as examples and enter a visit (Return the chart when you are finished). Make sure you are doing general consents, and method consents with signatures on the sig-pads. Make sure you are doing a medical history and a visit template for each of the 5 visits.

Write the info below and turn in by the end of each week to [Executive Director]. *MAKE SURE YOU PRACTICE IN TEST!!*

1: Patient Name _____ Visit Type _____ Time to complete visit _____

2: Patient Name _____ Visit Type _____ Time to complete visit _____

3: Patient Name _____ Visit Type _____ Time to complete visit _____

4: Patient Name _____ Visit Type _____ Time to complete visit _____

5: Patient Name _____ Visit Type _____ Time to complete visit _____

EHR Go Live is Monday, October 31.

Organizational Revenue Cycle Design

Fee Schedule Development

A cost analysis is a solid foundation for the development of the fee schedule. THE CENTER completed a comprehensive cost analysis to create a new fee schedule, which resulted in an expanded number of sliding fee levels and higher rates to more accurately reflect service costs. Those revisions lead to an increase in third-party revenue. The following cost analysis tools from THE CENTER are included:

- sliding fee schedule – sample of 10-level sliding fee scale implemented as a result of the cost analysis; and
- cost analysis policy, procedure, and worksheet – outlines the process used for cost analysis as well as fee schedule development.

THE CENTER Sliding Fee Scale

Family Size	0% - 100% Federal Poverty Level No Charge	101% - 125%	126% - 150%	151% - 175%	176% - 200%
		Federal Poverty Level FPACT No Charge			
	Patient Pays 0%	Level 1	Level 2	Level 3	Level 4
1	$0 - $931	$932 - $1,164	$1,165 - $1,396	$1,397 - $1,629	$1,630 - $1,862
2	$0 - $1,261	$1,262 - $1,576	$1,577 - $1,891	$1,892 - $2,206	$2,207 - $2,522
3	$0 - $1,591	$1,592- $1,989	$1,990 - $2,386	$2,387 - $2,784	$2,785 - $3,182
4	$0 - $1,921	$1,922 - $2,401	$2,402 - $2,881	$2,882 - $3,361	$3,362 - $3,842
5	$0 - $2,251	$2,252 - $2,814	$2,815 - $3,376	$3,377- $3,939	$3,940 - $4,502
6	$0 - $2,581	$2,582 - $3,226	$3,227 - $3,871	$3,872 - $4,516	$4,517 - $5,162
7	$0 - $2,911	$2,912 - $3,639	$3,640 - $4,366	$4,367 - $5,094	$5,095 - $5,822
8	$0 - $3,241	$3,242 - $4,051	$4,052 - $4,861	$4,862 - $5,671	$5,672 - $6,482
9	$0 - $3,571	$3,572 - $4,464	$4,465 - $5,356	$5,357 - $6,249	$6,250 - $7,142
10	$0 - $3,901	$3,902- $4,876	$4,877 - $5,851	$5,852 - $6,826	$6,827 - $7,802
11	$0 - $4,231	$4,232 - $5,289	$5,290 - $6,346	$6,347 - $7,404	$7,405 - $8,462
12	$0 - $4,561	$4,562 - $5,701	$5,702 - $6,841	$6,841 - $7,981	$7,982 - $9,122

** For family units with more than 8 members, add $330 for each additional member*

Key:

Below 100% of poverty level, patient must not be charged for services per Title X regulations
Below 200% of poverty level, no payment is required if FPACT or MediCal patient, FPACT/MediCal pays full fee. Otherwise patient pays partial fee.
Between 201% and 250% poverty level, patient pays partial fee
Between 251% and 325% poverty level, patient pays partial fee
Above 326% poverty level, patient pays full fee

Remember: The schedule must be proportional through all levels, even if those levels under 200% FPL are not used due to Medi-Cal and Family PACT. Same scale must be applied to labs, medications and supplies

201% - 225%	226% - 250%	251% - 275% Poverty Level Partial Patient Fee	276% - 300% Federal Poverty Level Partial Patient Fee	301% - 325% Federal Poverty Level Partial Patient Fee	326% and greater Federal Poverty Level Patient Full Pay
Federal Poverty Level Partial Patient Fee/ Title X					
Level 5	Level 6	Level 7	Level 8	Level 9	Level 10
$1,863 - $2,094	$2,095 - $2,327	$2,328 -$2,560	$2,561 - $2,793	$2,794 - $3,025	$3,026+
$2,523 - $2,837	$2,838 - $3,152	$3,153 - $3,467	$3,468 - $3,782	$3,783 - $4,096	$4,097+
$3,183 - $3,579	$3,580 - $3,977	$3,978 - $4,375	$4,376 - $4773	$4,774 - $5,170	$5,171+
$3,843 - $4,322	$4,323 - $4,802	$4,803 - $5,282	$5,283 - $5,762	$5,763 - $6,241	$6,242+
$4,503 - $5,064	$5,065 - $5,627	$5,628 - $6,190	$6,191 - $6,753	$6,754 - $7,315	$7,316+
$5,163 - $5,807	$5,808 - $6,452	$6,453 - $7,097	$7,098 - $7,742	$7,743 - $8,386	$8,387+
$5,823 - $6,549	$6,550 - $7,277	$7,278 - $8,005	$8.006 - $8,733	$8,734 - $9,460	$9,461+
$6,483 - $7,292	$7,293 - $8,102	$8,103 - $8,912	$8,913 - $9,733	$9,734 - $10,531	$10,532+
$7,143 - $8,034	$8,035 - $8,927	$8,928 - $9,820	$9,821 $10,713	$10,714 - $11,605	$11,606+
$7,803 - $8,777	$8,778 - $9,752	$9,753 - $10,727	$10,728 - $11,702	$11,703 - $12,676	$12,677+
$8,463 - $9,519	$9,520 - $10,577	$10,578 - $11,635	$11,636 - $12,693	$12,694 - $13,750	$13,751+
$9,123 - $10,262	$10,263 -$11,402	$11,403 - $12,542	$12.543 - $13,682	$13,683 - $14,821	$14,822+

THE CENTER Cost Analysis and Fees Policies

I. Cost Analysis

a. Cost analysis, using a Cost Center Report design, is conducted each quarter to determine the base fee for each service provided.

b. The schedule of discounts is updated each quarter based on the cost analysis.

c. Cost analysis is performed for each new service when implemented.

NOTE: Staff participated in cost analysis training provided by the California Family Health Council (Title X Grantee) in March of 2010. A copy of the current cost analysis can be found in the shared drive.

II. Fees

a. Fees are based on a quarterly cost analysis of all services provided.

b. A schedule of discounts is developed and implemented for individuals with family incomes between 101% and 250% of the Federal poverty level.

c. Fees are waived for individuals with family incomes above 101% and 250% of the Federal poverty level who are unable to pay for family planning services.

d. Clients whose documented income is at or below 100% of the Federal poverty level are not charged.

e. Individual eligibility for a discount is verified at each visit and documented in the client's financial record.

f. The Encounter Form for each patient shows total charges less any allowable discounts.

g. Eligibility for discounts for minors who receive confidential services is based on the income of the minor.

h. Voluntary donations from clients are accepted but are not tied to the provision of services, medications or supplies.

i. Client income is verified at each visit.

THE CENTER 2011 Cost Analysis

*This template was developed by George "Gerry" Christie and reprinted with acknowledgement of his work. The use of Mr. Christie's services was made possible to THE CENTER through support from California Family Health Council.

Time Frame for Report: 07/01/2010-06/30/2011

Unduplicated Patients (FPAR): 4715

					Distribution of Facilities			
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
FUNCTIONAL COST CENTER	Personnel	Other Costs	Donated Services	Total Before Dist.	Square Foot	% of Total	Cost of Facilities	TOTAL After Facility Dist.
Medical	386,093	45,843	-	431,936	3,540	49%	61,453	493,389
Laboratory	21,486	8,573	-	30,059	176	2%	3,047	33,106
Pharmacy	31,237	99,296	-	130,534	115	2%	1,997	132,530
Community Outreach	36,069	6,447	-	42,516	714	10%	12,397	54,912
Administration	234,620	96,281	-	330,901	2,653	37%	46,062	376,962
Facility	816	124,139	-	124,955			(124,955)	
Total	710,321	380,579	-	1,090,900	7,197	100%		1,090,900

		Distribution of Administration		
	(9)	(10)	(11)	(12)
	Total After Dist. (Col.(8))	Percent Health Care Costs	Cost of Administration	TOTAL After Admin. Dist.
Medical	493,389	69%	260,512	753,901
Laboratory	33,106	5%	17,480	50,586
Pharmacy	132,530	19%	69,977	202,507
Community Outreach	54,912	8%	28,994	83,906
Sub-Total	713,938	100%		
Administration	376,962			
Total	1,090,900		(376,962)	1,090,900

Amounts for Fee Determination Worksheets	
Medical	753,901
Laboratory	50,586
Pharmacy	20,2507
Community Outreach	83,906

MEDICAL COST CENTER

(A) SERVICE/PROCEDURE	(B) CPT CODE	(C) SERVICE UTILIZATION (FREQUENCY)	(D) RVS VALUE	(E) TOTAL SERVICE UNITS	(F) ADJUSTED TOTAL COST/ COST CENTER	(G) AVERAGE COST/ SERVICE UNIT	(H) SERVICE COST	(I) COST OF LIVING ALLOW-ANCE	(J) ADJUSTED COST
NEW PATIENT-BRIEF	99201	26	35.95	935		0.89	32.03	0.00	32.03
NEW PATIENT-LIMITED EXAM	99202	450	62.38	28071		0.89	55.58	0.00	55.58
NEW PATIENT-INTERMEDIATE EXAM	99203	508	89.77	45605		0.89	79.98	0.00	79.98
NEW PATIENT-COMPREHENSIVE	99204	205	138.77	28448		0.89	123.64	0.00	123.64
CONTINUING PATIENT-BRIEF	99211	18	17.27	311		0.89	15.39	0.00	15.39
CONTINUING PATIENT-LIMITED	99212	1270	35.95	45658		0.89	32.03	0.00	32.03
CONTINUING PATIENT-INTERMEDIATE	99213	913	60.26	55016		0.89	53.69	0.00	53.69
CONTINUING PATIENT-COMPREHENSIVE	99214	1862	90.21	167977		0.89	80.38	0.00	80.38
Preventive counseling, indiv 10 min	Z9751	1456	33.54	48837		0.89	29.88	0.00	29.88
Preventive counseling, indiv 15 min	Z9752	2246	57.71	129609		0.89	51.41	0.00	51.41
Preventive counseling, indiv 30 min	Z9753	1313	81.51	107023		0.89	72.62	0.00	72.62
Preventive counseling, indiv 45 min	Z9754	3	105.68	317		0.89	94.15	0.00	94.15
Teen Smart Extended	Z9761	422	97.97	41343		0.89	87.29	0.00	87.29
Teen Smart Brief	Z9760	1104	89.39	98683		0.89	79.64	0.00	79.64
IUD INSERTION	58300	87	67.84	5902		0.89	60.44	0.00	60.44
IUD REMOVAL	58301	43	87.58	3766		0.89	78.03	0.00	78.03
DIAPHRAGM/CERVICAL CAP FIT	57170	2	57.10	114		0.89	50.87	0.00	50.87
Condyloma Treatment (Destruction, vulva lesion(s)	56501	59	118.73	7005		0.89	105.79	0.00	105.79
Condyloma Treatment (Destruction, penis lesion(s)	54050	101	120.21	12141		0.89	107.10	0.00	107.10
COLPOSCOPY w/Biopsy & ECC	57454	118	101.88	12022		0.89	90.77	0.00	90.77
COLPOSCOPY w/Biopsy	57455	2	132.92	266		0.89	118.43	0.00	118.43
Colposcopy without biopsy	57452	9	103.51	932		0.89	92.22	0.00	92.22
Biopsy (vulvar)	56605	0	77.90	0		0.89	69.41	0.00	69.41
Endometrial biopsy	58100	0	103.15	0		0.89	91.90	0.00	91.90
Bartholin Cyst incision and drainage	56420	0	111.09	0		0.89	98.97	0.00	98.97
Chemical Wart Treatment - Vaginal	57061	6	105.68	634		0.89	94.15	0.00	94.15
CRYOSURGERY	57511	18	133.30	2399		0.89	118.76	0.00	118.76
IMPLANON INSERTION	11975	26	121.45	3158		1.80	218.61	0.00	218.61
IMPLANON REMOVAL	11976	0	134.38	0		1.80	241.88	0.00	241.88
IMPLANON REMOVAL W/ REINSERTION	11977	0	217.04	0		1.80	390.67	0.00	390.67
TOTAL				846172	753901				

2010/11 Clinical Diagnostic Laboratory Fee Schedule

(A) SERVICE/PROCEDURE	(B) CPT HCPCS Code	(C) SERVICE UTILIZATION (FREQUENCY)	(D) RVS VALUE	(E) TOTAL SERVICE UNITS	(F) ADJUSTED TOTAL COST/ COST/ CENTER	(G) AVERAGE COST/ SERVICE UNIT	(H) COST SERVICE ADJUSTED	(I) PER UNIT PURCHASE EXPENSE	(J) TOTAL BASE COST	(K) COST OF LIVING ALLOW-ANCE	(L) ADJUSTED COST
Chlamydia	87491	4115	49.04	201800		0.09	4.39	15.00	19.39	0.00	19.39
Gonorrhea	87591	4115	49.04	201800		0.09	4.39	15.00	19.39	0.00	19.39
Glucose Assay, blood quant	82947	1	5.48	5		0.09	0.49	5.00	5.49	0.00	5.49
Hemocult/Serocult	82270	27	4.54	123		0.09	0.41	15.00	15.41	0.00	15.41
Lipid Panel	80061	20	18.72	374		0.09	1.68	11.50	13.18	0.00	13.18
Pregnancy Test-Urine	81025	3739	8.84	33053		0.09	0.79	2.18	2.97	0.00	2.97
Prolactin	84146	7	27.08	190		0.09	2.43	7.70	10.13	0.00	10.13
Syphilis Screen (VDRL/RPR)	86592	18	5.96	107		0.09	0.53	7.25	7.78	0.00	7.78
Thin Prep	88174	13	28.31	368		0.09	2.54	20.00	22.54	0.00	22.54
TSH	84443	44	23.47	1033		0.09	2.10	7.70	9.80	0.00	9.80
UA Auto wo/micro	81003	3739	3.14	11740		0.09	0.28	4.00	4.28	0.00	4.28
UA Auto w/micro	81001	0	4.43	0		0.09	0.40	10.00	10.40	0.00	10.40
UA Dipstick w/micro	81000	3	4.43	13		0.09	0.40	4.00	4.40	0.00	4.40
UA Dipstick w/o micro	81002	55	3.57	196		0.09	0.32	3.00	3.32	0.00	3.32
Urine C&S	87086	1	11.28	11		0.09	1.01	24.00	25.01	0.00	25.01
HSV (Herpes) Culture - Male	87252	0	36.42	0		0.09	3.26	41.00	44.26	0.00	44.26
HSV (Herpes) Culture - Female	87255	2	47.31	95		0.09	4.24	41.00	45.24	0.00	45.24
HSV (Herpes) Select I & II	87273	2	12.98	26		0.09	1.16	52.00	53.16	0.00	53.16
HPV (DNA Amplified Probe) High	87621	0	49.04	0		0.09	4.39	38.00	42.39	0.00	42.39
Wet Mount	87210	364	5.96	2169		0.09	0.53	5.00	5.53	0.00	5.53
Routine Venipuncture	36415	95	3.00	285		0.09	0.27	8.00	8.27	0.00	8.27
Cyto-pathologist review	88141	10	30.70	307		0.09	2.75	80.00	82.75	0.00	82.75
HIV Orasure	86702	471	18.88	8892		0.09	1.69	18.00	19.69	0.00	19.69
HIV-1/HIV-2, single assay	86703	0	19.17	0		0.09	1.72	16.00	17.72	0.00	17.72
Hepatitis C, AB test	86803	0	19.94	0		0.09	1.79	15.78	17.57	0.00	17.57
Chorionic gonadotropin assay	84703	0	10.49	0		0.09	0.94	9.00	9.94	0.00	9.94
Hemoglobin	85018	0	3.31	0		0.09	0.30	5.00	5.30	0.00	5.30
Hemogram (Hematocrit)	85014	0	5.00	0		0.09	0.45	5.00	5.45	0.00	5.45
Biopsy (Colpo) per site	57455	12	75.00	900		0.09	6.72	75.00	81.72	0.00	81.72
Biopsy (Colpo) & ECC per site	57454	50	150.00	7500		0.09	13.44	150.00	163.44	0.00	163.44
TOTAL				470988	42186						

