Teamwork Leads to Getting Claims Paid

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Mary Pat Johnson acknowledges a financial interest in the subject matter of this presentation as an employee of Corcoran Consulting Group.

Challenges Today
- High deductibles
- Verifying benefits and coverage
- Collecting at time of service
- Denial management
- Refunds
- What's to come

Objectives
- Demonstrate the impact of collections issues on practice profitability
- Discuss how to improve collections at all levels
- Identify specific roles and responsibilities
- Review simple reporting and monitoring techniques
- Provide case studies of applied systems in actual practices

The Process

Check-in

Billing

Doctor

Technician

Check-out

The Revenue Cycle
- Contracting and Credentialing
- Patient registration
- Eligibility and benefits check
- Referral and Authorization
- Patient visit and coding and collection
- Data entry
- Claim submission
- Clearing house denial
- Payment posting
- Denial management
- Research aging
- Appeal
- Bill patient
- Collection agency
Front End

- First point of contact drives payment
  - Important to advise patient of their obligations
  - Notify them of the paperwork you require from them
  - Make sure you get the correct insurance information
    - Are you in network
    - Do they need a referral
    - Do we have a claims address on the card

- At check-in always ask for the card
- Pre-certification and pre-authorization
- Check Eligibility and Benefits
  - Co-pay
  - Deductible
  - Current with plan
- Consider outsourcing
  - Navinet
  - eSolutions
  - Your current EDI vendor/clearing house

Doctor/Tech Responsible

- Chart and code correctly, make sure your chart supports the codes you select
- Make sure the services you are providing are authorized and covered
- Make sure the charge ticket is complete, link diagnosis codes to CPT codes, mark all services performed, indicate next step
- Review reports for accuracy

Check Out and Data Entry

- Collect patient responsible balances that were unknown at check-in (i.e., refraction)
- Proof the encounter form
- Locate missing tickets
- Confirm demographic data and insurance is correct
- Scrub the information

Billing

- Post charges and payments daily
- Scrub your claims before you transmit
- Transmit and print claims daily
- Fix transmission errors daily
- Work denials as soon as they arrive
- Payment posting – utilize electronic posting
- Use event driven billing for your patient statements

Examples
Upon checkout patient instructs office to bill vision plan despite the medical record showing a complaint and diagnosis that support a medical claim.

How could this have been avoided?

Appointment Scheduling - Get clear information regarding reason for visit

Front desk - Obtain the one insurance the patient plans to use and verify eligibility for both vision and medical

Technician - Listen carefully patient’s reason(s) for visit. Do not copy over previous medical diagnosis as a reason for “recheck”

Checkout - Confirm insurance being billed and collect patient’s portion.

Global Period

CC: 2 week post CEIOL OD. Vision good, no pain.
SLE performed OU. Retina exam deferred.
Plan: Schedule cataract surgery OS
Billed 92014-24
Agree?

Global Period (Issue 2)

CC #1: 2 week post CEIOL OD. Vision good, no pain.
CC #2: Recheck cataract OS. Still having trouble w/glare and driving. Eyes “don’t work together”.
SLE performed OU. Worsening cataract noted OS Retina exam deferred.
Plan: Schedule cataract surgery OS
Billed 92012-24
Agree?
Global Period (Issue 2)

No issue with appointment scheduling
No issue with front desk check-in
Improved charting
  • Reason for billable exam noted
  • Seeking care unrelated to recent surgery OS
  • Complaints support indications for surgery left eye.
  • Consider 92012 or appropriate E/M code
  • Add modifier 24 and link diagnosis to exam

Minor Surgery Billing Rules

Your patient uses artificial tears for DES but is unhappy with the treatment. She asks for an alternative. You offer a trial of punctum plugs in the lower puncta and she agrees. The rest of the exam is unremarkable.

