



Maximize

Collections Through Efficient BILLING PROCESSES

BY AMY WEST

HAVE YOU EVER WONDERED IF YOUR ASC IS EFFICIENTLY BILLING AND COLLECTING? ARE YOU COLLECTING EVERY DOLLAR THAT IS DUE? TAKE THE TIME TO REVIEW ALL THE STEPS TO DETERMINE THE EFFECTIVENESS OF YOUR PROCESSES.



Amy West

VERIFICATION OF BENEFITS

A step frequently overlooked in establishing best practices in billing occurs even before the patient walks in the facility — verification of benefits. In a world where benefits and insurance plans change annually, and for some patients even more frequently, it becomes increasingly important that the time is taken to verify the patient's benefits for the procedure prior to the date of service. Determining if the patient has coverage for the upcoming procedure can decrease the cost of collections, as well as minimize the risk of having to write-off a balance.

There is a cost associated with verifying benefits. However, the cost has decreased over the years as insurance companies evolve and develop websites that offer most of the information. This allows your staff to retrieve information in a matter of seconds. If you want to determine the cost versus the return of

verifying benefits, compare the staffing expense to the dollars written-off for lack of authorizations, non-covered service, terminated coverage, etc. On top of these obvious costs, there are others associated with rejections such as submitting incorrect identification numbers. You will most likely get paid, but the delay in payment is a cost to your operation.

Take verification of benefits one more step, and determine the patient's expected liability. Even though this is just an estimate, it can help prepare you and the patient for the upcoming procedure. Sometimes information is misinterpreted, so it may be helpful to prepare a template for your staff to collect the information. A key to accurate verification of benefits is calling only several days prior to the procedure date. There can be many changes in the course of weeks or months. For example, another claim could be processed two weeks prior to the procedure date which would change possible deductible amounts. Place a courtesy call to the patient prior to the date of service informing them of the expected liability. This should always be communicated as an estimated amount, as different variables in the plan and procedure could result in a higher or lower patient liability. If your center collects at time of service, ensure that this is communicated to the patient during the courtesy call.

REGISTRATION

Upon registering the patient on the day of the procedure, make certain that the information collected is accurate and current. Registration personnel should carefully review the insurance information, as well as the demographic information entered into the system. Remember to make a copy of the insurance card (scanned if possible). Question the patient on additional forms of insurance. A patient might forget that they have a secondary insurance, so the reminder may help to pull together all this information.

After entering the insurance and demographic information into your system, take the time to print out the data on a form for the patient to review for accuracy and completeness. If information is missing, politely ask the patient to provide it. Something as simple as a phone number can mean the difference between payment and nonpayment. Once the patient has left the facility, it is exponentially more difficult to obtain correct information. If there is an expected patient payment at the time of service, ask for payment offering the various forms available (cash, check, credit card). An efficient registration process can truly improve your cash flow.

CHARGE ENTRY

Once the physician codes the procedure, have someone trained in coding review the operative report to make certain that it is correct and complete. This step is critical in ensuring that all codes are billed correctly the first time. Missed codes could equate to thousands of unbilled dollars. Understanding the appropriate modifiers to use is equally important. Some payers require special modifiers; investigating this prior to submitting to a new payer is key.

Once a procedure is performed, the claim should be submitted within 48 hours. Most payers now accept electronic claims. Take advantage of filing claims electronically, as they generally are processed quicker, speeding up your payment.

Consider hiring an external auditing consultant or firm annually to ensure that claims are being coded correctly and completely. This can either confirm that your coding processes are correct or serve as a measure to help rectify any problems.

PAYMENT POSTING

There are several items to consider in regard to payment posting. Most billing software allows for the contracts to be loaded into the system. In doing this,

you will reap several benefits. If the contract is loaded in a manner that automatically adjusts off the contractual allowance, the payment poster has one less step in the process. Also, this automatic adjustment assures the payment poster that the amount received is correct (or not) without having to manually refer to a list or sheet.