PHARMACY COST CENTER

(A) SERVICE/PROCEDURE	(B) SERVICE UTILIZATION (AMOUNT)	(C) RVS VALUE	(D) TOTAL SERVICE UNITS	(E) ADJUSTED TOTAL COST/ COST/CENTER	(F) AVERAGE COST/ SERVICE UNIT	(G) COST SERVICE ADJUSTED	(H) COST OF LIVING ALLOWANCE	(I) ADJUSTED COST
ORAL CONTRACEPTIVES (High Cost)	147	5.88	864		2.34	13.77	0.00	13.77
ORAL CONTRACEPTIVES (Low Cost)	129	3.00	387		2.34	7.03	0.00	7.03
Paragard	19	185.00	3515		2.34	433.66	0.00	433.66
MIRENA IUS	67	283.02	18962		2.34	663.43	0.00	663.43
Implanon	64	325.00	20800		2.34	761.84	0.00	761.84
CONDOMS (each)	1227	0.06	74		2.34	0.14	0.00	0.14
MEDS/VAG. INFECTION - cream/supp	60	3.14	188		2.34	7.36	0.00	7.36
MEDS/VAG. INFECTION - oral	274	1.13	308		2.34	2.64	0.00	2.64
MEDS/STD	796	1.49	1186		2.34	3.49	0.00	3.49
Aldara	20	55.32	1106		2.34	129.68	0.00	129.68
Acyclovir	76	1.49	113		2.34	3.49	0.00	3.49
Azitrhomycin	235	0.66	155		2.34	1.55	0.00	1.55
Ceftriaxone	30	0.69	21		2.34	1.62	0.00	1.62
Ciprofloxacin	158	0.53	84		2.34	1.24	0.00	1.24
Doxycycline	37	0.42	16		2.34	0.98	0.00	0.98
Fluconazole	254	0.53	135		2.34	1.24	0.00	1.24
Phenazopyridine	14	0.53	7		2.34	1.24	0.00	1.24
SMX/TMP	100	0.33	33		2.34	0.77	0.00	0.77
FEMALE CONDOM	0	0.06	0		2.34	0.82	0.00	0.82
DEPO	181	14.82	2682		2.34	34.74	0.00	34.74
Ortho EVRA Patch	37	16.48	610		2.34	38.63	0.00	38.63
Nuva Ring	141	47.25	6662		2.34	110.76	0.00	110.76
ECP	469	14.64	6866		2.34	34.32	0.00	34.32
Safer Sex Pack	3275	6.60	21615		2.34	15.47	0.00	15.47
TOTAL			86390	202,507				

Insurance Contracting

The anticipated increase of patients with commercial or government-sponsored health care coverage means that family planning providers need to expand their scope of contracting with health insurance companies. An increase in the number of health plans that agencies bill will require increased management to ensure compliance with the new contracts. Tools to manage contract requirements include but are not limited to filing timeframes, authorizations, referrals, and the renewal process. The following tool from PPAZ assists the agency in the management of insurance contracts by summarizing the important features of the contract and identifying the location of these details within the physical contract for each insurance plan.

PPAZ Payer Contract Cheat Sheet

** Identifying details have been changed*

ITEM	DESCRIPTION / DETAIL OF ITEM	SECTION/PAGE LOCATION WITHIN CONTRACT
Payer Name	BC/BS of Arizona	Page 1
Effective Date	January 1, 2013	Page 3
Payer Contact	Jane Doe, 555-515-2202	
Term		Page 17, sec. 6.1
Termination Clause		Page 17, sec. 6.2
Timely Filing	180 Days from DOS	Page 11, sec. 4.1.1
Claims Turn-around		Page 12, sec. 4.1.2
Claims Appeal		Page 11 sec. 4.1.1
Offset/Refund		Page 12 sec. 4.1.2
Assignment Successors		Page 20, sec. 9.6
Indemnification		Page 13, sec. 4.3.2
Amendment		Page 20, sec. 9.1
Rates		Addendum, page 24 & 26
Dispute Resolution		Page 19, sec. 8.2
COB		Page 13, sec. 4.2

Billing Processes during a Patient Visit

Pre-visit/Arrival/Check-in

The revenue cycle process begins when the patient makes an appointment. Several activities related to the billing process occur during the pre-visit and patient arrival. During this first step, key patient demographic, insurance, and income data are collected and verified. The goal of this data collection is to determine who will be responsible for cost of the services provided. Procedures ensure the standardization of processes as well documenting the specific requirements for the activity. The participating agencies developed tools and procedures for data collection when the appointment is scheduled and when the patient arrives for the visit, including:

- Patient information form – verification of patient information including income documentation (BRIDGER).
- Clinic visit record – collection of family planning annual report required data (BRIDGER).
- Scheduling process – tasks needed as well as data required to schedule a patient visit (PPAZ).
- Registration process – activities to be completed when a patient is registered (PPAZ).
- Superbill – used to document services provided (BRIDGER & THE CENTER).
- Visit workflow – tasks to be completed during a visit (PPAZ).

BRIDGER Patient Information Form

I voluntarily request services from Bridgercare. I authorize Bridgercare to release any information necessary to process my insurance benefit to be paid directly to Bridgercare. I accept full financial responsibility for any uncovered costs based on my sliding fee assignment. I understand that I may set up a payment plan. Amounts with no payments for more than 90 days may be released to an outside agency for collection with reporting of same to credit bureaus. Essential services will not be denied for inability to pay.

Patient Signature: _____ Date: _____

Do you have insurance, Medicaid or Montana Cancer Control Program coverage? Yes No

Insurance coverage does NOT affect your eligibility for our discounts.

_____ I do not want to be considered for sliding fees. I understand that if I am insured, I may be left with a balance or copay. I also understand that I cannot retroactively be considered for sliding fees for this date of service.

Initial here: _____

_____ I wish to be considered for sliding fees. *Please complete the box below.*

Please fill out this box in order to be considered for reduced fees.
We may request income verification.
Record your income BEFORE taxes. This is your gross income.
Inclusion of a spouse or cohabitating sexual partner's income is required by our Federal grant regardless of how you share expenses. Thank you!

Staff use only.

Number of household members (including yourself): _____

Your Current Employment: _____ hrs/wk at $_____ an hour OR salary of $_____ per year. _____

If you have a 2nd job: _____ hrs/wk at $_____ an hour OR salary of $_____ per year. _____

Partner Current Employment: _____ hrs/wk at $_____ an hour OR salary of $_____ per year. _____

If partner has 2nd job: _____ hrs/wk at $_____ an hour OR salary of $_____ per year. _____

Other Income:	tips/commission	$_____ per week	_____
	parental support	$_____ per month	_____
	grants/stipends/scholarships	$_____ per month	_____
	trust accounts	$_____ per month	_____
	unemployment/disability	$_____ per month	_____
	child support/alimony	$_____ per month	_____
	rental income that you receive	$_____ per month	_____
	other income	$_____ per month	_____

FEMALES ONLY:

Are you a female age 19-44?	Y	N
Are you pregnant or seeking pregnancy?	Y	N
Are you able to get pregnant?	Y	N
Are you a US Citizen & a Montana Resident?	Y	N

PLANFIRST:
Yes No

Monthly Income: _____

Received inc verif? Yes No

Date:

Staff Initials:

Fee Scale: 1 2 3 4 5

BRIDGER Client Visit Form

Patient # _____/_____/_____/_____/_____/_____

DOB _____/_____/ _____

Patient Initials _____

Monthly Income _____ Family Size_____

Gender □ M □ F

NON TITLE X PATIENT?

Please check why.

_____ menopausal _____ smoking cessation

_____ post EAB _____ depression visit

_____ thyroid visit _____ FF IUD or Implant

_____ Mental Health visit

COMPLETE AT FIRST VISIT ONLY

HISPANIC □ Y □ N Limited English / Interpreter Needed? □ Y □ N

RACE **(check all that apply)**

□ White □ Native American / Alaskan □ Other □ Unknown
□ Black □ Asian □ Pacific Islander / Hawaiian

COMPLETE AT EACH VISIT

1. VISIT DATE _____/_____/ 2013

PURPOSE OF VISIT **(check one)**

□ 1. Initial Exam
□ 2. Annual Exam
□ 3. Other Medical
□ 4. Pregnancy Test
□ 5. Education/ Counseling
□ 6. ECP
□ 7. Adolescent Birth Control Visit

CLIENT INSURANCE STATUS **(check one)**

□ 1. Public (Medicaid, HMK, Champus)
□ 2. Private Health Insurance
□ 3. Uninsured
□ 4. Unknown

ENDING CONTRACEPTIVE METHOD
(complete before & after blocks)

1.Abstinence
2.Diaphragm/ Cap
3.Female Condom
4.Female Sterilization
5.Fertility Awareness
7.Depo - 3 Mo. Inj.
8. Hormonal Patch
9. Hormone Implant
10. IUD
11. Male Condom
12. None
13. Pills - Orals
14. Other
15. Spermicide (only)
16. Sponge
17. Unknown
18. Vaginal Ring
19. Vasectomy

Method Before Visit _____ (1st visit only) **Method After Visit** _____

IF NO METHOD AT THE END OF VISIT, GIVE REASON

IF PREGNANT: ☐ 2. Seeking Pregnancy ☐ 4. Infertility
☐ 1. Planned ☐ 3. Not Currently Sexually Active ☐ 6. Other
☐ 7. Unplanned

REFERRED ELSEWHERE **(check all applicable)**

☐ 03. Abnorm. Breast F/U
☐ 08. HIV Treatment
☐ 10. Mental Health
☐ 14. Pregnancy
☐ 20. Primary Care
☐ 19. Follow-up for Medical Findings
☐ 22. Follow-up for Elevated BP
☐ 23. Weight Management

PROVIDERS OF SERVICES **(check all applicable)**

□ 1. Physicians
□ 2. PA, NP, CNM
□ 3. Other Clinical Providers (RNs)
□ 4. Non-Clinical Providers (Educators - Interns)

MEDICAL SERVICES PROVIDED **(check all applicable)**

□ 03. Annual Physical Exam Deferred

EXAM & LAB SERVICES

□ 11. Blood Pressure Normal
□ 12. Blood Pressure Abnormal
□ 13. Breast Exam
□ 14. Colo -Rectal Cancer Screen
□ 15. Pelvic Exam
□ 16. Hgb / Hct
□ 17. Hep B Screen *slid only*
□ 18. Hep C Screen *slid only*
□ 19. Male Genitalia Exam
□ 21. Pap Test (smear or liquid)
□ 24. UTI Treatment
□ 25. Urinalysis (dipstick or micro)

CONTRACEPTIVE SERVICES

□ 29. EC-Immediate Need
□ 30. EC– Future Need
□ 31. Hormonal Injection-Depo
□ 32. Hormone Implant In/Out
□ 33. IUD Insert *slid only*
□ 34. IUD Removal

PREGNANCY SERVICES

□ 35. Negative HCG
□ 36. Positive HCG

STD SERVICES

□ 37. Chlamydia *slid only*
□ 39. Gonorrhea *slid only*
□ 40. Herpes Cult / Serlgy *slid only*
□ 42. HIV Rapid/Serum Test
□ 43. HPV Test *slid only*
□ 44. HPV Vaccine
□ 46. Syphilis Test *slid only*
□ 47. STI Treatment
□ 48. Wart Treatment
□ 49. Wet Mount
□ 50. Pt Delivered Partner Therapy

9. COUNSELING SERVICES PROVIDED **(check all applicable)**

□ 51. Initial
□ 52. BSE / TSE
□ 53. BCM /EC
□ 54. STI Counseling
□ 55. Immunization
□ 57. Adolescent Counseling
□ 58. Reprod. Life Plan
□ 60. Nutrition / Exercise
□ 61. Other
□ 63. Pregnancy Options x 3
□ 67. ETOH/Drug Use/Cessation
□ 68. Tobacco Cessation
□ 69. Depression /Anxiety
□ 70. HIV Counseling
□ 71. Intimate Partner Violence

PPAZ Appointment Scheduling Process

1. Ask what type of appointment the patient wants to schedule
2. Ask if patient is a New or Established patient
    - **If New** - Ask for patients' zip code or ask if they know which office they would like to be seen at
    - **If Established** - Ask for patient **Name, Date of birth (DOB)** and search chart. Ask if they want to continue being seen at their current location (look up on NextGen Encounter tab)
3. Does patient have Health Insurance?
4. Locate next available appointment and inform patient of the **location, date, & time**. If patient okay with availability, set appointment
5. **If New patient** - Ask for Name (first, last), DOB, Address, & best phone number they can be reached
   If Established patient - Confirm information on NextGen is current & make any necessary changes
6. If patient is using Insurance, always ask if they are the Policy Holder (Medicaid patients are always their own policy holder)
    - If patient is Policy Holder, continue asking what insurance they have and get Member ID & Group ID number (follow Insurance information)
    - If patient is **NOT** the Policy Holder, be sure to input Policy Holder information:
        - Name
        - DOB
        - Relationship to patient
        - Address
        - Social Security # (if SS# not available, inform patient it needs to be provided at appt)
7. Put notes into Detail Box Following Scheduling Guidelines & SAVE appt
    - Reminder: If using Insurance, select Financial Class
8. Confirm appointment with patient (**Date, Time & Location**) Ask patient if they need address

PPAZ Registration Process

Policy

This policy is to ensure the best customer service for patients at each phase of their visit. Information collected and provided by the call center, as well as center staff is to follow the standard procedure to ensure a speedy check-in and to avoid unnecessary wait times for initial call back.

Scope

Call Center, Call Center Manager, all Health Center Staff and Center Managers

Team Members Responsible for Initiating Process:

Center Managers, Call Center Manager, Team Leads and Lead Customer Service Representatives (CSR)

Procedure

Call Center

The call center will be required to verify (if established patient) or collect (if new patient) the required information in PMS to ensure a speedy check-in at registration. This information includes the following:

- Patient name
- Patient date of birth
- Patient address
- Patient phone number
- Insurance information to be entered into insurance field
- Standard comments in field relating to visits – See Standard Appointment Comment Guidelines

For Health Center Staff Booking Appointments in the Centers for Patients

Anytime health center staff is booking appointments for a patient at the center level, they are obligated to follow the standard comments required for each type of appointment - **See Standard Appointment Comment Guidelines**

Health Center Front Desk Staff Procedure & Responsibilities

The front desk staff is responsible for ensuring a prompt check-in, and **must not wait** for patient paperwork to be given back to front desk before completing check-in and creating encounters in PMS. All necessary information required for check-in in PMS is taken by the call center and will be available for each patient as they arrive to the center.