Billed 920xx – 15
68761-E2
68761-E4

Minor Surgery Billing Rules

No issue with appointment scheduling
No issue with front desk check-in
No issue with charting

Billing Issues
  • No unrelated, billable exam
  • Exam performed to determine the need for surgery
  • Bill for procedure only.

Cosmetic Denial

Patient is schedule for a bilateral blepharoplasty. Surgery Scheduling contacts payer for verification of benefits and pre-certification requirements. Verbally told no pre-cert needed. Surgery is performed and claim is denied as cosmetic.

How could this have been avoided?

Cosmetic Denial

Clinic/Surgery Scheduling – perform all necessary testing, chart supports functional diagnosis, pre-certification obtained in writing prior to surgery regardless of what the insurance rep may tell you, get ABN or Notice of Exclusion signed
Check out – confirm ABN/Notice of Exclusion is signed
Billing – know the payer policy and keep clinic updated

Pre-certification/Authorization 1

HMO Established patient returns after 2 weeks with dry eye complaint. Authorization is for 99213. Doctor briefly examines the patient and inserts plugs in RLL and LLL (68761). Insurance denies 68761 and pays visit.

How could this have been avoided?
Pre-certification/Authorization 1

Front Office - After first visit, request authorization for 68761-50 just in case. The National Medicare rate for 68761-50 is $229.54 vs. $73.08 for 99213

Clinic - Chart does not support separate exam code. If 68761 is not highlighted on encounter form, stop and request authorization before proceeding

Pre-certification/Authorization 2

New patient has HMO insurance and 92004 visit is approved for today. Doctor examines the patient and removes a foreign body (65222). Insurance pays for office visit and denies FB removal.

How could this have been avoided?

Appointment scheduling – confirm/obtain authorization before visit. Add information to appointment to print on encounter form

Front desk check – confirm authorization and highlight approved codes on encounter form

Clinic – if add-on, stop and get approval/auth or reschedule if non urgent, add 25 modifier to exam

Check out – collect patient portion

Billing – confirm authorization number is attached to claim

Billed with wrong doctor

Credentialing – new doctor joined the practice but his Medicare ID number is still pending.

Clinic – Dr. A sees the patient, Dr. B reviews the chart and signs off

Billing - Claim is filed under Dr. B

Agree?

Place of Service

Data Entry - you have a new employee entering surgeries into your practice management system and she select place of service office (POS 11) instead of ambulatory surgical center (POS 24) over a 3 month period

Now what?
**Place of Service**

Billing – Identify those procedures that were overpaid (i.e., YAG 66821, Bleph 15823) vs. those that need just need POS corrected (CEIOL 66984)

Attempt to submit a reopening for those claims that were not overpaid correcting the POS.

Submit a voluntary refund for the overpayment (the difference only) on the other claims. This may or may not be accepted.

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**Surprise Bill**

Appointment scheduling - scheduled patient for office visit with Dr. Retina

Front desk check in - gets patient’s ID card, they are Medicare only

Clinic – doctor wants an OCT and performs intravitreal injection with expensive anti-VEGF drug

Check out – attempts to collect 20% but patient is irate and refuses to pay

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**Clean Claim**

- Educate your doctors and staff
  - Modifiers
  - Diagnosis code linkage
  - Frequency of exams and tests
  - NCCI bundles
  - National and Local Medicare Policies
- Make sure claim write-offs are accurate

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**Optimize Collections**

- Maximize the practice’s ability to collect
  - Gather and confirm patient’s insurance
  - Notify patients of your collection policy
  - Collect patient responsible balance at time of service
  - Follow procedure when patient’s don’t pay

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**Adjust and Prevent**

- All practice employees have the ability to positively or negatively impact collections
- Submit Clean claims
- Verify insurance eligibility
- Collect patient responsible balances at time of service
- Use of ABNs when appropriate
- Internal auditing and modify your process when its not working
- Training and continual monitoring
- Use the Resources

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**More help...**

For additional assistance or confidential consultation, please contact us at:

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