6 BILLING TIPS *Insurance Companies Hate*

Leverage these principles to keep more of your hard-earned reimbursements in your bank account

In the love/hate symbiotic relationship between medical providers and insurance payors, it comes as no surprise that the love side of the relationship for one is often the hate side for the other.

For example, while providers love to get paid their maximum allowable reimbursement as quickly as possible, payors love paying as little as possible as slowly as possible.

Oops. Did we say that out loud? It's not meant as an indictment, just a frank acknowledgement of the primary financial motivators within the system we all deal with in our current healthcare reimbursement system.

Understanding this fundamental lay of the land, it does little good to complain, point fingers or stoke the hate side of the relationship in order to enhance your financial position. What does work is to focus on leverage points within the current system that can significantly improve your ability to collect more reimbursement faster, legally and ethically.

Through more than 20 years of providing billing systems and services for tens of thousands of independent practices nationwide, we've gleaned these six key billing tips that have made the biggest difference for practices in getting more of their reimbursement faster.

In reality, they're more than tips. They are fundamental billing processes every practice should have in place. If you make certain they are implemented in your practice, you will love the results that show up on your bottom line. And yes, payors will hate the fact that you cracked the code on payment optimization. But it's your time to turn the tables, level the playing field and receive more of what you've earned.

Fundamental Principles

These 6 insights are based on two simple principles of medical billing that are fundamental to improving collections and speed:

Improve Accuracy

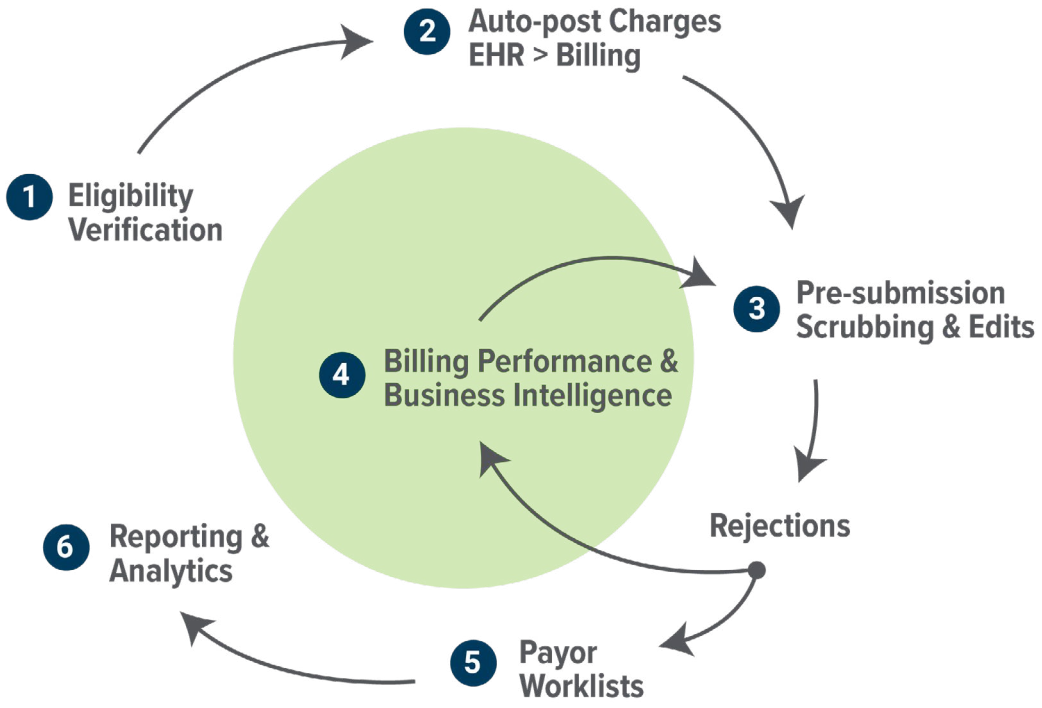
A major reason practices miss out on reimbursement is simply this: on average 64% of rejected claims are never reworked. Claims can be rejected for any number of accuracy issues, but unresolved rejected claims are simply money out of your pocket and into the payor's.

Learn from Mistakes

Reworking claims can be expensive and tedious but reworking the same types of claims for the same reasons over and over, no matter how efficiently, is a formula for staying stuck. Systematically capturing the reasons for rejection and deeply analyzing payment data, then utilizing that knowledge to avoid future rejections can be a geometric game-changer.