Check-In For New Patients

1. Patient signs in
2. Health Center Staff to give patient the patient information form (PIF) and HIPAA/General Consent form to sign.
3. If insurance, collect Insurance Card and ID
4. Verify eligibility, collect co-pay, if applicable
5. Give patient paperwork to work on while they wait
6. Check patient into PMS
7. Print fee ticket
8. Put necessary paperwork in chart for intake Health Center Assistant (HCA)
9. Put chart up for intake

Check-In For Established Patients

1. Patient Signs in
2. Health Center Staff asks if any demographics have changed
   - If yes, Health Center Staff to furnish patient with new PIF to fill out.
   - If no, process patient
   - If at Title X Center, a new PIF must be furnished every 6 months
3. If Insurance, collect Insurance Card and ID
4. Verify eligibility, collect co-pay, if applicable
5. Give patient paperwork to work on while they wait
6. Check patient into PMS
7. Print fee ticket
8. Put necessary paperwork in chart for intake HCA
9. Put chart up

Intake HCA

1. All consents and forms are to be reviewed and processed in the back:
   - Request for Services, if applicable
   - Request for Surgery or Special Services, if applicable
   - CIIC's
   - CI's
2. HCA to review paperwork with patient and witness signature on all documents
3. Ensure paperwork for completeness
4. Complete vitals if indicated
5. Complete subjective for visit as needed
6. Complete education
7. Organize chart
8. Chart up for clinician

BRIDGER Superbill

NEW **EST** **EST >3 yrs** since last visit

None **X3** **X19** **MCCP** **PlanFirst** Inc Verif needed? N or Y *(if yes, limit OCs)*

NEW OFFICE VISITS			
New Minimun		99201	☐ $48
New Low	FF	99202	☐ $76
New Moderate	FF	99203	☐ $120
New High	FF	99204	☐ $140
New Complex	FF	99205	☐ $176
ESTABLISHED OFFICE VISITS			
Est Minimum		99211	☐ $28
Est Low	FF	99212	☐ $48
Est Moderate	FF	99213	☐ $76
Est High	FF	99214	☐ $120
Est Complex	FF	99215	☐ $148
NEW ANNUALS			
New CPE (12-17)		99384	☐ $136
New CPE (18-39)		99385	☐ $160
New CPE (40-64)		99386	☐ $160
New CPE (65+)	FF	99387	☐ $160
ESTABLISHED ANNUALS			
Est CPE (12-17)		99394	☐ $120
Est CPE (18-39)		99395	☐ $120
Est CPE (40-64)		99396	☐ $140
Est CPE (65+)	FF	99397	☐ $140
PROCEDURES			
IUD Insert *V25.11*	FF	58300	☐ $120
State Fund IUD Insert		58300 ST	☐ $120
IUD Insert *FAILED*		58300F	☐ $120
Wet Mount *FF IUDs*	FF	87210 FF	☐ $16
Wet Mount *State IUDs*		87210	☐ $16
IUD Removal *V25.12*		58301	☐ $80
IUD Check		99214 NC	☐ nc
Nexplanon Insert	FF	11981	☐ $150
Nexplan. Insert+Removal	FF	11977	☐ $250
Nexplanon Removal		11976	☐ $150
Nexplanon Check		99214 NC	☐ nc
Diaphragm Fit		57170	☐ $72
Diaphragm Refit		57170 RT	☐ $36
HPV Tx Simple Female		56501	☐ $52
HPV Tx Ext Female		56515	☐ $65
HPV Tx Simple Male		54050	☐ $52
HPV Tx Ext Male		54065	☐ $65

LABORATORIES			
Pregnancy Test		81025	☐ $7
Pregnancy Test	NC	81025NC	☐ $0
Chlamydia	FF	87491	☐ $32
Chlamydia Anal	FF	87491AN	☐ $32
Chlamydia Throat	FF	87491TH	☐ $32
Gonorrhea	FF	87591	☐ $32
Gonorrhea Anal	FF	87591AN	☐ $32
Gonorrhea Throat	FF	87591TH	☐ $32
Conventional Pap		88164	☐ $32
ThinPrep *HPV protocal only*		88142	☐ $52
Thin Prep	FF	88142 FF	☐ $52
Repeat Pap	FF	88164 FF	☐ $32
Repeat Pap *unsat.*		88164 RT	☐ nc
Spec. Coll. ***X19** PAPS!!*		Q0091	☐ $8
HPV *per protocal*		87621	☐ $48
HPV *pt requested*	FF	87621 FF	☐ $48
HPV ordered charge only if run			☐ $48
Wet Mount		87210	☐ $16
Hemaglobin		85018	☐ $16
Hemacult		82270	☐ $12
Urine Dip	FF	81002	☐ $8
Urine Dip & Micro	FF	81000	☐ $12
Confidential HIV for X3		86701	☐ $36
Confidential HIV Non-X3		HIVnonX3	☐ $36
Anonymous HIV	HI	AnonHIV	☐ nc
HSV Culture		87252	☐ $72
HSV Serum		86696	☐ $44
Hep B Surf Atbdy		86706	☐ $44
Hep B Surf Atgn		87340AG	☐ $28
HepC		86803	☐ $36
VDRL (Syph)		86592	☐ $16
FTA-ABS		86780	☐ $36
VACCINES			
HPV Vaccine FF=$150		90649	☐ nc
Hep A Vaccine		90632	☐ nc
Hep B Vaccine		90746	☐ nc
MMR		90710	☐ nc
VaccineAdmin(*all vaccines!)*		90471	☐ $28
VaccineAdmin-Subsiquent*		90472	☐ $14

Subsequent vaccines: charge 90471 **and 90472*

Diaphragm Size:_____		DIA___	☐ $32
Jelly		JELLY	☐ $10
Condoms x ____		CONDM	☐ $0.20
Condoms X19 x ____		A4267	☐ $0.20
Skyn/non-latex x ____		SKYN	☐ $0.40
Cycle Beads		BEADS	☐ $16
Rocephin		J0696	☐ $6
Zithromax		ZITH	☐ $12
Paragard IUD		J7300	☐ $400
State Paragard		ST IUD	☐ nc
Mirena IUD		J7302	☐ $500
Nexplanon		J7307	☐ $400
Depo		DEPO	☐ $32
Inject. Admin*(depo, rocephin)*		96372	☐ $16
Ortho Evra Patch		PAT	☐ $44
Nuvaring		RING	☐ $44
PlanB		PLB1	☐ $32
PlanB OTC	FF	PLB OTC	☐ $32
OC's x _____		S4993	☐ $32
circle one: GES15 CRY OCY REC TRILO 777 LUT NORQ			
Shipping & Handling	FF	S&H	☐ $7

DIAGNOSIS :_____

Rendering Provider:_____

Pmt: $ Don: $

cash check
card non

Prior balance/credit: $

Staff Initials:

DIAGNOSIS CODES:

V72.31 Annual Exam or 1/2
V70.0 Routine Med Exam
or ↓ 19yr. BCM start
V25.01 OC Rx - start
V25.02 BCM - other method start
V25.49 BCM - other method cont.
V25.03 ECP Rx & Counsel
V01.6 STI exposure - contact
V04.89 Vaccine for Viruses
V25.11 IUD Insert V25.12 IUD Removal
V25.11 IUD Insert V25.12 IUD Removal
V25.13 IUD remove + reinsert
V25.5 Nextplanon Insert
V25.43 Nextpl. surveillance or removal
V73.89 Hep HIV HSV screen
V73.88 Chlamydia Screen
V74.5 STD Screen
V73.81 Routine HPV screen
V76.19 Breast Exam
V78.0 Iron Def. Anemia Screen
V81.6 Urine Screen

V67.09 Post EAB Exam
V72.41 -neg HCG V72.42 +pos HCG
V26.49 Preconcep.Health Coun.
V76.51 Fecal Occult Screen
V81.1 Hypertension Screen
611.71 Breast Pain
610.1 Fibrocystic breasts
611.6 Galactorrhea
611.79 Nipple Discharge
795.05 Pos. HPV test(cervical)
616.0 Cervicitis/Endocervicitis
795.01 ASCUS pap
795.02 ASCUS can't exclude↑grade
795.03 LGSIL pap
795.04 HGSIL pap
622.7 Cervical Polyp
795.08 Unsat.CervicalCytology Smear
795.07 Satis.Pap w/out endo.cells
627.1 Post-menopausal Bleeding
627.2 Menopause Symp. □OC
627.3 Postmen.Atrophic.Vagin.
626.0 Amenor. (prim,2nd) □OC
625.3 Dysmenorrhea □OC

256.4 PCOS □OC
626.2 Menstruation, Exces.
626.4 Menstruation, Irreg.
625.4 PMS
627.0 Perimen.Menorrhagia □OC
789.0 Abdom. Pain *(specify site:)*
1,2,3,4,5 RUQ LUQ RLQ LLQ MID
784.0 Headache □OC
625.8 Pelvic Pain
780.79 Fatigue/Malaise
782.62 Hot Flashes
704.00 Hair Loss
704.1 Hirsutism
799.81 Decreased Libido
311 Depression
780.50 Sleep Disturbances
706.1 Acne
788.1 Dysuria
599.70 Hematuria
599.0 UTI
625.6 Stress Incontin.Female
788.63 Urinary Urgency
788.41 Urinary Frequency
617.9 Endometriosis □OC
614.9 Pelvic Inflam.Disease
621.2 Uterine Enlargement
626.8 Dysfunc.UterineBleeding

789.30 Pelvic Mass
218.9 Uterine Fibroids
626.7 Post-coital Bleeding
623.5 Vaginal Discharge
698.1 Vaginal Itching
616.2 Bartholin's Gland Cyst
616.10 Vaginitis/ BV
616.50 Vulvar Ulceration
629.89 Gen.SebaceousCystFem.
704.8 Folliculitis
939.2 Vag.Foreign Obj.Removal
112.1 Candidiasis
099.53 Chlamydia
098.0 Gonorrhea
054.10 Herpes, Genital
054.9 Herpes, Oral
078.0 Molluscum Contagiosum
131.01 Trichomonas
110.3 Tinea Cruris
123.2 Pediculosis Pubis
078.11 Condylomata
240.9 Enlarged Thyroid
244.9 Hypothyroidism
788.7 Penile Discharge
608.89 Scrotal Mass
620.2 Ovarian Cyst
V25.8 HGB

THE CENTER Superbill

Client Name:_____ Visit Type: _____ ☐ SLO ☐ AG ☐ FPACT ☐ MediCal ☐ CDP ☐ Private Pay _____%

DOB: _____ DOS: _____

Chart #: _____ HAP #: _____

	Y	N		Y	N
Limited English Proficiency	☐	☐	Substance Abuse	☐	☐
Homeless	☐	☐	Disabled	☐	☐

Office Visit

New Client E & M

☐	99201	10 min M/F
☐	99202	20 min M/F
☐	99203	30 min M/F
☐	99204	45 min ***F Only***
☐	Modifier 25 (procedure + E&M)	

Established Client E & M

☐	99211	5 min M/F
☐	99212	10 min M/F
☐	99213	15 min M/F
☐	99214	25 min ***F Only***
☐	Modifier 25 (procedure + E&M)	

Education & Counseling

☐	Z9750	Group M/F *
☐	Z9751	Indiv. 10 min M/F *
☐	Z9752	15 min M/F
☐	Z9753	30 min M/F
☐	Z9754	45 min M/F

* one time only codes

Teen Smart

☐	Z9761	Extended
☐	Z9760	Brief

CDP

☐	99359	Case Management
☐	99202	New
☐	99213	Established

Note: E&C codes reflect total face-to-face time and may be used by all trained staff

NOT Covered by FPACT or CDP

☐	83001	FSH
☐	84144	Progestin
☐	84146	Prolactin
☐	84443	TSH
☐	Z7610G	Pyridium
☐	HPROF	Health Profile
☐	82270	Hemoccult
☐	PTRTX	Partner Treatment
☐	36415	Venipuncture

LABS: Core Screening Tests (All S-codes except S60)

Use for symptomatic or asymptomatic clients as clinically indicated based on individual assessment

☐	86701	HIV - I (blood)
☐	86592	VDRL, RPR
☐	86702	HIV/ORASURE
☐	87491	Chlamydia w/ amp
☐	87591	GC DNA w/ amp
☐	87800	Inf. agent antigen detection (direct probe)

Primary Diagnosis -- S Code Required for Every Claim

S-Code		Labs by S-Code
☐	S10.1 OC/Patch/Ring Eval/Initiate	1(a)(c), 2(c), 7, 8,
☐	S10.2 OC/Patch/Ring Maint	9(d), 10(b)(d), 16
☐	S10.3 Complication/TAR	
☐	S20.1 Injection Eval/Initiate	2(c), 7, 9(d), 10(b)(d),
☐	S20.2 Injection Maintain	16
☐	S20.3 Complication/TAR	
☐	S30.1 Implanon	2(c), 7, 16
☐	S30.2 Implanon Maintain	
☐	S30.3 Complication/TAR	
☐	S40.1 IUC Eval/Initiate	7, 11, 12, 13, 16
☐	S40.2 IUC Maintain	
☐	S40.3 Complication/TAR	
☐	S50.1 Barrier Eval/Initiate FAM, NFP, LAM	7, 16
☐	S50.2 Barrier Maintain FAM, NFP, LAM	
☐	S50.3 Complication/TAR	
☐	S60.1 Preg. Test ONLY	7 only
☐	S60.2 Preg. Confirmation	

(a) Only if elevated cholesterol or cardiovascular risk
(b) Only if history of abnormal fasting blood screen
(c) Limited to one every six months per client
(d) Limited to one per year per client

LABS - Specific to S-Code Diagnosis

(S-Code required for Lab claims)

☐ 1	80061	Lipid Profile
☐ 2	80076	Liver Function Test (LFT)
☐ 5	81002	UA Dipstick w/o Micro
☐ 7	81025	Urine Preg. Test
☐ 8	82465	Cholesterol
☐ 9	82947	Glucose
☐ 10	82951	2hr Glucose Tolerence Test (GTT)
☐ 12	85014	Hematocrit
☐ 13	85018	Hemoglobin
Cytology Orders for lab:		
☐ 16	88174	Thin Prep

Current Method

__	Oral Contraceptive	__	Rely on Female Method
__	Vaginal Ring	__	Fertility Awareness
__	Contraceptive Patch	__	Other Method (includes withdrawl)
__	3-Month Injection	__	Female Sterilization
__	Hormonal Implant	__	Male Serilization/Vasectomy
__	IUD	__	Abstinence (includes partner)
__	Male Condom	__	None: Infertile/Same Sex Partner
__	Cervical Cap/Diaphragm	__	None: Pregnant/Partner Pregnant
__	Spermicide Alone	__	None: Seeking Pregnancy

Procedure

PROCEDURE *Use Surgical Modifier -AG*

Note: NMI's use surgical modifier + specialty modifier

☐	11975	Implant Insertion & Supplies
☐	11976	Implant Removal
☐	11977	Implant Removal w/Reinsertion
☐	58300	Insert IUC
☐	58301	Remove IUC
☐	57170	Fit Diaphragm / Cap

SURGICAL SUPPLY TRAY

☐	11976 UA	Implant Removal Supp.
☐	58300 UA	IUC Insertion Supplies
☐	58301 UA	IUC Removal Supplies

Use modifier ZM for local or ZN for general anesthesia supplies

SCREENING MAMMOGRAM REFERRAL

☐	G0202	Mammogram, bilat

(Females ages 40-55, once/year for FPACT)

MEDICATIONS/SUPPLIES

☐	X1500	Condoms _____
☐	X1500	Spermicide
☐	X1500	Lubricant
☐	J7307	Implanon
☐	X1500	Diaphragm
☐	X1500	Sponge _____
☐	X7706	OCs _____
☐	X7728	Patch _____
☐	X7730	Ring _____
☐	X7722	EC (max 2 pkts/visit & 6 pkts/yr)
☐	J1055	DMPA
☐	X1522	ParaGard
☐	X1532	Mirena IUS
☐	Z7610*	Estradiol *bill with SDC 626.6*

** See reverse for additional use of Z7610*
Biller: Itemize dose, quantity and cost of Meds/Supplies in REMARKS on claim.