When paid correctly, posting the payment and transferring patient liability is relatively simple. Track rejections to determine if there are specific trends with payers or processes. Use the information to tighten up internal processes or to follow up with payers. You may want to consider taking this up one more level by reviewing the journal codes uti-

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lized for payment posting. Review the codes in an effort to categorize denials for future reports. Generating and analyzing monthly journal transactions will help to uncover issues. For example, if denials for lack of authorizations are coded as such, discovering the issue is easy by running the reports on a management level. Once uncovered, trace the issue back to its origin—verification of benefits.

Explore Electronic Remittance Posting (ERP). Combining ERP with contracts in the billing system will result in an efficient posting process. Automating this process reduces human error and

highlights claims that need additional follow up.

On a daily basis, it is important that rejections or incorrect payments are reported to the responsible personnel to ensure that timely follow up on claims occurs. Each day that passes without following up on the claim could be one more day of nonpayment.

ACCOUNTS RECEIVABLE MANAGEMENT

Each step of the billing process is essential in optimizing cash collections, and AR management is no exception. This is often a neglected area due to the laborious tasks of working outstanding claims. However, there is a bright side. If managed correctly and consistently, working the outstanding accounts successfully is possible.

Relay expectations to your billing staff so they have a clear understanding of goals when considering the accounts receivable. Once the target is set, help to establish a process to meet these milestones. If the goal is that the aging should reflect less than 5% of total dollars outstanding 90+ days, and currently the aging reflects 30% dollars outstanding 90+ days, then a plan of action needs to be deployed, as well as a maintenance plan once the desired goal has been met.

Take advantage of online resources when following up on accounts. Many payers have made great strides in the past few years with their websites. Many offer information on claim status, while some allow you to resubmit corrected claims online. Using the internet as a tool to follow up on accounts can equate to savings on labor, as well as quicker cash collections. Always choose the online option over phone calls when possible. Anyone who has sat on the phone for 30 minutes or longer to check on the status of a claim can appreciate this.

Many facilities utilize a clearinghouse to process electronic claims. Select a clearinghouse that incorporates and details the entire cycle. Some clearinghouses can give you step-by-step information on a claim—from submission to payer acceptance to payment.

For those really difficult claims, it is important to remember one thing: Don't give up! Persistence pays off when dealing with insurance carriers. If the claim is coded properly and billed within the timely filing limit, the insurance carrier should pay. This is assuming that the patient's coverage was in effect at the time of service and the procedure is covered (verification of benefits). A key to the success of following up on these difficult claims is a knowledgeable staff. Understanding the issues revolving around a denial is pivotal in knowing what course to take to rectify the situation and obtain payment.

The same logic applies to patient balances. Set a goal, layout a plan, and execute it. Consistency in working these accounts will yield results. It may be wise to review the patient statements. Are they clear and concise? Does the patient know where to send the bill, or are there different options (e.g. calling in a credit card payment)? Are patients called as part of the follow up process? If so, are the calls based on the amount of the balances (e.g. higher balances receive more calls)? It is helpful to collect patient liability at the time of service when possible. It should not be expected that 100% of patient liability can be collected at the time of service, but whatever is collected improves immediate cash flow and reduces expenses.

Managing the processes that result in claim reimbursement can be time consuming and sometimes difficult, but it is a vital element of a successful ASC. Having a team of individuals who understand the process and work together to achieve the goals is the number one factor. The reimbursement process in health care is ever changing. Insurance carriers change criteria, and remaining informed is critical. The suggested processes can help to ensure your facility is maximizing cash collections.

For more information on PE's billing services contact us at (877) 442-3687.

Amy West joined the PE team in 2004, and currently serves as vice president of billing services. She has extensive experience in implementing successful billing practices and maximizing revenues while streamlining processes to ensure efficiencies. She earned her B.S. in Economics and a Masters in Business Administration. Should you have questions or comments about this article, please email awest@endocenters.com.



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