Don't Get Spooked by Denials

Tips & Tricks to Preventing Denials in Your Practice

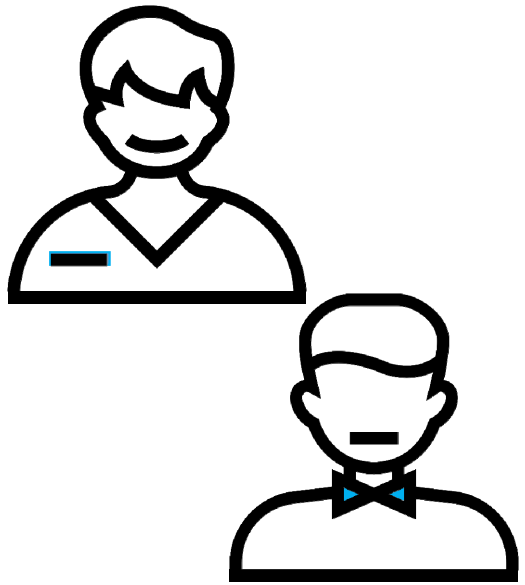
Presented by eMDs and Metropolitan Practice Management

Top 10 Coding & Billing Related Errors

1. Lack of information
2. Expired eligibility
3. Services not covered
4. Referral or prior authorization required
5. Coding is not specific enough
6. Incorrect diagnosis or procedure codes
7. Claim not filed on time
8. Duplicate billing
9. Undercoding and overcoding
10. Further documentation requested to support medical necessity

It Starts In the Front-Office

- **Communication Skills - Your staff must be able to speak clearly, and interact comfortably with your patients.**
- **Detail Oriented – Your staff should be focused on the details and it should be second nature.**
- **Tech Savvy – Your staff should have a basic knowledge of your practice management software and other basic computer programs.**
- **Industry Knowledge - Your staff also needs to know the nuances of insurance policies and how to educate your patients about their plans.**



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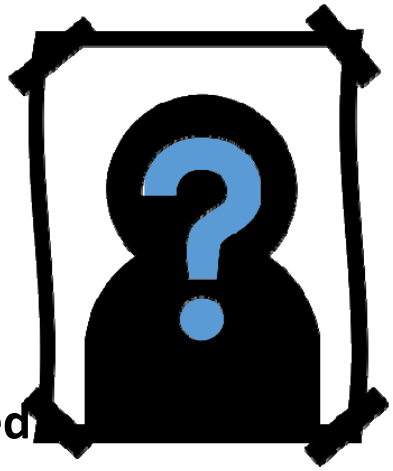
Check Patient Identifier Information

- Is the patient's name spelled correctly?
- Is the patient's date of birth and sex correct?
- Is the correct insurance payer entered?
- Is the policy number valid?
- Does the claim require a group number to be entered?
- Is the patient relationship status to the insured accurate?
- Does the diagnosis code correspond with the procedure performed?
- Does the procedure code for the service that was performed match the authorization obtained?
- For multiple insurances, is the primary insurance accurate for coordination of benefits?



Is the service covered?

- **Check eligibility, check it again, and then one more time**
  - At the time of booking
  - Prior to the appointment
  - When they arrive for the appointment
- **Use eligibility checks to help provide patient estimates**

Is the Service Covered?

- Patient's policy status and effective date of coverage on the date of service
- Type of plan and coverage details
- Payable benefits
- Out of pocket expenses (co-pays, co-insurances, deductibles)
- Plan exclusions
- Claims mailing address and electronic payer id
- Referral and pre-authorization requirements

Make the Shift to Electronic Eligibility

- **Do away with manual eligibility checking it is costing your practice money!**
- **Electronic eligibility features work in real-time for supported payors**
  - ANSI X12 270 transaction is used for inquiries about coverage, services covered for a particular patient including out of pocket expenses.
  - ANSI X12 271 transaction is the healthcare eligibility/benefit response.
  - Use of both 270 and 271 transactions allows healthcare service providers to create HIPAA compliant files requesting eligibility details for a patient.
  - 271 transactions i.e, eligibility responses are mapped to the specific patient account, and while scheduling a patient appointment, eMDs practice management system sends the 270 inquiry and the 270 response is a real-time feature.
  - This allows the front desk staff to confirm the eligibility response and based on the active coverage, appointment is scheduled and confirmed to the patient.

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Manual vs. Electronic Verification

12.64

Minutes Per
Manual Transaction

2 Visits

Revenue lost per day to
manual eligibility checks

$6,000

Spent annually on just
1,250 manual checks.

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Do You Have the Proper Referrals and Authorizations?

- Check for prior authorizations and referrals during appointment setting
- Eligibility checks will reveal if they are needed
- Make sure the patient has appropriate paperwork at the time of the appointment
- Include the authorizations and referrals with claim submission