****** CHARGES ******

Patient Visit Fees _____
Patient Lab Fees _____
Supplies (prescription) _____
Subtotal _____
Donation _____
Total Collected _____
Waived _____

Collected By: _____

☐ Charges on back

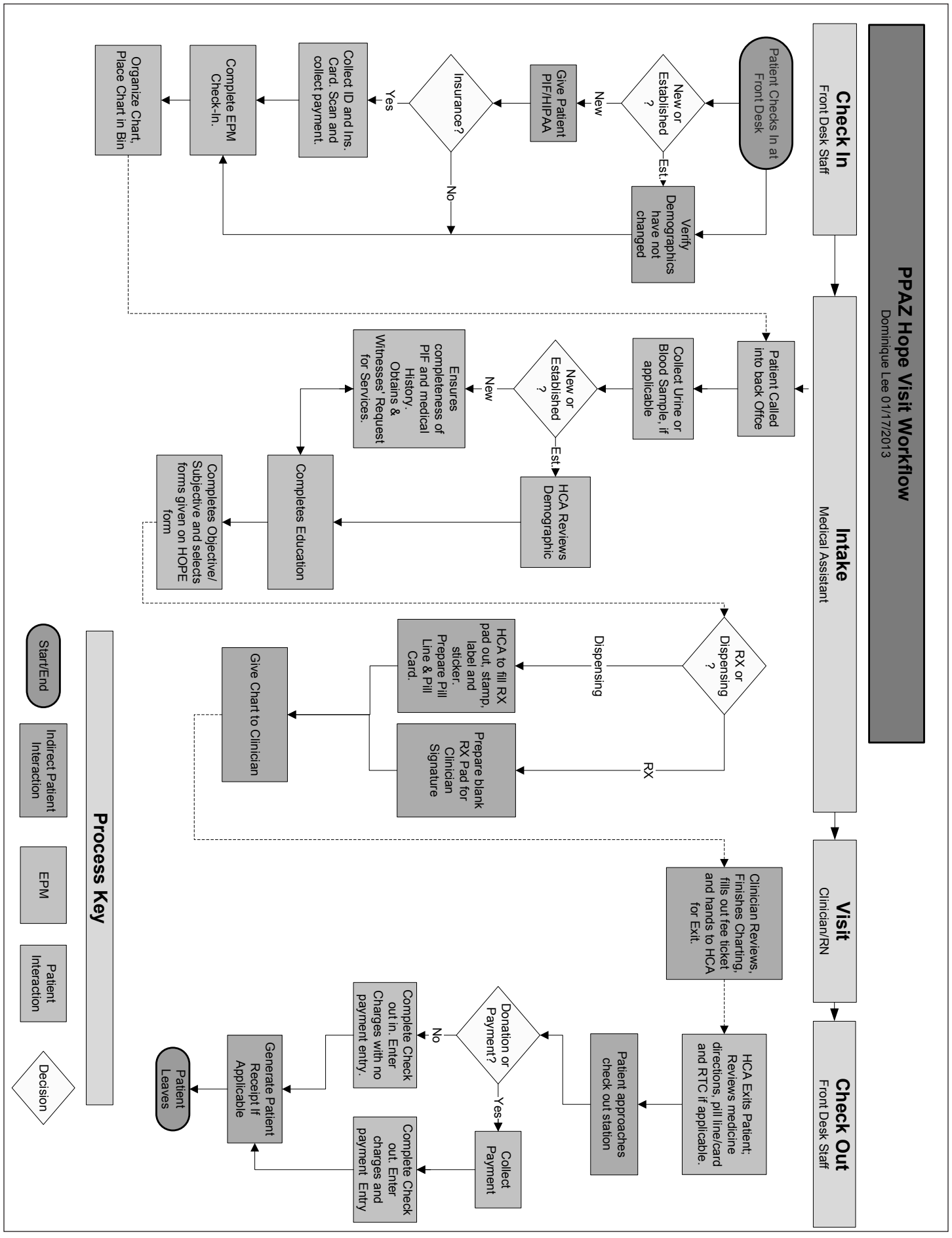
By signing below, I agree that I have received the services listed on this form including products/prescriptions, drugs/device given onsite or by written order, and/or that I have given a specimen for the performance of a laboratory test or examination.

Date: _____ Patient Signature: _____ Print name: _____

Date: _____ Clinician Signature: _____ PSA _____

Return to Clinic for _____ ***in*** _____ ***Week(s)***

PPAZ Sample Workflow



Billing Processes during a Patient Visit

Insurance Verification Process

Insurance verification before a patient visit is important as a means to determine who is responsible for paying for the visit. This process identifies the insurance responsibility for the cost of the visit, as well as any patient payments that will need to be collected. To ensure standardization of the insurance verification process, the case study participants developed policies and procedures for collection of necessary data, contacting the insurance company to collect verification data, and entry of data into the PMS. PPAZ completes those tasks by using the following processes and tools:

- electronic insurance verification process – the process used in the PMS to electronically verify a patient's insurance;
- insurance coverage cheat sheet – summary of verification requirements by payer; and
- insurance verification template and instructions – template for insurance verification report attached to appointment.

PPAZ Electronic Insurance Verification Process

For individual online insurance verification

- Select> Appointment List icon
- Fill in the appointment date then click "Find" button to populate the appointment list
- Select the patient to verify
- Right click on the patient record and select "Eligibility" and select "Submit"
- The "Eligibility Inquiry" screen will come up (red colored fields are mandatory fields and must be completed)
- Click on the drop down arrow to select patient insurance
- Click on the drop down arrow to select requesting physician (should be a physician)
- Requesting location should just state as "default" (auto populates)
- Click on the drop down arrow to select type of service ("Health Benefit Plan Coverage" should be selected when valid choice is not available)
- Date of service should always be today's date (future date is not accepted)
- Then select "OK" button to the bottom right of the screen
- "Ready to Submit" field will come up as "Submitting Eligibility Verification" with the status bar (individual insurance verification should take no longer than 30 seconds for the results to come back); The verification results may come back in few different ways so the Transaction Information section needs to be carefully reviewed
- If a screen comes up that reads, "the system is unable to process transactions at the current time" resubmit in about 5 to 15 minutes for completed verification
- If the result still comes back same, payer website verification is recommended
- A successful verification does not give any "Rejection Reason"
- From the successful verification, expand the "Benefit Information" section
- Then expand the "Health Benefit Plan Coverage" section where it will indicate the copay, co-insurance, and deductible information

- Please be advised every payer may come back with verification section grouped differently so be sure to click on every section that may seem possible to have the patient's responsibility amount
- If the scanned image of the card is in NextGen, then please view the image to confirm the copay on the front of the card
- Always expand the "Additional Information" section to view the COB and other pertinent information
- Insurance verification is stored under "Insurance" folder, "Elig/Referral" tab per the screen shot below
- Select the record and right click and the verification will open

For Batch Online Insurance Verification Submission

- Select> Appointment Lookup (same screen as individual verification)
- Select the various patients to verify
- Right click on the patient record and select "Eligibility" and select "Submit"
- Uncheck the "Submit in batch mode"
- Then click "OK" button to process
- The eligibility report will appear which gives a summary of the verification
- Invalid verification needs to be redone at the payer's website or by calling the payer to verify
- The full insurance verification has been placed on "Insurance" folder under "Elig/Referral" tab for each of the patients below (same location as the individual verification)
- Insurance Coordinator will document the insurance verification in a concise IV note

PPAZ Insurance Coverage Cheat Sheet

MEDICAID	Repro	Depo	Impla-non	Mirena	Paragard	BCM Removal	Urine	PTO	PCV	ABP	ICA	Wart Tx	Gardasil	STI/ Inf ck
APIPA	* age <21	*q90days	*		*	*		*		Medically Necessary with prior authorization (Verification Required)	* w/ ref	* w/ ref		* w/ ref
BRIDGEWAY	* age <21	*q90days	*		*	*	*	*			*	*		*
CARE 1ST	* age <21	*q90days	* w/PA		* w/PA	*	*	*			*	*		*
CMDP	* age <21	*q90days	* w/PA		* w/PA	*								
HEALTH CHOICE	* age <21	*q90days	*		*	*	*				*	*		*
PHP	* age <21	*q90days	*		*	*		*			* w/ ref	* w/ ref		* w/ ref

Immunizations are not covered by MEDICAID - patients need to be referred to county health clinic or health department.
*q90days - Per AHCCCS Depo is only to be administered every 90+ days no sooner

Commercial	Repro	Depo	Impla-non	Mirena	Paragard	BCM Removal	ABP	ICA	Wart Tx	Colp	Gardasil	STI/Inf Ck
AETNA-HMO							* w/ ref or PA					
AETNA-PPO	*	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	* up to age 26	*
BCBS***	*	**VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	* up to age 26	*
CIGNA	*	**VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	* up to age 26	*
CIGNA HMO	*	*	*	*	*	*	VERIFY	VERIFY	* w/ ref	* w/ ref	* w/ref	* w/ref
HEALTHNET - AZ ONLY	*	**VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	* up to age 26	*
HUMANA	*	**VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	* up to age 26	*
GREAT WEST	*	**VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	* up to age 26	*
UHC	*	**VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	* up to age 26	*
UMR	*	**VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	VERIFY	* up to age 26	*

PLEASE READ TO PATIENT

REPRODUCTIVE EXAM DISCLAIMER
Insurance covers only one (1) repro exam per year this means that you will be eligible for next repro after 366 day from your last repro.
* If patient requires a referral for the services please let the patient know that we need their primary care doctor to fax the referral
** Per Insurance Depo is only to be administered every 90+ days no sooner
*** for BCBS - if patient's card is missing a Policy/ID# get subscriber's SSN and the alpha group # off of card
ref = Referral
PA = Prior Authorization

PPAZ Insurance Verification Template

Date	Person Number		Primary Insurance	Policy Number	Group Number
Terminated	**Prior Auth**	**Referral**	**Secondary Insurance**	**Policy Number**	**Group Name**

Co-Pay	Deductible	Co-Insurance	Policy Number	Hra

FAMILY PLANNING								
Visit			**Birth Conrol Method**					
	PA	RF		PA	RF		PA	RF
RHE	☐	☐	DEPO	☐	☐	MIRENA	☐	☐
HOPE	☐	☐	PARAGD	☐	☐	INSERT	☐	☐
PARTIAL	☐	☐	IMPLN	☐	☐	REMVL	☐	☐
CONSULT	☐	☐	URINE	☐	☐		☐	☐
PCV	☐	☐		☐	☐		☐	☐
NOTE								

ABORTION								
Abortion Procedure			**Birth Conrol Method**					
	PA	RF		PA	RF		PA	RF
ICA	☐	☐	DEPO	☐	☐	MIRENA	☐	☐
ABP	☐	☐	PARAGD	☐	☐	INSERT	☐	☐
RH	☐	☐	IMPLN	☐	☐	REMVL	☐	☐
NOTE								

IMMUNIZATION					
	PA	RF		PA	RF
HEP A	☐	☐	GARDASIL	☐	☐
HEP B	☐	☐	FLU SHOT	☐	☐
HEP AB	☐	☐	OTHER	☐	☐
NOTE					

OTHER SERVICES					
	PA	RF		PA	RF
WART	☐	☐	COLPPOSCOPY	☐	☐
INFECTION CHECK	☐	☐	OTHER	☐	☐
NOTE					

Note:

RHE: 1 per 365 days

Depo: 1 per 90 days. 1st shot must have a clinician visit.

Asymptomatic Screening & PTO: Clinician visit is required.

PPAZ Insurance Verification Template Instructions

HOW TO READ THE INSURANCE VERIFICATION FORM

The insurance form is based on services. One patient can have multiple services. When providing a service that is linked to insurance, collect as follows:

Co-Pay = Collect co-pay only. Co-pay is collected once per visit. If more than one service is provided to a patient and each service is covered with co-pay only, then collect the co-pay for the entire visit. Note that there could be services associated with a deductible in addition to those with co-pay. In that case, both co-pay and deductible amounts are collected.

Deductible = Collect DEDUCTIBLE only. Refer to the insurance contracted pricelist to determine patient's obligation. Again note that a co-pay may be required for another service provided in the visit in addition to the coinsurance and the deductible.

Co-Pay Deductible = Collect co-pay and insurance contracted price.

Fully Covered = When providing service that is fully covered do not collect any money from the patient.

Not Covered = Patient insurance does not cover that service. Collect PROMPT PAY price.

IMPORTANT FACTS:

1. An encounter can only have one E&M code.
2. Deductible amount is the PPAZ's contracted price with each payer for each type of service.
3. In some instances prompt pay price may be lower than PPAZ contracted price with the insurance company. Patient is obligated to pay the contracted price regardless.
4. Patient should be advised that collection of co-pay and/or deductible is an estimate of their charges for the day, and they will be billed for any outstanding charges after PPAZ submits their insurance claim. Patient's final obligation is determined after receiving EOB from insurance company. Patient will be responsible for all monies that become receivable after receiving final settlement (which is EOB) from insurance company.
5. A patient is only coved for one RHE per 366 days. If patient requests an early exam, prompt pay price will apply.
6. An insurance patient can only get 1 depo shot per 90 days. Prompt pay price will apply if the patient is requesting follow-up shot earlier than the 90th day from the date of last shot. Up to 3 follow-up depo shots can be given to the patient if approved by the clinician. Follow-up shots do not require E&M code and therefore co-pay may not be collected for the shot, but depending on the patient's plan, a deductible will still apply and be collected for each follow-up shot.
7. When there are two (2) insurance plans on the IV form it is very important that you select the primary insurance to attach to the claim.

HOW TO ACCESS IV FORM IN NEXTGEN

IV Form is saved in the notes section of the patient appointment schedule.

STEP 1: Double click on patient's appointment.

STEP 2: Click on **NOTE** tab located on the right side of the appointment window.

STEP 3: Double click on the notes labeled **IV-###** to open the form (in the example below you will see **IV-ICA**)

SCENARIO 1: RHE FULLY COVERED AND IUC FALLS UNDER CO-PAY & DEDUCTIBLE

Patient is scheduled for RHE and plans to have Paragard inserted. Instructions on the form are as below:

FAMILY PLANNING					
VISIT		BIRTH CONROL METHOD			
RHE	Fully covered	**DEPO**	Co-pay	**MIRENA**	Not covered
HOPE		**PARAGD**	Co-pay deductible	**INSERT**	Deductible
PARTIAL		IMPLN		**REMVL**	Deductible

If above patient gets RHE and Paragard on the same date the encounter will have following items:

1. 99384 – 99395: One of the RHE code
2. J7300: Paragard code
3. 58300: Insertion of IUC

RHE is fully covered under patient's insurance plan and patient will not owe any monies for this portion of the visit. Since the patient is getting Paragard inserted in the same visit, patient is only obligated to pay contracted price for Paragard and insertion. Since the visit (E&M Code) is RHE which is fully covered under patient insurance plan, **Co-pay will not be collected**. For Paragard and insertion of Paragard patient will be responsible to pay the PPAZ's insurance contracted price schedule.

SCENARIO 2: PATIENT IN THE ABOVE SCENARIO CHANGES HER MIND AND DECIDES TO GET DEPO SHOT INSTEAD OF IUC

Following item will be charged to this encounter:

1. 99384 – 99395: One of the RHE code
2. J1055: Depo injection

In the above scenario, patient will only pay the co-pay which will apply towards depo injection. Administration fee (96372) will not be charged to the patient since depo injection was administered at the time of visit.

SCENARIO 3: PATIENT IS SCHEDULED FOR ASYMPTOMATIC STI SCREENING AND HIS/HER PLAN REQURES CO-PAY & DEDUCTIBLE FOR CLINICIAN VISIT

All insurance patients needing any type of lab work must be assessed by clinician. Clinician will take a brief history from the patient and establish the need before writing the prescription for lab work. Patient will be obligated to pay PPAZ the co-pay (for the visit) and the deductible for both the visit and all CLIA waived labs (those that we do in-house). For all non-CLIA waived labs (those that we send out), the **patient will receive a bill from the 3rd party lab** once the insurance claim process in completed. **Note that the lab bill is in addition to any outstanding fees due that might be billed by PPAZ.**

In the above insurance instruction patient will be obligated to pay the co-pay for the clinician assessment portion of the visit and deductible amount (refer to insurance price list) will be collected for all CLIA waived labs.

LIST OF CLIA WAIVED LABS

SIM	Description
80053	COMPREHEN METABOLIC PANEL
81003	URINALYSIS, AUTO, W/O SCOPE
81025	URINE PREGNANCY TEST
82270	TEST FOR BLOOD, FECES
83001	GONADOTROPIN (FSH)
83002	GONADOTROPIN (LH)
84443	ASSAY THYROID STIM HORMONE
84703	CHORIONIC GONADOTROPIN ASSAY
85013	SPUN MICROHEMATOCRIT
uhv86701	HIV UNIGOLD
87210	SMEAR, WET MOUNT, SALINE/INK

Billing Processes during a Patient Visit

Self-pay – Income Verification Process

For Title X providers, income verification is critical for determining the patient sliding fee scale level. To correctly assess a patient's status on the sliding fee scale, it is important for staff to collect accurate patient income data. It is imperative to provide staff training and ensure that they feel comfortable discussing income with the patient in order for the staff to succeed in that data collection. The development of scripts and training tools is useful as a way to increase staff comfort with income discussions. Information about visit fees available for patients before the visit also aids in the income verification process. BRIDGER uses the following policies and tools for income verification:

- income verification policy – the agency standard for staff when verifying patient income;
- frequently used staff communication with patients about fees - scripts for staff to use with patients;
- patient communication tools – signs displayed in the health center to communicate about a patient's responsibility for fees; and
- what to expect – website material for patients on what to expect at a visit to BRIDGER.

BRIDGER Income Verification Policy

Bridgercare requests verification of household income to accurately and consistently assign sliding fee scale discounts per Title X guidelines (FP/Admin. Man. 6.7-1).

All patients over age 20 eligible for less than full fees on the current schedule of discounts will be asked to provide verification of income.

The following forms of verification can be used to verify reported household income.