6 Tips

Here are the 6 tips that leverage these principles to keep more of your hard-earned reimbursement in your bank account. The graphic illustrates where each process fits in the billing flow.



01

Electronic Eligibility Verification

It seems pretty obvious that if a patient's insurance coverage information isn't up-to-date or accurate, there will likely be rejected claims on the other end. Yet it's amazing how many practices fail to implement this simple, automated process that saves so much money downstream.

Your practice management system should include an automated insurance eligibility check function that within seconds can verity a patient's coverage. As a policy, every patient's eligibility should be checked before every visit. Jobs change, and coverage changes constantly. Never rely on a previous verification.

The best practices set up an automated process to check the patients on the next day's schedule 24 hours prior to the visit, with automated alerts that inform both the patient and the staff of issues so they can be resolved prior to the visit.

02 Auto-post Charges

An important part of how you get paid is speed of reimbursement. This starts right in your practice with how long it takes to move from a final patient encounter to coded super bill to a claim entering the billing system. Some practices struggle here with paper documents, tardy providers, and manual transfers. All of these delays translate to greater delays in getting paid and increased probability of errors that will show up as rejected claims.

Model practices utilize EHR systems that provide coding as part of the encounter, and an automated process that automatically submits the final coded super bill electronically directly into the billing system.

"some practices struggle with paper documents that may translate to greater delays in getting paid."

03 Pre-submission Scrubbing & Edits

Sometimes referred to as claims scrubbing, this automated process checks each claim against thousands of data points to ensure it is accurate and complete prior to submittal. Identified issues can be rectified prior to submission to avoid rejection on an avoidable technicality.

The most advanced practice management/billing systems and services now achieve first-pass claims acceptance rates in the high 90 percent range. Lower acceptance rates than this means you run the risk of more of your money staying with the payor.

04 Cloud-based, Billing Performance & Business Intelligence

While claims rejections are never the preferred outcome, when intelligently processed, they can provide valuable insights into avoiding future rejections of the same type.

The most advanced billing systems continuously analyze the reasons for rejection of a specific claim, code and payor in order to identify what needs to be changed for the claim to be accepted. This knowledge is accumulated in a deidentified claim scrubber database and shared among all users of the cloud system. In essence, you benefit from the learning mistakes of thousands of practices, and they benefit when a claim of yours is rejected and analyzed. Utilizing this approach, these systems are able to consistently maintain 97%+ first pass acceptance rates despite constantly changing payor requirements.

05

Collection Worklists by Payor

Because the majority of practices still lack processes for efficiently reworking rejected claims, this is a rich area for potential improvement. Even marginally improving your success rate – remember, the national average for non-reworked claims stands at 64% – can significantly improve bottom line results.

The key is systems and processes. Efficiencies are improved when designated billing staff can focus on specific payors and develop deeper knowledge of how to navigate claims rework successfully for that payor. This is further enhanced by prioritizing claims to maximize returns, for example by submittal date or dollar amount.

Advanced billing systems offer functionality to create collection work lists by payor with options for customized prioritizing and other workflow features to maximize successful claim recovery.

"efficiencies are improved when designated billing staff can focus."

06

Reporting & Analytics on Payor Performance

Advanced analytics and reporting engines available in leading billing and practice management systems can provide valuable insights into the effectiveness of both your own billing operations and specific payors you work with.

For example, reports can analyze by payor performance on measures such as net reimbursements, rejections, most frequently rejected procedures, most frequent rejection codes, turnaround time, seasonality, etc. These analytics can help highlight where to focus with specific payors both for initial claims submittal and reworking any rejected claims.

At a higher level, advanced analytics can help a practice analyze its most profitable procedures and reimbursement streams in order to focus patient services and procedure groupings most effectively.

Now is the Time to Feel the Claims Love

Perhaps like many other independent practices, you more frequently find yourself on the hate side of the claims relationship with large payors – feeling beholden to their reimbursement practices, with little power to significantly change the system.

Take heart. Today's advanced billing and practice management systems can level the playing field with affordable systems and tools that payors would just as soon you didn't discover.

Maybe it's time to start feeling the love of faster, more complete reimbursement for your practice. Just don't tell your payors what you're up to.

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