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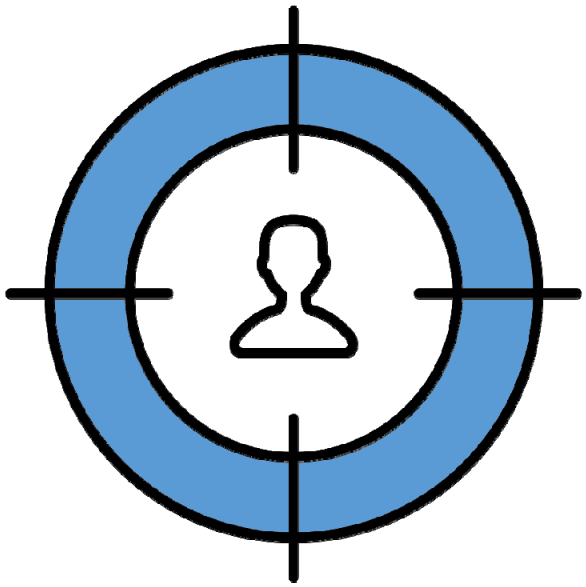
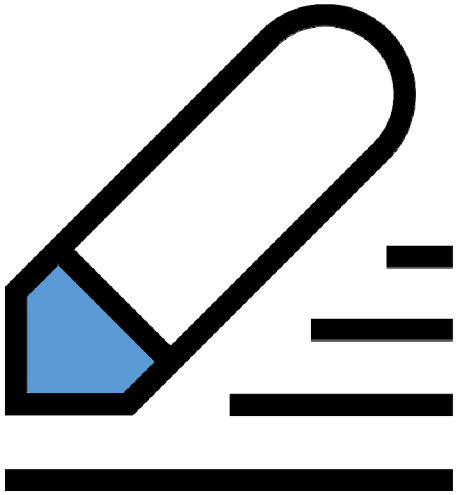
Code to the Highest Level of Specificity

- Coding to the highest level of specificity is the best way to reduce denials
- It's a team efforts. Coding is a shared responsibility of the provider, coder, and biller
- The numbers "0" or "9" are often indicators that an unspecified code was assigned.



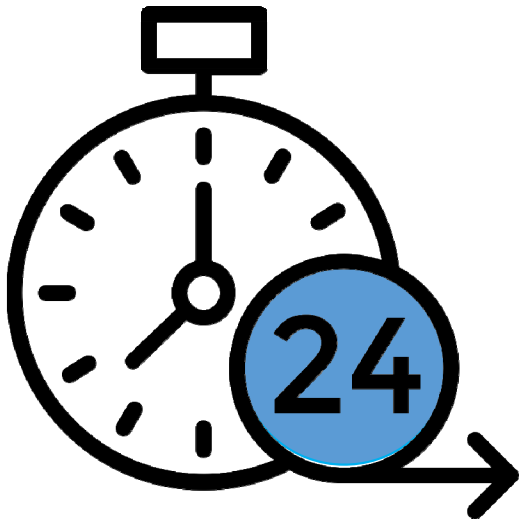
Check for Proper Coding

- Are you using the proper procedural code?
- Is the diagnosis code correct?
- Do you have the appropriate modifiers attached?



Ensure Timely Filing

- **Each payers deadlines could be different**
  - Make sure you know the deadlines
  - Create a cheat sheet for your coders/billers to quickly reference
- **Track and document receipt of claims**

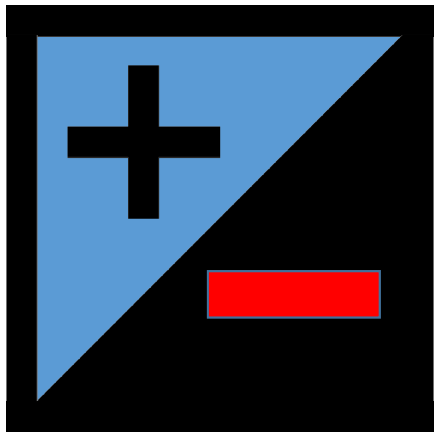


Avoid Duplicate Billing

- Largest percentage of denied claims come from duplicates - claims resubmitted before the response from the payer
- Keep a firm handle on your claims inventory
- Work your claims on a regular schedule
- Keep your rejection queues as organized as possible

Make Sure You are not Under/Overcoding

- Undercoding is when the coding does not adequately reflect the full extent of the services performed by the physician
- Overcoding is the reporting of a higher code than what accurately reflects the work performed by the physician
- Both can have a negative impact on your practice!!



Is Your Documentation in Order?

- Patient medical history
- Physical reports
- Physician consultation reports
- Discharge summaries
- Radiology reports
- Operative reports

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eMDs & MPM RCM Services

- **Certified Industry Experts –** A talented set of dedicated, certified industry experts are assigned to your practice.
- **Smart Technology –** Automation and innovation help our clients move faster and smarter.
- **Extensive Training and Education –** During implementation, you receive comprehensive training on best practices to re-engineer your workflow processes to be high performing and highly efficient.
- **Total Transparency –** Your practice maintains 100% control over your data. We work within your system so you can run any report at any time to see what we are doing.
- **Proven Results –** Our proven systems have collected billions of dollars of claims for more than 50,000 medical professionals who have benefited from our technology and processes.

Workforce Augmentation Services

- **You hire our employees to do billing work for your practice**
- **You can pick the scope of work!**
  - Could include: date entry, ops support, low balance follow-ups, denial management or whatever you don't have extra time for, aren't good at, or don't like to do.
- **No hiring, no training, no worry about sick days/vacation**
- **Highly educated and skilled staff**
- **Fully secure**

Customer Case Studies

"We're looking at opening a second practice next door because of the increased revenue,"

- Reduced Days in AR by **20 Days**
- Reduced AR Over 90 Days by **64%**
- Increased AR Under 30 Days by **43%**
- Increased Collected Revenue

"Impact on my cash flow has exceeded my expectations. I thought it would take a few months...It was immediate. We saw a 14% increase in the first 3 months."

- Days in AR decreased by **29%**
- Payments increased **8%**
- Patient volume increased **19%**
- DAR dropped below **30 days**
- AR (0-30) increased **16% to 48%**

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