- Two recent (within past 2 months) paycheck stubs
- Signed note from employer verifying wage and number of hours worked weekly
- Tax return
- W-2
- Bank statement
- Profit and loss statement for self-employed individuals

Patients will be advised that Bridgercare requests income verification when scheduling appointments. They will also be advised that patients may make payments toward balances, and that service will not be denied for inability to pay. Patients may self-report income, and this information will be used to determine sliding fee scale placement for Title X services if they do not have verification at a visit. Clinic staff will ask patients to bring verification at a subsequent visit as needed, or if stated income has changed. Staff will request verification of partner's income if it is included in household income per Title X guidelines. Clients who report no income will be asked what financial resource is covering their current essential living expenses i.e. savings, family assistance, etc.

Under no circumstance will lack of income verification impede provision of service, or preclude placing clients on the fee scale per stated income.

Staff becoming aware of particular circumstances (such as large medical bills) which place a client under extreme financial duress, despite income, are asked to apprise the Director of the circumstance, so that further discount may be offered to the client to facilitate his/her receipt of necessary Title X services.

BRIDGER Frequently Used Staff Communication with Patient about Fees

1. We say, "Your visit was XX, your labs were XX, and your birth control (or supplies were XX)" when we are explaining the total cost for services the patient received at a visit. We do this at every check out.

   Rationale: Patients, especially those with little health care consumer experience, may have "sticker shock" over the total fee, and not realize that separate services each have an associated charge. This helps to educate them.

2. "You are eligible for a X% discount on our sliding fee scale, so your portion of today's visit is X. Are you able to do all of that today, or would you like make a partial payment?"

   Rationale: Giving patients this option communicates that we will work with them. Often patients can pay the full amount. If you can collect a partial payment, the remaining balance will be smaller, and less overwhelming to the patient. Sometimes patients may be more inclined to abandon a larger balance they owe, because they don't see how they can come up with the lump sum.

3. "Grants (or grant funds) cover about 20% of our costs to provide care. Are you able to contribute (in addition to your visit fees) today?"

   Rationale: We are working on asking all clients to contribute, per Title X guidelines.

4. For clients not eligible for a discount on our sliding fee scale, "Our full fees are typically about 1/3 less than local private providers."

   Rationale: This helps non-discount eligible patients, especially those without insurance, understand that they are still receiving great value for their health care dollar, and why we ask everyone for a contribution regardless of fee level. We do an annual fee comparison in our community to be sure we are providing accurate information.

5. "You will still be eligible for the sliding scale if your visit is submitted to insurance."

   Rationale: Often patients assume that their insurance coverage will nullify any other discount they may be eligible for. It's helpful to reassure them. This may be one reason insured patients don't advise family planning providers of their coverage.

6. "Depending on your insurance coverage, some, most or all of your fees may be covered."

   Rationale: Many patients don't have a clear idea of how insurance works. The ACA is designed to, over time, increase the amount of preventive care covered by many policies. Also see number 5, many patients may wrongly assume that their insurance will decrease the Title X discount they are eligible for.

7. "If insurance doesn't cover anything, you will only be charged at your X discount level."

   Rationale: This is another version of numbers 5 and 6. Insurance is intimidating and many individuals have negative perceptions of it, i.e. "it never covers anything." Communicating the same message in different ways can help the patient understand.

8. "Our grant bases your discount on household income, including for non-married partners, regardless of how you share expenses."

   Rationale: Many patients presume that if they don't share expenses with their partner, their partner's income should not be included for consideration in determining their discount.

9. We gently suggest, "You may want to let your partner know that their income is included for our sliding fee scale – they may be willing to share this cost with you."

   Rationale: We try to help patients strategize around sharing costs for reproductive healthcare. Some patients are upset by this income requirement, however, it may help to mention that access to contraception and reproductive healthcare benefit both partners in the household.

10. "Let us know if your income or situation changes – We want to help you qualify for fees that fit your income level!"

    Rationale: Many patients' income status is not stable – they may start or change employment, or unfortunately lose a job, or work a seasonal job or their hours may change. We want to reassure them that our goal is to be accurate and fair and help them access all discounts and/or programs for which they are eligible.

BRIDGER Waiting Room Sliding Fee Sign

bridgercare
formerly Bridger Clinic

How to apply for sliding fees:

Provide accurate income information for yourself and your partner if you live together.

Bring verification of your income.
(Examples: 2 pay stubs, 2 monthly bank statements, student loan documents, unemployment info, etc.)

Tell us if your income changes! We want to help you qualify for fees that fit your income level.

bridgercare
formerly Bridger Clinic

75% of our services are not covered by grant, federal, or state funding.

Please donate as generously as you can to support your clinic.

BRIDGER What to Expect

First, call 587-0681, text 570-3047, or schedule online. Bridgercare does same-day, next-day, and advance scheduling.

When you Arrive: Check in at the front desk. (These are the same people that you spoke to on the phone when you scheduled your appointment).

You'll be asked your name, if you have insurance or Medicaid (it's OK if you don't), and if you have income verification.

All new patients and most returning patients will need to update paperwork. Paperwork will include some or all of the following:

- Personal Information: The clinic will ask for your birthdate, telephone number, and an address where the staff can reach you.
- Income Information: This is how the clinic will assess if you are eligible for a fee reduction. Most fees and services are based on client income and family size. If you are concerned about how you will pay for a visit, talk to one of our staff members.
- *Whatever you tell the clinic staff will not be shared with anyone outside of the clinic.*

Once you have completed the paperwork and returned it to the front desk, you will wait in the waiting room until your first name is called by a clinical assistant.

The Visit:

You will first meet with a clinical assistant. This person will ask you questions about your medical history, take your blood pressure, and get your weight.

It is important to remember that everything you tell the clinic staff is confidential and private. This means that whatever you tell the clinic staff will not be shared with anyone outside of the clinic.

After talking with the clinical assistant for a few minutes, you will be left in the room until your provider (a nurse practitioner or physician assistant) enters to see you. When the provider meets you, it is important to tell them if you have any problems or concerns. Maybe you have questions about:

- *periods that aren't normal*
- *pain during sex*
- *vaginal discharge or discomfort*
- *body changes - "What's normal for my age?"*
- *your health - Have you been sick or do you have a serious illness?*

The provider will talk to you about lots of things during your visit. You may talk about birth control methods and condoms. They will ask:

- *if you need birth control*
- *if you or your partner are currently using birth control*
- *if you would like to get a form of birth control at today's visit*

The Exam:

Depending on what type of visit you are having, you may be asked to undress. The provider will leave the room while you do this. (You will be given a disposable gown to put over yourself.) You will then sit on the exam table and wait. The provider will knock on the door and ask if it is OK to re-enter.

The clinician will review your medical history and ask more questions. It is important to answer the questions truthfully. Remember that everything you tell the staff is confidential and private and that *the clinic staff cares about you and your health.*
The questions they ask may seem personal, but they help the staff take care of you. As the clinician does your exam, they will explain what is happening throughout the exam.

Depending on what type of visit you are having, you may have a breast exam, a pelvic exam, or a pap smear. (If you are a male, a testicular exam may be performed.) Tests for sexually transmitted diseases (STDs) are done during the visit. The provider will determine what tests to order based on your medical history and sexual activity.

Remember to tell your provider if you are uncomfortable or don't understand a procedure or test! It's OK to ask questions! The staff is very used to answering questions and welcomes your comments.

Now, you are done with the exam! What's next?

- you'll get dressed
- you'll talk to the clinician about the exam
- it's OK to ask about any concerns you may have

If you have an infection, you will get medicine or a prescription for medicine to treat it. If you want a birth control method, you will get a supply of that method. If you need condoms and they aren't offered, ask for them!

The clinician will tell you if you need to return to the clinic.
Remember that most men and women are nervous about having an exam. Ask questions, listen to the answers, and let the clinic staff help you through the visit. Your health is important!

Checkout:

When your visit is complete, the provider will walk you to the front desk. The front desk will help determine if you have fees for the day and help you understand how to schedule a follow-up appointment, if necessary.

After leaving the clinic, if there is something you forgot to ask, don't hesitate to call. The clinic staff regularly answers questions!

Billing Processes during a Patient Visit

Visit Documentation

To submit a bill to an insurance provider, the services provided by the clinician and other staff must be documented in the patient chart. That documentation serves as the source for translating the services into diagnosis and procedure codes that are used for submitting claims for reimbursement. The participating agencies developed the following tools to assist clinicians with documenting services accurately, as well as providing the accurate codes:

- coding tool – a quick-list of frequently used codes for visits (PPAZ);
- abbreviation cheat sheet – standardized abbreviations used agency-wide to ensure consistent abbreviating and help non-clinical staff translate documentation (PPAZ); and
- charting tool – label affixed to all charts to ensure key patient data is collected at every visit (THE CENTER).

PPAZ Coding Cheat Sheet Sample

*This is a partial list and does not represent all of the codes used at PPAZ.

AB DX:	
626.0	Amenorrhea (missed period)
635.90	Abortion unspecified
635.91	Abortion incomplete
635.92	Abortion complete
638.9	Failed attempted AB without complication
634.90	Miscarriage
E960.1	Rape
V22.2	Pregnant state incidental
631.8	Blighted ovum
AB FOLLOW UP:	
V67.00	AB follow up exam
Colpo:	
795.05	Cervical high risk human papillomavirus (HPV) DNA test positive

FAMILY PLANNING	
V25.01	Counseling for prescription oral contraceptives
V25.02	Depo
V25.02	Initiation of other contraceptive methods
V25.03	Encounter for emergency contraceptive
V25.11	Insertion IUC
V25.12	Removal IUC
V25.13	Removal reinsertion IUC
V25.40	Contraceptive surveillance unspecified
V25.41	Oral contraceptive surveillance
V25.43	Implanon surveillance/removal
V25.49	Surveillance of previously Rx'd methods
V25.5	Implanon insertion
996.32	Unsuccessful device insertion
V26.49	Natural family planning

FAMILY PLANNING 1ST VISIT COMMERCIAL INSURANCE	
626.0	Amenorrhea
626.8	Other disorders of menstruation (this includes cramps)
625.4	Premenstrual Tension Syndromes (PMS)
784.0	Headaches
626.4	Irregular menses
780.79	Fatigue
706.1	Acne
799.22	Irritability
346.90	Migraine headaches (unspecified)
782.3	Water retention
783.1	Excessive weight gain
625.8	Other symptoms of genital area (Female)
564.00	Constipation
788.1	Dysuria
780.96	Generalized pain (NOS)
611.72	Lump in breast
996.32	Unsuccessful device insertion
PCV:	
V72.42	Pregnancy examination or test, positive result
STI SCREENING/INFECTION CK DX:	
078.0	Molluscum contagiosum
078.11	Genital warts
099.53	Other STI due to Chlamydia
099.40	Urethritis unspecified
625.8	Other specified symptoms (female)
607.9	Unspecified disorder of penis
623.8	Vaginal inflammation
623.9	Vaginal irritation
616.10	Vaginitis
V02.8	Carrier or suspected carrier STI
V01.6	Exposure to STI
V69.2	High risk sexual behavior (I prefer to use this as a secondary Dx)
V65.5	Worried well (better to use as a secondary Dx – not likely to be paid)
V73.88	CT and Gonorrhea
V73.89	HIV screening (86701)
V72.41	Pregnancy test – Negative
V72.42	Pregnancy test – Positive

WWE:	
V72.31	WWE
611.72	Lump or mass in breast
MALE PHYSICAL:	
V70.0	Male physical
VACCINATION:	
V04.89	Gardasil ignjection
V05.8	Vaccination and inoculation; other specified disease

PPAZ Abbreviation List

*This is a partial list and does not represent all of the agreed-upon abbreviations used at PPAZ.

A	
a̅	Before
abn	abnormal
abd	abdomen
B	
BID	Twice a day
BTB	Break Through Bleeding
C	
c	With
CA	Cancer
cpd	Cigarettes per day
D	
D & J	Diaphragm & Jelly
D.M.	Diabetes Mellitus
dimp	Dimpling
E	
exp	Explained
EG	External Genitalia
F	
Fam. hx	Family History
FAM	Fertility Awareness Method
G	
gu	Genito Urinary
gm	Gram
Gran	Granularity
H	
HA	Headache
Hr	Hour
hgb	Hemoglobin
I	
info	Information
inst	Instructions, instructed
irreg.	irregular
K	
KOH	Potassium
L	
Lab	Laboratory
Lap	Laparoscopy
LUQ	Left Upper Quadrant
M	
M	Murmur
Mod	Moderate
ME	Menstrual Extraction
N	
N/A	Not Applicable
na	No Answer
NT	Non-Tender
O	
OB	Obstetrics
osteo	Osteoporosis
OTC	Over-the-Counter
P	
p	After
PID	Pelvic Inflammatory Disease
post	Posterior
Q	
q	Every
QA	Quality Assurance
qd	Every Day
R	
R	Right
RLQ	Right Lower Quadrant
R/O	Rule Out
S	
S & C	Spermicide & Condom
sugg	Suggest, suggested, suggestion
T	
TNTC	Too numerous to Count
TyES	Tylenol Extra Strength
U	
U/A	Urinalysis (Chemstrip 9)
UCG	Urine Pregnancy Test
UPI	Unprotected Intercourse
V	
vag	Vagina
W	
wk	Week
WNL	Within Normal Limits
XYZ	
Yr	Year

THE CENTER Charting Tool

EVENT/PROBLEM: _____ ❑ **Translator**_____

❑ **Pregnancy Prevention** ❑ **Planning Pregnancy** ❑ **Reproductive Health**

WT_____ HT_____ BP_____

LMP_____/NA UPIC ❑ Y ❑ N When: _____

Pregnancy Intent: ❑ Y ➔ Timing _____ ❑ Preconception Counseling
❑ N ➔ Current BCM _____ Partner(s) BCM _____

Last Pap _____ ❑ NA/Male ❑ WNL ❑ ABNL _____

Last CT/GC _____ Risk: ❑ Y ❑ N ❑ Offered ❑ Sent ❑ Declined

Last Buccal _____ Risk: ❑ Y ❑ N ❑ Offered ❑ Sent ❑ Declined

COUNSELING/EDUCATION:

❑ BCM Ed x_____minutes per protocol ❑ STI/HIV Prevention Ed per protocol
❑ Adolescent Counseling per protocol ❑ Preconception Ed per protocol
❑ Sexual Abuse/Coercion Counseling ❑ Smoking Cessation Counseling

SERVICES:

Emergency Contraception: ❑ Offered ❑ Dispensed # _____ ❑ Declined
Safer Sex Pack (30 condoms+lube): ❑ Offered ❑ Dispensed ❑ Declined
Other:_____

Billing Processes during a Patient Visit

Patient Check-out

The final step in the patient visit is check-out and several revenue cycle activities may occur right before the patient leaves the health center. Those activities can include the review of the superbill to ensure all services are captured and documented, as well as the collection of all necessary patient fees. PPAZ developed the following procedure for patient check-out to ensure accurate documentation of charges into the PMS.

PPAZ Insurance Encounter NextGen Check-out Process

Check-out for Insurance encounters

In the Appt Book window, right click on the desired patient appointment listing and select **Checkout**

The **Update Patient Information** window displays. These **Client Defined Fields** are required for Title X reporting purposes > **Autoflow** *past this screen for insurance encounters*

The **Charge Posting Screen** displays

Click **New**

Input the first **SIM** as it appears on the completed Fee Ticket

Press the **Tab** key to populate the SIM description

Tab to or click in the **Diag** fields and type the diagnoses codes as they appear on the Fee Ticket

Click **Next** and repeat the process until all SIMs have been posted

Click **Save**

Click **Autoflow**

Only charges that are 100% patient responsibility will display in the Pat Amt column which does not always include associated deductibles, co-pays, or non-covered services

The **Patient Balance** screen displays > click **Autoflow**

Unlike Title X and Self-pay encounters, the balance displayed in red will not account for deductibles, co-pays, and/or non-covered services – **DO NOT** rely on this total to be an accurate total of the insurance patient's out-of-pocket amount. Refer to the Insurance Verification Form attached to the appointment.

The **Payment Entry** window displays

Prompt the patient for payment of their co-pay, deductible and non-covered services

DO NOT type the amount paid in the Pay Amt field - use the Pay column in the bottom portion of the screen to apply payment. The Recalc feature will total the amounts and display it correctly in the Pay Amt field up top

Use the **Pay Code drop-down** to select the payment type (i.e. Cash, Debit, etc.)

If paying by credit or debit card, use the **Tracking** field to type the authorization code as it appears on the receipt

Apply payments to their corresponding line item in the **Pay** column in the **bottom portion of the screen** , being mindful to apply office visit co-pays to the visit line, etc.

