3 Tips to Improve Your Billing

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Every practice knows that billing and collecting gets harder every day. Insurance companies change their rules and parameters, patients owe a larger proportion due to co-pays and high deductible health plans, and there are more audits than ever before.

Here are three areas of focus to assure you are getting paid what is due:

1. DOUBLE CHECK ALL PATIENT INFORMATION, ESPECIALLY ELIGIBILITY.

If you are an office-based practice, ask for and verify patient demographics (name, address, phone, social security number, guarantor, and insurance) at every opportunity. Train your staff to ask questions like, "Has anything changed?" and "Has your employment situation changed recently?" If you deal with workers comp or motor vehicle insurances, ask which insurance applies to this visit. Make sure that all of your front desk staff (scheduling, registration, etc.) have training that emphasizes the importance of their role in capturing this essential information. As part of their training, have one of your billers or your billing company illustrate how much extra work is required when the information is incorrect.

If you are a hospital-based practice that depends on the hospital to capture the demographics, schedule periodic meetings with the hospital executives responsible for getting the data. Show them the denials your practice is experiencing and a trend of the error rate in the demographics. They are generally interested in process improvements for the hospital billing, so don't be shy about offering suggestions!

In both cases, if the technology is in place, insist on eligibility checking as early in the process as possible. For office-based practices, this should happen after (if not during) the scheduling process so that you know the insurance status of each patient who is seen. For hospital-based practices, encourage the hospital to perform the eligibility checking promptly after registration. If eligibility checking technology isn't in place, make it a priority to get implemented.

Following these steps will minimize downstream billing errors and facilitate timely payment.

2. MEASURE DENIALS, AND FOLLOW-UP ON THEM AGGRESSIVELY.

In most practices, a large majority of claims are paid the first time they are filed. But some percentage is not. This percentage varies widely: from a best practices low of around five percent to as much as 30 percent or even more. Monitoring this denial rate (technically "first pass denial rate") tells you how effective your upfront processes are (see Tip 1) and how well your billing edits and checks are performing.

When denials do occur, make sure there is a process for resolving them and submitting an appeal. Often the billing staff in a practice is short on time and will simply refile the claim. This is not an effective process. Good billing results differ from mediocre results based on how well denials are

worked. A second denial measure is to monitor the percentage of charges that are denied and never paid. This percentage should be in the low single digits.

If you use a billing service, ask them to provide these statistics on a regular basis.

3. PAY ATTENTION TO PATIENT BALANCES.

Of course, not all cash for your practice will come from insurance companies. Every year, the portion from patients increases and this trend is not likely to change. Here are a few practical ideas.

Traditional patient billing happens after the insurance payment is received. Best practices suggest that you send a statement immediately after receiving the insurance payment (i.e. the same day) and follow-up with a second statement in no more than 30 days. An automated reminder phone call can also be used around the 30 day mark. It is best if you can offer a secure online portal where patients can make their payment via credit card: collect their email during the upfront demographics process. If no payment has been received after 60 days, a final "pre-collections" letter is recommended, with referral to your collections agency at 90 days. Of course, you may establish a payment schedule for some patients.

Even before the traditional patient billing process, it is essential that office-based practices collect co-pays before the patient is seen. This often requires training of the front desk staff, most of whom will be uncomfortable asking for money. Train them to ask, "How would you like to pay for your co-pay today?" Not, "Would you like pay your co-pay?" Secondly, if you've run the eligibility check, you will know (from many but not all insurance companies) what the patient's deductible or co-insurance is likely to be. You are fully within your rights to ask for some or all of that payment prior to seeing the patient. At a minimum, ask for their credit card that will be charged once the insurance has been processed. For practices that see repeat patients, be sure that the scheduling and registration staff know about any outstanding patient balance and ask for the payment prior to being seen. For example, scheduling can say, "I see that you have an outstanding balance of $50. Can you give me a credit card now to take care of that?" Clear policies are important for your front desk personnel: don't put them in the position of having to decide if, or when, a patient pays. Require them to collect payment but give them an escalation person when there is an issue.

Hospital-based practices do not have the same luxury as office-based practices since there are few, or no, opportunities to collect monies in advance. However, it is critical that your hospital-based practice work with hospital intake personnel to educate patients. They need to know to expect a separate bill from your group. A good way to do this is to provide an "Introduction to your Radiologists" (or similar for your specialty) that explains your role, credentials and years of training. Photographs are recommended to personalize the introduction.

Following these 3 steps doesn't guarantee that you will collect every dollar but it does assure that you will collect most of what you are owed!