Navigating Medical Billing & Collections in 2022!

A healthy revenue cycle is imperative to sustain the costly work of providing healthcare, but it's not always easy to make sure your practice is paid for the services it has rendered. It can be particularly challenging because healthcare providers are often reimbursed by third-party payers after the patient has already come and gone, and there is a lag between rendering services and receiving payment.

Moreover, insurance claims might be rejected or denied for various reasons. Human error plays a major role in many of these denials, as up to 75% of claims are coded incorrectly. Claim denials can be very costly for the medical practice and many write off underpaid or denied dollars, costing the practice revenue losses on an institutionalized basis.

What are the best ways your practice can minimize losses and ensure timely and complete payments for the work you've already done?

1. Understand the billing process.

You may feel overwhelmed and even a little intimidated by billing and collections. However, it's important to start by understanding the process, even if someone else will ultimately be responsible for the day-to-day matters. By taking ownership of this part of your business, you can ensure timely claims submission and avoid fraudulent activities.

How the medical billing process starts

The billing process typically begins with registering the patient, verifying insurance eligibility, and collecting the patient portion – copayments, coinsurance and deductibles – at the time of service.

Physicians provide coders with procedure and diagnosis codes for each patient visit. These codes come from the physician's notes, taken diligently during the patient encounter in question. Physicians then convert these notes into a formal medical script. This script is what coders use to determine the appropriate ICD-10 and CPT codes. Each code should come with a charge so the payer knows the amount to reimburse.

How the medical billing process continues

Coded claims are then entered into the practice management system and uploaded to a clearinghouse and submitted to individual insurance carriers. The insurers either accept the claim for payment or reject it. You can track all your practice's claims as they move through the payer adjudication process. Through this process, payers decide how much money, if any, to reimburse you.

Payments are received from the carriers, and any balances are transferred to either a secondary carrier or the patient. All rejected, unpaid or partially paid claims should be promptly handled by a medical biller to ensure payment.

Tip: For more information on medical billing read our blog on "Navigating the complexities of revenue cycle management!"

2. Look at the big picture.

Once you understand how billing works, it's time to examine the broader issues that can impact your billing process and identify the approach that works best for your practice.

Many practices often only look at overall payments or number of claims denied, but they don't go deeper to do an assessment of how efficient and effective their billing process is. Doing a thorough analysis of billing key performance indicators (KPIs), benchmarking to industry standards and creating a revenue management strategy are essential to the long-term success of a medical practice.

Looking at the big picture includes staying current on industry and regulatory trends and understanding how they can impact the health of your medical practice's revenue cycle.

3. Invest in staff training.

Once you create a standardized and measurable billing process, you need properly and thoroughly trained staff members to implement it. It's never wise to skimp on this step or assume that only the staffer who submits the claims needs training.

A healthy revenue cycle begins with well-trained front desk staff who have the tools available to check

Clearly delineate the actions that are taken at each step of a flowchart, put enough of the right staff in place to do each job, and train them.

4. Pay attention to details when submitting claims.

Claims that are not filed correctly will not be paid, so take the time to ensure that all codes are correct and all requirements have been met.

While HIPAA and the ACA regulations have codified the adoption of national standards for electronic healthcare transactions, code sets, and unique health identifiers, there still remain millions of rules and edits that are to be considered when billing each claim line.

It goes without saying that complete information is essential, sending a claim to the right payer is critical, although in a delegated payer environment. It may be difficult to know which payer, risk-bearing medical group or health plan is responsible for payment. That can result in delay as claims ping-pong back and forth. It's also key to scrub claims regularly, which involves identifying and performing corrections for errors in billing codes. The process generates cleaner claims, a reduction in denials and improved payer communication. By getting it right from the outset and enabling multiple types of edits to the claim before it is submitted by providers, your medical practice will be more efficient and find greater success with reimbursement.

If you're ready to look into outsourcing please visit: https://towerps.com/Tower_Nephrology-Medical-Practice-Resources-Billing-and-Coding.html

Learn more at: towerps.com

Contact Tower today for more information regarding technology support for your practice. Please contact Tower Physicians Solutions at 630-243-5731 or email us at info@TowerPS.com

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