Payment amounts that are "stacked" at the bottom of the Pay column indicate they have been incorrectly applied and will result in an undue credit balance.

These **MUST** be corrected prior to saving.

Click **Recalc**

Click **Save**, then **Autoflow**

The **Itemized Bill** window will appear, prompting the user to print a receipt > *click* **Print** *and issue patient the receipt*

Click **Autoflow** to complete the checkout process

Billing Processes after a Patient Visit

Creation of Claim

To ensure payment for a patient visit, the health center submits a summary of the visit services, known as a claim, to the insurance company. Claims are submitted utilizing a standard claim form called a CMS 1500. This form can be created manually or electronically from charges entered into a PMS. Claims can be printed and mailed to the payer or transmitted electronically. When claims are submitted electronically, a data file known as an Electronic Data Interchange (EDI) is created. An EDI permits two or more parties to electronically exchange data. PMS software has the ability to create EDI files for submission to payer. To ensure effective creation of claims, the participating agencies have created these procedures to document the process as well as promote standardization:

- charge capture and entry process – outlines the steps for entering charge data into the PMS and creating the paper or electronic claim (THE CENTER); and
- insurance batch creation – the specific steps to create an EDI file within the PMS (PPAZ).

THE CENTER Charge Capturing Process

A. PURPOSE:

To define the procedures for capturing charges for services provided to patients at CAPSLO Health Services clinics.

B. POLICY:

This policy applies to all payer types – FPACT, Medicaid, Cancer Detection Program and Private-Pay.

1. Every patient visit will be recorded on an Encounter Form generated by CAPSLO Health Services' Practice Management System (PMS). The PMS will assign a unique identification number to each Encounter Form. All services, medications and supplies will be recorded on the Encounter Form.
2. Identification information required on each Encounter Form: patient name, date of birth, date of service, payer information (including sliding fee %), and medical record number. All billable services on the Encounter Form must be documented in the patient's medical record.
3. All service items marked on Encounter Form will be entered in PMS within 5 business days of the visit date.
4. Patients are asked to sign and date the Encounter Form upon check-out.
5. At the time of service, clients who are responsible for paying any fee for their services will be offered a copy of their Encounter Form, including fees and waived amounts.
6. The Encounter Form is signed by the staff person providing service.

C. PROCEDURES:

1. Check-In:
   a) Check PMS to ensure that an appointment exists for every patient encounter indicating name, reason for visit and location.
   b) Add any walk-in appointments to the schedule.
   c) Print the Encounter Form and review for completion.
   d) Print labels with information corresponding with the patient's Encounter Form to identify labs, documents, etc. completed by the back office staff and medical provider.

e) The Encounter Form is to remain with the medical record throughout the visit for recording of services rendered.

f) Upon check out of patient, payment of patient fees is to be recorded on the Encounter Form, patient is asked to sign the Encounter Form. Upon request, a copy may be provided to the patient as receipt of services rendered.

2. Data Entry:

a) Verify patient name and medical record number on the Encounter Form to the PMS data entry screen before entry.

b) Verify payer responsibility and sliding fee discount before entry.

c) Begin data entry with process date equal to date of service on Encounter Form.

d) Enter all diagnosis codes marked on Encounter Form.

e) Data entry of services rendered to be entered in PMS within 5 business days of service delivery.

f) All services entered must be listed on Encounter Form and supported in patient's medical record.

g) Primary diagnosis and rendering Clinician required for each billable service item entered.

h) Patient payments will be entered into the PMS.

PPAZ NextGen Insurance Batch Creation Process

1) Select Encounter icon on the top of the screen.
2) On Encounter lookup screen:
   1. Select "Unbilled" and "Rebilled" from the "Bill Status" drop down selection.
   2. Select "Commercial" and "Medicaid" from the "Financial Class" drop down selection.
   3. Unselect "Include records without charges".
   4. Post yesterday date for "Enc Create Dt to" field.
3) Click Find.
   1. Insurance encounters will populate on the Encounter List section
   2. Select all by checking the box next to the "Encounter List" headers (as pointed by the arrow)
   3. Right click the mouse
   4. Select "Claim Edit" – Claims will be checked for errors – This can take a while depending on how many claims there are.
   5. Claim Production Status report will list the claims needing edits.
   6. Once all corrections have been done on the Claim Edit then re-run Claim Edit Report to check if claims are clean.
      Then right click and select 'Bill" and a report will generate.
      Select "EDI File"icon to build claims for electronic submission
   7. Under Submitter Profile Library select Navicure
   8. Under File Options
      a. Click on yellow folder on right side
      b. Go to drop down and select "My Computer"
      c. Select S drive "Share drive"
      d. Open folder 1_PMG
      e. Open folder "Billing Files"
      f. Open folder "Claim File"
      g. Select "Open" button
      h. Select "Find" button and this will populate the claims which have been created
      i. Select "Process' button
4) The "Electronic Send Report" will populate
   1. Export to Excel
   2. Go to drop down and select "My Computer"
   3. Select S drive "Share drive"
   4. Open folder 1_PMG
   5. Open folder "Billing Files"
   6. Open folder "Send Report" and select the appropriate month and year folder
   7. Select "Save"
5) Log into Navicure
   1. Expand the "Files" screen
   2. Select "Upload" tab
   3. Select the "Browse" button and follow the instructions below:
      a. Select S drive "Share drive"
      b. Open folder 1_PMG
      c. Open folder "Billing Files"
      d. Open folder "Claim File"
      e. Double click on claim file with today's date
   4. File Messages will state that it is scheduled for processing.

Billing Processes after a Patient Visit

Claims Submission

Upon creation of the claim or EDI file, the next step is to submit the claim to the third-party payer. During this process, it is critical to have consistent and accurate information in order to ensure that the third-party payer will accept and pay on the claim. Additionally, each payer has specific timeframe requirements for submitting claims and the payer will not accept claims that are not submitted in a timely manner.

When using a clearinghouse, it is also important to develop a system that ensures all claims in an EDI are accepted by the clearinghouse. The clearinghouse will reject a claim when the data does not match or there is missing information. Those clearinghouse hurdles are in place to increase the likelihood of the agency submitting clean claims to the payer.

The following are tools and procedures used by the participating agencies to assist with claims submission:

- payer timely filing cheat sheet – summary of the timeframes for claims submission to third-party payers (PPAZ);
- billing process – the steps for creating and submitting claims (THE CENTER);
- clearinghouse claims submission workflow – process used to upload the EDI to the clearinghouse site (PPAZ); and
- clearinghouse checklist – process to assess whether claims are properly uploading to the clearinghouse site (BRIDGER).

PPAZ Payer Timely Filing Cheat Sheet

	Aetna PPO	**Aetna Signature Administrator PPO**	**Aetna HMO**	**Open Access Aetna Select**	**Aetna Select**	**Aetna Student Resource**
Timely Filing Limit	120 days	120 days	120 days	120 days	120 days	120 days
REFERRALS:	Not required		Yes, except for FP services	Not Required	Yes, except for RHE	Yes, except for RHE & Family Planning
Rapid HIV	NC	NC	NC	NC	NC	NC
Claims		Need to drop to paper				

THE CENTER Billing Process

I. Electronic & Paper Claims

A. Assigning a Batch

1. Select Edit from the task menu and from there select Default Batch. A window will open. Double click in the empty text box. Another window will open. When assigning a new batch, click the box New in the lower left hand corner. A batch title will be assigned. Be sure to select the box "set as default" (in the lower right hand corner) if the batch will be used for more than one transaction, then click OK. If a batch is open, select your initial from the alphabet boxes, then "set as default" by clicking the box in the lower right corner and then click OK.

B. Charge Entry

1. Select Billing from the main menu. A box for "billing criteria" will appear. This is where the search can be narrowed to a certain day and location, or single patient, etc. Select a group to bill. See the following pages for an example of how to select for a date of service and facility site (usually what is selected when billing each day of service).
2. Once the group has been selected, they may be sorted alphabetically by placing the mouse at the top of the column for "Patient" and press the right button on the mouse. Then select "sort ascending."
3. Double click on the correct patient and go to the Visit Info screen (it usually automatically appears first).
4. Under Visit Info, enter Company (CAPSLO), Doctor (Dr. Doe), Facility (will usually automatically be entered according to visit), Attending (Dr. Doe) - this is very important because this field prints on the UB-92, Resource (the NP/MD/PA the patient was seen by), Visit (usually automatically entered), Entered (today's date, usually automatically entered). Be sure that there is an insurance carrier listed. If there isn't, go to the Patient Information Icon (the triple yellow folders) and enter in the insurance information, including the number on the EVC slip attached to the billing form.
5. Next select the Charges tab to enter in charges for the visit. Enter in the ICD-9 code (the S-code or V-code) and the secondary diagnosis (if applicable). Use the down arrows to add rows to enter more than one diagnosis, and use the down arrows to move to the Procedures View List. Enter the procedure code under code, or description under the description heading. Only the first few letters for the description must be entered, which simplifies entering medications because they all begin with the same few numbers for the procedure code. Once again, use the down arrow to create more rows to enter in charges. Be sure to change the quantity if necessary.
6. Additional Visit information Screen
    a) Contraceptive Methods
        (1) Use the dropdown bar to choose the appropriate method.
        (2) If the patient received multiple methods (oral contraceptive and condoms) select both methods by using the dropdown bar to the right. Up to three methods can be selected.
7. Tests
    a) All tests default to "No" so select "Yes" for all tests ordered or performed as indicated on the Encounter Form
    b) Enter the result of the pregnancy test as indicated on the Encounter Form (S60.2)
    c) Clinical breast exams (CBE) are performed during 99214 and 99204 visits that include a Pap smear
    d) HIV testing is "initial" testing not "confirmatory."
8. Save and return to previous screen

C. Claims Submission

1. Electronic Claims
    a) After all charges are entered, go to the Notes screen. Under the Claim Header (optional) window, enter in the description of all supplies listed in the charges. For example, if the patient received "30 Condoms" type "30 Condoms @.33=$9.90". After entering all notes, go to the upper left of the page and select Additional Visit Info. A new screen will come up, and enter in the contraception method(s) at the time of the visit, and the testing done for that visit.
    b) After all the info has been entered, "approve" the visit. To do so, go to File at the upper left corner, and select Approve (the 2nd from the bottom). Save the information if prompted. Once approved, close the visit by clicking Close and move on to the next patient.
    c) Once all the visits are entered for the batch, it is ready to send. Go to the Billing Criteria window by selecting the magnifying glass icon in the upper left corner, or close the window and select Billing from the Main Menu.

d) Under Billing Criteria, select all visits by clicking the dot next to it (near the date selection box on the right). Also select "approved" from the dropdown bar by Status. Click OKAY. From the next window, place the mouse at the top of the column with the small boxes will have a red check mark. Then go to File in the upper left corner and select File Claims. Select Electronic UB-92 by clicking the mouse in the box. Click "okay" and the system will screen the files and accept or reject them.

e) If any files are rejected, they will come up as red in the list and their status will be changed to "File Rejected". To rebatch, make the necessary changes as mentioned in the "notes" section of the visit. After changes as mentioned in the "notes" section of the visit. After changes have been made, they can be re-approved and batched electronically again.

f) If the files are accepted, their status will be changed to "Batched – Primary". Continue to the next step.

g) Sign in to the Centricity EDI version of the program on the desktop (available only on the Billing Computer). Go to the EDI Submission from the main menu. A list of the batches that have been created will appear. Check the box for the batches to be transmitted. Hit "Send" at the bottom left corner. This may take a few moments to transmit, once transmitted the status of the claims will be changed to "Sent" automatically.

2. Paper Claims

a) After all charges are entered, go to the Notes screen. Under the Claim Header (optional) window, enter in the description of all supplies/meds listed in the charges. Remember that the UB-92 prints all entries in order of most expensive to least expensive so indicate the line number in front of the corresponding description. For example, if the patient received "30 Condoms" type "30 Condoms@.33=$9.90". After entering all notes, go to the upper left of the page and select Additional Visit Info. A new screen will come up (see diagram), and enter in the contraception method(s) at the time of visit, and the testing done for that visit.

b) After all info has been entered, "approve" the visit. To do so, go to File at the upper left corner, and select Approve (the 2nd from the bottom). Save the information if prompted. Once approved, close the visit by clicking Close and move on to the next patient.

3. Printing Paper Claims

a) Go to the Billing Criteria window by selecting the magnifying glass icon in the upper left corner, or close the window and select billing from the main menu. Under Billing Criteria, select All visits by clicking in the dot next to it. Also select "Approved" from the drop down bar by Status. Click OKAY. From the next window, place the mouse at the top of the column with the small boxes (all the way to the left) and right click. Choose Select All and all the boxes will have a check mark. Then go to File in the upper left corner and select File Claims. A box will appear and place a check in the box for Print UB-92 by clicking the mouse in the box. Select the correct printer, and print. A prompt will appear with the option to mark claims as FILED, choose yes.

b) After the forms have been printed, sign each one in the box "Provider Signature" in the bottom right corner. At the same time, skim the form to be sure all the appropriate boxes are filled (ex: patient sex, birth date, insurance number, and all description notes are in the bottom left box (comments). Also, the computer will print out "O/P MediCal" for all FPACT patients, but Alliance has not set it up to do so for MediCal and CDP patients. So for these patients, in the box #50, (labeled PAYER), handwrite "O/P MediCal" next to CDP and for MediCal patients, handwrite "O/P" next to it.

c) Put the forms in a large envelope and address it with CenCal's address (stored on the billing computer's desktop labeled "CenCal Address"). In the bottom left corner of the envelope write the account to charge the mailing to (310 for SLO, 311 for AG). Since there is usually a combination of billing forms from the sites, you may simply alternate the codes with each mailing.

d) Forms face down in printer paper tray with the top of the form at the front of the paper tray.

e) If the UB-92 prints out of alignment, it can be fixed—however BE CAREFUL. Go to the ADMINISTRATION window (from the main menu) and select Administration Settings. Select Reports, then select Claim then UB-92 then Modify, then Report Setup, then change in VERY SMALL increments of inches. A small change makes a big difference.

II. Private Pay Claims

A. Charge Entry

1. Enter Diagnosis & Procedure codes
2. Double click on the first procedure
3. Enter the amount as indicated on the Encounter Form under FEE

4. Enter the same amount under ALLOWED
5. Click NEXT on the bottom left to go to the next procedure
6. Continue this process until all procedures are completed

B. Applying & Waiving Payment

1. Approve the visit and a prompt will appear stating, "The patient has a balance of $XX and a deposit of $XX. Would you like to apply?" Click YES.
2. If the patient balance is greater than the deposit, waive the remaining amount. To do this go to the TRANSACTION tab for the visit and double click on last transaction listed. Go to the ADJUST column and at the very top type an "=" and use the down arrow. This should adjust any remaining balance left for any procedures. Next, under Adjustment Reason column, use the dropdown menu to select Waived for each procedure that had any amount waived (the column says "Sliding Scale" unless you change it). Click OK.
3. If the deposit is greater than the patient balance, go back to procedures to look for any mistakes in keying in the charges, or look on the Encounter Form to check if the patient has made a donation. If they have made a donation, go back to charges and under procedure code type "D" and donation should appear in the description. Change the fee to the amount of the donation and then repeat the approval process to apply the payment.

C. Additional Information

1. After the transaction is complete, fill in any information necessary under the Additional Information tab (as with all claims).

II. Creating a Visit

A. Create a Visit for CDP Follow-up

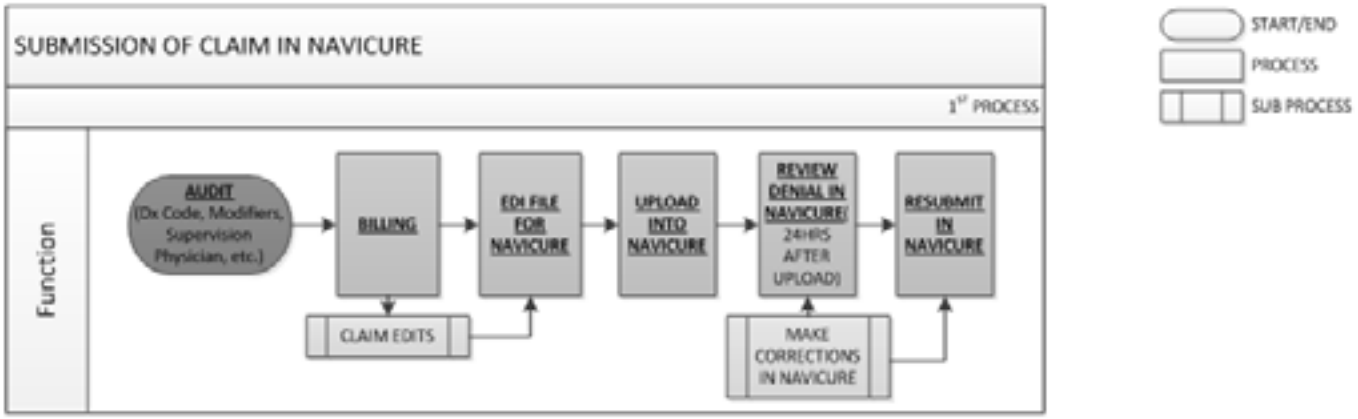
1. From Main Menu select Billing
2. In billing criteria, type in the first three letters of the last name, a comma, then the first three letters of the first name for the patient on the Encounter Form. Click OK.
3. Select the correct patient by double clicking on the patient's name, or by clicking once to highlight the patient's name and then click OK.
4. At the near top of the page, there will be a row of icons. Select the icon of the white bag with a red cross on it (New Visit). Select the correct patient by typing in the first three letters of the last name, a comma, then the first three letters of the first name for the patient on the Encounter Form. Click Search, and select the correct patient by double clicking on the patient's name or by clicking once to highlight the patient's name and then click OKAY.
    a) Under Company type "E" then tab. CAPSLO Health & Prevention will appear.
    b) Under Doctor type "B" then tab. Dr. Doe's name will appear.
    c) Under Facility type "S" then tab for SLO, or "A" then tab for Arroyo Grande
    d) Under Attending type "B" then tab. Dr. Doe's name will appear.
    e) Under Resource type "Doe" then tab. Dr. Doe's name will appear.
    f) Under Visit Date, be sure to change the date to the date on the Encounter Form.

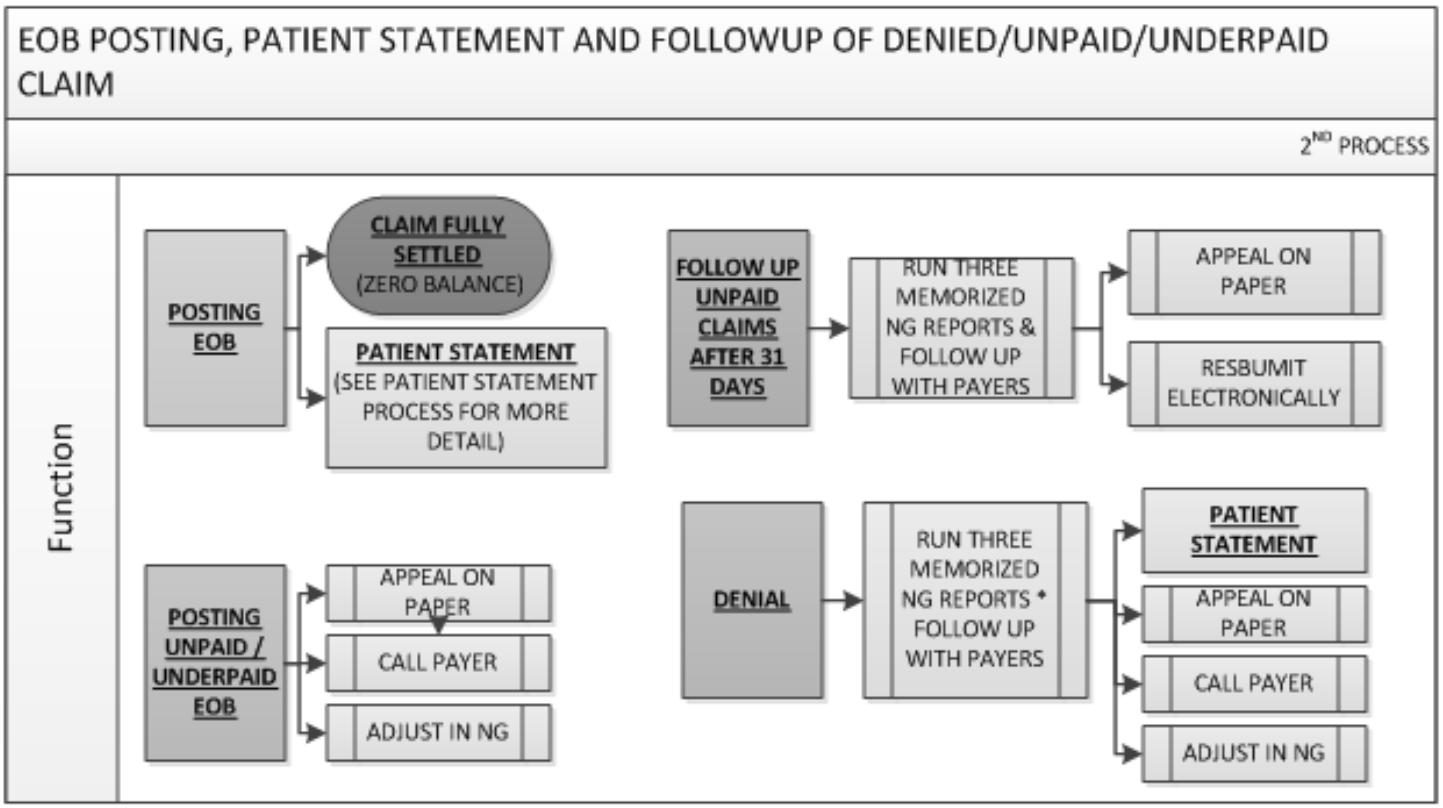
    **For CDP claims, the Follow-up Case Manager will write "Billed on xx/xx" for the date. Do NOT use the date on the upper right corner because that is the date the patient was originally seen, not the follow-up date for which billing is being done.

B. Charges

1. Select Charges Tab
    a) Under Diagnosis Code type V76.19
    b) Under Procedure Code type 99358
    c) Approve the Visit

PPAZ Clearinghouse Claims Submission Workflow





BRIDGER Clearinghouse Checklist

Instructions: In NextGen, go to Tasks>Lookup>Files>837 Electronic Claims File>. Enter the dates of submission you are looking for, based on the last Uploaded dates we have checked. In Navicure, go to Files, expand the window, and using Custom Date, enter the same dates to search for. Copy and paste the results into this word document (newest on top). Now, check each entry against each NextGen result (don't have to copy and paste anything from there since it doesn't allow you to export- just verify everything matches up to each other using the filename as a reference). Initial after each entry as you check it. Save!

Up to:	File Name	File Type	File No	File Size	Uploaded Date
3/11/13	Navicure03112013no1	Professional CLM File	25309682	33.7 KB	03/11/2013
	Navicure03072013no1.txt	Professional CLM File	25195037	46.22 KB	03/07/2013
	Navicure03012013no1.txt	Professional CLM File	25033828	67.3 KB	03/01/2013
	Navicure02282013no1.txt	Professional CLM File	24992801	44.36 KB	02/28/2013
	Navicure02252013no1	Professional CLM File	24907642	74.14 KB	02/25/2013
	Navicure02222013no1.txt	Professional CLM File	24836955	32.79 KB	02/22/2013
	Navicure02152013no1.txt	Professional CLM File	24641063	18.03 KB	02/15/2013
	Navicure02142013no1.txt	Professional CLM File	24601588	23.77 KB	02/14/2013
	Navicure02082013no2.txt	Professional CLM File	24443319	20.49 KB	02/08/2013
	Navicure02082013no1	Professional CLM File	24441915	60.88 KB	02/08/2013
	Navicure02072013no1.txt	Professional CLM File	24399034	51.11 KB	02/07/2013
	Navicure02012013no1	Professional CLM File	24239336	21.35 KB	02/01/2013
	Navicure01312013no1.txt	Professional CLM File	24203247	20.74 KB	01/31/2013
	Navicure01252013no1.txt	Professional CLM File	24046261	72.37 KB	01/25/2013
	Navicure01212013no1.txt	Professional CLM File	23903067	87.18 KB	01/21/2013
	Navicure01162013no1.txt	Professional CLM File	23772320	18.13 KB	01/16/2013
	Navicure01142013no2.txt	Professional CLM File	23707718	3.77 KB	01/14/2013

Start Time	End Time	Status	Submitter	Checked By
08:39:57 PM	08:40:59 PM	ACCEPTED	TW	SP
02:59:32 PM	03:01:49 PM	ACCEPTED	TW	SP
06:12:09 PM	06:13:55 PM	ACCEPTED	TW	SP
12:51:04 PM	12:52:34 PM	ACCEPTED	TW	SP
08:32:31 PM	08:34:21 PM	ACCEPTED	TW	SP
05:42:08 PM	05:43:36 PM	ACCEPTED	TW	SP
07:28:10 PM	07:28:54 PM	ACCEPTED	TW	SP
03:10:58 PM	03:13:13 PM	ACCEPTED	TW	SP
07:25:45 PM	07:26:38 PM	ACCEPTED	TW	SP
06:08:17 PM	06:09:41 PM	ACCEPTED	TW	SP
12:53:32 PM	12:55:20 PM	ACCEPTED	TW	SP
02:07:53 PM	02:09:25 PM	ACCEPTED	TW	SP
03:15:48 PM	03:17:09 PM	ACCEPTED	TW	SP
06:29:08 PM	06:30:20 PM	ACCEPTED	TW	SP
02:56:32 PM	02:58:49 PM	ACCEPTED	TW	SP
04:54:43 PM	04:56:07 PM	ACCEPTED	TW	SP
07:05:52 PM	07:06:13 PM	ACCEPTED	TW	SP

Billing Processes after a Patient Visit

Payment Processing

Payments are received from third-party payers through an electronic funds transfer (EFT) or by a check. An explanation of benefits (EOB) is attached to all payments. The EOB describes the visit data and the amount paid by the payer, including any disallowed services or contractual adjustments. For EFT, the agency will receive an electronic remittance advice (ERA) that includes a confirmation of the electronic funds transfer as well as patient-specific information. Data from each payment that is gleaned from the ERA is then posted to a patient's account in the PMS manually or electronically depending on the agency's ability. Any necessary adjustments for contractual or other allowances are part of the posting process. The steps to manually post payments are detailed in the following procedure from THE CENTER.

THE CENTER Payments Procedure

I. Payment Entry & Processing EOBs

A. Documentation

1. Make three copies of the check and one copy of the entire EOB
2. Send one copy of the check and the copy of the EOB to Finance
3. Send one copy of the check to the Deposit Clerk at the Admin. Office
4. Keep one copy of the check and the original EOB for Billing file
5. Original check goes to Deposit Clerk at the Admin. Office for deposit

B. Payment Entry

1. Go to Payment Entry from the main menu
2. Select a default batch to enter payments, a new batch is recommended for each check (if you need to open a batch, see procedure under Assigning a Batch in Electronic Paper Claims)
3. At the Payment Entry screen enter the batch (or change the batch from here by double clicking in the box and selecting new – be sure to check the box "set as default" before clicking "okay"
4. Enter the patient's ticket number or name
5. Enter the date of deposit (date of entry), check amount, check number (if Medicaid payment this is the warrant number), and check date
6. For the first patient, select NEW from the bottom left and the patient's charges for that visit will come up
7. To manually apply payment to the specific visit for that patient, type the payment amount on the corresponding procedure line in the payment column and press the Arrow key
8. Enter all payments for that visit, then arrow to the Adjust Column and adjust the balance for each procedure paid with that check only by typing "="
9. Continue to adjust the balance only for those procedures payments have been applied to
10. Click "okay" when all applicable payments and adjustments have been applied for that visit
11. Type in the next ticket number for the next patient
12. Continue this process until the check balance at the upper right of the screen is zero and all payments on the EOB have been applied
13. When the entire check has been entered click Next and the screen will zero out

14. When an entire check cannot be completely applied at one time:
    a. Save the entered information clicking CLOSE in the bottom right corner
    b. A prompt to save the information will appear, click YES
    c. An alert will appear that the batch cannot be closed with unapplied funds, click OKAY
15. To resume applying the payment, select Transaction Management from the Main Menu
    a. Select YES from the unapplied funds criteria in the criteria box that appears
    b. Click OKAY then double click on the corresponding check
    c. Continue applying the payment as above

II. Posting Payments

A. Private Pay Processing

After a patient is seen, she/he returns to the front desk with the completed Encounter Form. Based on the procedures, medications, etc. designated by the Clinician and/or Medical Assistant, the visit cost will be determined by the Receptionist using the Sliding Fee Scale and Schedule of Discounts. Payment may be received in the form of cash, check or credit card.

1. Select Billing from the main menu and select the patient's visit
2. Go to the transaction tab under the patient's visit and select patient payment
3. Complete appropriate field according to the payment type then press CTL+P to print a receipt (a copy should be offered to the patient)
4. Fill out the Private Pay section on the Encounter Form including: charges, payments, donation (if applicable) and waived fees (if applicable)
5. Prepare the cash/check/credit card slip for deposit by securing the form of payment in the folded receipt and placing it in the cash bag in Reception
6. Go to Payment Entry from the main menu and enter charges as instructed under Payment Entry in Payments
    a. The payment is applied to patient's charges automatically once the visit is saved
    b. If any amount needs to be adjusted because it was waived, go to the "adjust column" from the transaction tab and adjust the remaining amount
    c. Select waived from the adjustment reason column (next to the adjust column) so that all waived fees are tracked
7. At the end of the day, print a deposit slip for all payments for the day
    a. Select Reports from the Main Menu
    b. Select Financial folder and click on daily deposit
    c. Complete the appropriate fields and print
    d. Fold the deposit slip with the payments and receipts from the cash bag and place all in an envelope

Billing Processes after a Patient Visit

Accounts Receivable Management

Accounts receivable management is the follow-up on claims that have not been paid. When insurance claims are not paid there are two possible reasons – it has been denied based on the information on the claim or it was lost in translation on the way to the payer and has not been processing in its system. Either of those reasons requires the agency to take action to resolve the status of the claim. Thus, it is important to identify unpaid claims and follow up with the insurance company when appropriate. The use of electronic remittance and standard reports from the PMS helps manage that process. For health centers, many self-paying patients may also have outstanding balances. Following up on outstanding patient balances can result in additional revenue for the agency. One possible technique to manage outstanding patient balances is the use of a collection agency. The following procedure and policy refer to the accounts receivable management at the participating agencies:

- claims follow-up procedure – actions related to addressing unpaid claims in the agency's system (THE CENTER);
- insurance payment follow-up – letter sent to patients when an outstanding balance exists after insurance accepts a claim (BRIDGER); and
- collection policy – details on the use of collection agency (BRIDGER).

THE CENTER Claims Follow-up Process

I. Rebilling Denied Claims

A. At the end of the EOB, there will be a list of Denials. Next to each denial at the far right hand corner there will be a RAD code which indicates why the claim has been denied. To find out what the RAD code means, flip to the last page of the EOB and look for the code listed. All possible RAD codes are also listed in the FPACT/Medi-Cal binders under the RAD section.

1. Select Billing from the Main Menu
2. Enter the ticket number (listed as the medical record number on the EOB) under the box for ticket number for billing criteria, and click OK
3. Double click on the visit listed to open it up to make changes. Under the charges tab, uncheck any items that are not denied by clicking in the box with the red check mark to remove the check. Be sure all items to be re- billed are checked.
4. Make all corrections as indicated by the RAD code
5. After all necessary corrections have been made
6. At the Status box, use the drop down arrow and choose "Approved Primary" from the options listed
7. The box to the left of Status is Visit Description. Type what was re- billed here, abbreviations or the billing code may be used, and the date it was re-billed. This makes it convenient for quick referencing without opening up the visit.
8. Continue this process for all denials

II. Adjusting Denied Claims

A. If a claim has been denied that cannot be re-billed (for ex: patient was ineligible at time of service, or Z9751 has already been billed once in their lifetime), the amount of the claim needs adjustment

1. Go to Payment Entry (from the Main Menu or from the row of icons to the right of the billing icon)
2. Enter in the ticket number in the corresponding box and type tab. Double check to be sure it is the correct patient and correct date
3. Click NEW from the bottom left corner

4. Adjust the correct procedure by selecting from the list and typing "=" then tab (or just type in the amount) in the Adjust column
5. Under the Adjustment Type column use the drop down arrow to select the appropriate reason for the adjustment (often this will be Ineligible or Disallowed)
6. Click OKAY and the visit box will close
7. Click Next from the bottom right corner
8. Go on to the next task

III. Accounts Receivable

A. Check the status of any unpaid claims every month

1. From main menu select ACCOUNTS RECEIVABLE
2. For criteria, select ALL DATES (place a dot in the circle) and under STATUS use the drop down arrow to select COLLECTION. Click OKAY.
3. A list of all the claims in collection status will appear
4. If a partial payment has been made on the claim, there will be a + in the box to the right of that claim
5. If no payments have been made for the claim, the box will be blank
6. Check the DESCRIPTION column and see if any notes have been made to show the claim/items have already been re-billed
7. Also check the LAST FILED column to see how long it has been since the claim was filed
8. Resend any claims that have been overlooked by Medicaid or when an issue is discovered prior to receiving a formal denial

IV. Checking for Missing Billing Forms

A. At the end of the month, make sure that all claims for the month have been entered. To search for missing claims:

1. From Main Menu select BILLING
2. For criteria select Date Range to be from the first day of the month to the last day of the month. Then under STATUS use the drop down arrow to select NEW. Click OKAY.
3. If there are any outstanding new claims they will be listed. A list of patients may be printed by using Print Screen. In this case, pull the charts for each corresponding patient to verify that the patient did in fact have a visit on that date (to look up chart numbers, highlight patient then right click and select "modify patient info" then click "Additional" tab to find the medical record number). If so, bill according to the services rendered. Feel free to ask the back office staff to clarify any documentation questions you have regarding what to bill. If the patient was not seen, cancel the appointment in the system.
4. Repeat the process searching for any claims with the STATUS In Progress for the same month.

BRIDGER Insurance Payment Follow-up Letter

Bridgercare
300 North Willson Ave
Suite 2001
Bozeman, MT 59715

Addressee
Jane Smith
555 Family Planning Way
Bozeman, MT 59715

IF PAYING BY CREDIT CARD, FILL OUT BELOW		
CHECK CARD USING FOR PAYMENT □ MASTERCARD □ VISA		
CARD NUMBER	CVV	AMOUNT
SIGNATURE		EXP. DATE
STATEMENT DATE 4/10/13	PAY THIS AMOUNT $25.00	ACCOUNT NBR 123456789
SHOW AMOUNT PAID HERE: $_____		

4/10/13

Dear Jane Smith,

We have received final payment from your insurance carrier for medical services rendered on 11/27/12. The outstanding balance of $25.00 is your responsibility and is due immediately.

If you disagree with the payment made by your insurance carrier, please contact them directly to discuss those concerns. Your insurance contract is an agreement between you and the insurance company, and as the subscriber, you are responsible for the terms of that agreement. However, if we need to re-bill any claims on their instruction, please let us know.

We understand some patients may experience financial difficulties. If this is the case, please let us know so we can assist you in arranging payments. Out payment plan at the clinic requires $10/month minimum on top of any new balances. If you have questions about your account, please contact us at (406) 587-0681 between 9-5 weekdays.

Sincerely,

Billing Staff
Bridgercare
300 North Willson Ave
Bozeman, MT 59715

BRIDGER Collection Policy

PRECOLLECTION

Precollection letters will be mailed to patients 20 years and older with an unpaid balance that is in arrears over 90 days of $25 or more. Those patients have 30 days in which to respond to that letter and set up a payment plan. The alert PCL will go into CMX and a red note indicating the unpaid balance sent to Centron for the precollection letter will go into that patient's chart. As soon as the patient calls and sends in a payment or discusses a payment plan both the alert and the red note will be removed. A minimum payment of 20% of the balance is needed to remove that patient from collection.

COLLECTION

If we have not heard from that patient in 30 days, the account automatically goes to collection. At that point, any money received is subject to the 30% collection fee assessed by Centron. Patients should send any payments on the amount turned over to Centron directly to them. The alert COL will go into CMX and "COL" will be on the comment line with initials and the date. The red note indicating that the balance is in collection will remain in the chart until paid.

Patients may come into the clinic to put money toward their balance. At that time we need to verify their address and phone number, explain that this does not take them out of collection and inform them that any future payments need to go directly to Centron. We can accept payments but they must be tracked carefully so that the fee is paid to Centron and the remainder applied to the balance. Checks or cash should go to Business Manager or Executive Director to enter into CMX with a note including the patient's name, chart # and that it is a payment toward a balance in collection.

Patients wanting to make new appointments who are in collection can do so. At that time we need to verify their address and phone number, verify that they currently have a balance that is in collection, give the patient an idea of what their new visit will cost. Patients should be ready to pay for 50% of their office visit and 100% of any supplies taken based on their sliding fee scale on the day of service whether insured or not. If it sounds like this is a hardship or there are extenuating circumstances, the patient needs to visit with Executive Director.

Billing Processes after a Patient Visit

Management Reporting

Agency leadership needs to understand the financial health of the health center on the road to maximizing revenue. This involves the use of a variety of reports to summarize key indicators and to identify trends. Reports for the revenue cycle process include data on revenue collected as well overall management reports on revenue collected or service utilization, the latter of which can be used to assess possible revenue trends. The participating agencies utilize the following reports:

- monthly summary report – sample of a summary agency-wide management report (PPAZ);
- insurance performance summary – monthly tracking of key revenue cycle indicators, broken down by Medicaid and commercial payers (PPAZ);
- charges, revenue, and visits report – monthly tracking of key indicators by site over a six-year period (THE CENTER); and
- financial review – summary of financial dealings of the agency (BRIDGER).

PPAZ Summary Report by Agency

Monthly Report			
Month Ending	4/30/13		
Location	All Centers		
	Current Month	Previous Month	Change
	4/1-4/30	3/1-31	
Calls and Appointments			
Call Volume	15,000	14,000	7.1%
Answer Rate	80%	80%	0%
Conversion Rate	35%	45%	-22.2%
Appointment Show Rate	80%	75%	6.6%
# of Walk-Ins	1000	1100	-9.1%
Visits	4,000	4,100	-2.4%
Medical Visits	2,000	2,200	-9.1%
Non-Clinician Visit	1,000	900	11.1%
STI	500	400	25%
Lab Only	500	500	0%
Retail Sale Visit	1,000	1,000	0%
BCM – Rx	800	850	-5.9%
PAC	100	75	33.3%
Misc.	100	75	33.3%
By Gender (excl. retail)	3,000	3,100	-3.2%
Male	300	330	-9.1%
Female	2,700	2,770	-2.5%
By Payer (excl. retail)	3,000	3,100	-3.2%
Self-Pay	1,500	1,600	-6.3%
Title X	500	400	25%
Commercial	500	600	-16.7%
Medicaid	500	500	0%
Numbers used in this table are for illustrative purposes only and do not reflect the actual productivity of PPAZ.			

PPAZ Insurance Performance Summary

		2011	2011	2012	2012	2012
		11/1/2011	12/1/2011	1/1/2012	2/1/2012	3/1/2012
Transactions	Commercial	900				
	Medicaid	250				
Denials After Adjudication	Commercial	100				
	Medicaid	75				
RVU Trend	Commercial	2000				
RVU Trend	Medicaid	200				
Charge	Commercial	180000				
	Medicaid	30000				
Adjustment	Commercial	175000				
	Medicaid	95000				
Payments	Commercial	170000				
	Medicaid	40000				
A/R Ending Balance	Commercial	160000				
	Medicaid	100000				
Days In A/R	Commercial	40				
	Medicaid	150				
	Weighted Average	50				
% of A/R 90+ Days	Commercial	65%				
	Medicaid	50%				
Net Collection Rate	Commercial	95%				
Non-Contractual Adj	Medicaid	90%				
Statements	# of Statements	1100				
	Value of Statements	120000				
	$ Received from Statements	9000				
Net Third Party % of Charges		16%				
Net Third Party % of Payments		20%				
Net Third Party % of Transactions						

Numbers used in this table are for illustrative purposes only and do not reflect the actual productivity of PPAZ.

2012	2012	2012	2012	2012	2012	2012
4/1/2012	5/1/2012	6/1/2012	7/1/2012	8/1/2012	9/1/2012	10/1/2012

THE CENTER Charges, Revenue, and Visits Tracking Report

	SLO 2008	SLO 2009	SLO 2010	SLO 2011	SLO 2012	SLO 2013	AG 2008	AG 2009	AG 2010	AG 2011	AG 2012	AG 2013
January												
Charges	40,000	38,000	38,500	75,000	60,000	70,000	30,000	30,000	35,000	70,000	80,000	75,000
Visits pts 19 yrs & less	80	90	70	70	40	60	100	80	70	100	100	90
Total Visits	450	400	450	500	400	450	550	450	400	500	450	450
February												
Charges	45,000	35,000	35,000	70,000	60,000	68,000	30,000	30,000	35,000	60,000	65,000	70,000
Visits pts 19 yrs & less	60	90	75	60	50	60	90	70	100	100	80	90
Total Visits	350	300	325	500	450	450	300	350	300	450	450	500
March												
Charges	35,000	40,000	40,000	68,000	65,000		32,000	35,000	30,000	50,000	65,000	
Visits pts 19 yrs & less	20	40	60	60	40		80	90	90	100	70	
Total Visits	300	450	350	500	450		350	350	300	450	500	
April												
Charges	40,000	38,000	38,500	75,000	60,000		30,000	30,000	35,000	70,000	80,000	
Visits pts 19 yrs & less	80	90	70	70	40		100	80	70	100	100	
Total Visits	450	400	450	500	400		550	450	400	500	450	
May												
Charges	45,000	35,000	35,000	70,000	60,000		30,000	30,000	35,000	60,000	65,000	
Visits pts 19 yrs & less	60	90	75	60	50		90	70	100	100	80	
Total Visits	350	300	325	500	450		300	350	300	450	450	
June												
Charges	35,000	40,000	40,000	68,000	65,000		32,000	35,000	30,000	50,000	65,000	
Visits pts 19 yrs & less	20	40	60	60	40		80	90	90	100	70	
Total Visits	300	450	350	500	450		350	350	300	450	500	
July												
Charges	40,000	38,000	38,500	75,000	60,000		30,000	30,000	35,000	70,000	80,000	
Visits pts 19 yrs & less	80	90	70	70	40		100	80	70	100	100	
Total Visits	450	400	450	500	400		550	450	400	500	450	

	SLO 2008	SLO 2009	SLO 2010	SLO 2011	SLO 2012	SLO 2013	AG 2008	AG 2009	AG 2010	AG 2011	AG 2012	AG 2013
August												
Charges	45,000	35,000	35,000	70,000	60,000		30,000	30,000	35,000	60,000	65,000	
Visits pts 19 yrs & less	60	90	75	60	50		90	70	100	100	80	
Total Visits	350	300	325	500	450		300	350	300	450	450	
September												
Charges	35,000	40,000	40,000	68,000	65,000		32,000	35,000	30,000	50,000	65,000	
Visits pts 19 yrs & less	20	40	60	60	40		80	90	90	100	70	
Total Visits	300	450	350	500	450		350	350	300	450	500	
October												
Charges	40,000	38,000	38,500	75,000	60,000		30,000	30,000	35,000	70,000	80,000	
Visits pts 19 yrs & less	80	90	70	70	40		100	80	70	100	100	
Total Visits	450	400	450	500	400		550	450	400	500	450	
November												
Charges	45,000	35,000	35,000	70,000	60,000		30,000	30,000	35,000	60,000	65,000	
Visits pts 19 yrs & less	60	90	75	60	50		90	70	100	100	80	
Total Visits	350	300	325	500	450		300	350	300	450	450	
December												
Charges	35,000	40,000	40,000	68,000	65,000		32,000	35,000	30,000	50,000	65,000	
Visits pts 19 yrs & less	20	40	60	60	40		80	90	90	100	70	
Total Visits	300	450	350	500	450		350	350	300	450	500	
Annual Total	480,000	452,000	454,000	852,000	740,000		368,000	380,000	400,000	720,000	840,000	

Numbers used in this table are for illustrative purposes only and do not reflect the actual productivity of THE CENTER.

BRIDGER Financial Review

FY 12 July 1, 2011– June 30, 2012					
Income					
	Budget	FY 12	FY 11	% Change	Budget Comparison
Patient Fees	600,000	580,000	570,000	2%	97%
Title X Fed Grant	300,000	280,000	300,000	-7%	93%
Private Insurance	300,000	290,000	290,000	0%	97%
Patient Donations	88,000	75,000	85,000	-12%	85%
State General Fund (Contraceptives)	75,000	25,000	50,000	-50%	33%
Fundraising Revenue	40,000	45,000	50,000	-10%	113%
Medicaid (Public Hlth. Insurance)	24,000	20,000	25,000	-20%	83%
In Kind Personnel, Fundraising Contr.	30,000	3,000	30,000	-90%	10%
Private Grants	35,000	15,000	50,000	-70%	43%
Mat.Child Health, Prev. Health, (Fed Grants)	6,500	6,000	20,000	-70%	92%
STD Funds - CDC Grant (covers aprox.1/3 tests run)	20,000	25,000	15,000	67%	125%
HIV Grant (Anonymous Testing) + Donations	10,000	15,000	12,000	25%	150%
Rebates	0	1,000	5,000	-80%	0%
Interest	1,000	3,000	4,000	-25%	300%
Carryover					
Total	$1,529,500	$1,383,000	$1,506,000	-8%	90.42%

FY 12 July 1, 2011– June 30, 2012					
Expenses					
	Budget	FY 12	FY 11	% Change	Budget Comparison
Personnel Wages + Payroll Taxes	700,000	800,000	850,000	-6%	114.29%
Contraceptives	200,000	215,000	190,000	13%	107.50%
Fringe Benefits FICA, Mcare, WC, Hlth, Unemp.	115,000	50,000	80,000	-38%	43.48%
Paps, HPV, STI Lab testing	75,000	75,000	78,000	-4%	100.00%
Rent, cleaning	80,000	75,000	75,000	0%	93.75%
Medical, lab supplies (in house)	25,000	20,000	25,000	-20%	80.00%
Insurance: Prof. Liability, Med. Dir., Business	20,000	15,000	28,000	-46%	75.00%
In Kind personnel, fundraising services, supplies	25,000	3,000	34,000	-91%	12.00%
Misc., Incl. Ahlers CVR Proc. MT	15,000	16,000	25,000	-36%	106.67%
Marketing - Advertising	25,000	24,000	65,000	-63%	96.00%
Office Supplies	12,000	15,000	16,000	-6%	125.00%
Continuing Education/ Travel	3,000	10,000	11,000	-9%	333.33%
Accounting	8,000	7,000	7,500	-7%	87.50%
Bankcard processing fees	8,000	9,000	9,100	-1%	112.50%
Health Education Expenses - Supplies	8,000	20,000	10,000	100%	250.00%
Telephone, Internet access	7,000	7,500	6,400	17%	107.14%
Maintenance - repairs- IT	17,000	30,000	3,000	900%	176.47%
Equipment Puchase (EHR) (FY12 expenditures came from reserves)	65,000	0	45,000	-100%	0.00%
Postage	4,500	2,500	3,500	-29%	55.56%
External Financial Review	4,000	3,900	3,800	3%	97.50%
Fundraising Expenses	10,000	9,500	9,500	0%	95.00%
Insurance Billing Clearinghouse Fees	0	1,800	0		0.00%
Dues, Subscriptions	2,000	6,000	2,500	140%	300.00%
Total	$1,428,500	$1,415,200	$1,577,300	-10%	99.07%
Net Income		($32,200)	($71,300)		

Numbers used in this table are for illustrative purposes only and do not reflect the actual financial data of BRIDGER.

About NFPRHA

The National Family Planning & Reproductive Health Association (NFPRHA) represents the broad spectrum of family planning administrators and clinicians serving the nation's low-income and uninsured.

NFPRHA serves its members by providing advocacy, education, and training to those in the family planning and reproductive health care fields.

For more than 40 years, NFPRHA members have shared a commitment to providing high-quality, federally funded family planning care – making them a critical component of the nation's public health safety net. Every day NFPRHA members help people act responsibly, stay healthy, and plan for strong families.

Tell Us What You Think

NFPRHA surveys its membership to inform its advocacy, assess member priorities, and gain valuable perspective on service delivery in the safety-net setting.

Please consider taking a moment to **complete a brief survey** related to this case study, as well as the *Life After 40: The Family Planning Network and the ACA* project.

The survey will be used to help produce more useful and relevant *Life After 40* resources for the membership.

National
Family Planning
& Reproductive Health Association

www.nationalfamilyplanning.org

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