Proactive Medical Billing Tips to Maximize Revenue

Any medical provider knows how difficult it is to align payments to the value of their services. To get paid efficiently and on time, medical providers need to establish better systems and procedures that provide lasting success. By preventing problems before they happen, healthcare practices can maximize their revenue, ensuring they're properly reimbursed, and they are able to continue providing care to their communities.

Here are several steps your nephrology practice can take to be more proactive in your medical billing procedures:

1. Establish a Clear Collections Process

All providers need a collections process to ensure the financial health of their practice. Establishing a step-by-step approach clarifies the procedures for all involved, and it can greatly improve revenue cycles by ensuring patients are properly and thoroughly informed of their responsibilities.

2. Manage Claims Properly

Approximately 80% of all medical bills contain errors, and because of how strict insurance companies are about correct medical billing and coding practices, they'll likely be rejected. The cycle of submission, rejection, editing, and resubmission can take weeks, often resulting in providers waiting for months before receiving payment for their services.

Because of the wasted time and effort involved in editing and resubmitting claims, it's important that claims are accurate and complete the first time. This involves inputting the information correctly and double-checking claims for any possible errors before submitting them.

3. Minimize Coding Errors

Within a claim, medical coders describe the performed procedures using standardized codes, making the claims easier to decipher and process. These codes can use ICD-10-CM, CPT and HCPCS Level II classification systems.

While this provides a standard method of describing procedures, errors can still occur. The most common errors, such as incorrect, mismatched, or missing codes, are often caught by clearinghouses before they become an issue. However, some common errors are more difficult to catch.

4. Promptly Handle Denied or Rejected Claims

A rejected claim is one that hasn't been processed yet due to the discovery of one or more errors. It's preventing the insurance company from paying the bill as it's written. A denied claim, on the other hand, is a claim that the insurance company has processed and has deemed unpayable due to a discovered violation of the payer-patient contract or some vital error caught after processing. In both of these cases, the payer will return the claim to the biller with an explanation of the problem. A rejected claim can be corrected and resubmitted, but a denied claim must be appealed before resubmission, a much more costly and time-consuming process.

Checking for errors in a claim can minimize the occurrence of rejections and denials, but if they do occur, be sure to handle them as quickly as possible. Keep in touch with a representative of the payer — they can help clarify problems with the original claim and provide information on current claims as they are processed. All of this can help expedite the claim editing process and minimize appeal and resubmission times.

5. Look for Ways to Improve

The healthcare field is constantly changing, and physician practices should follow suit if they want to maximize efficiency and revenue. By tracking performance and keeping current on the latest healthcare regulations, practices can identify problem areas and implement new ways of addressing them.

To ensure optimum efficiency and accuracy, physician practices should take the following steps:

- **Track pending accounts receivable:** The outstanding money owed is an important figure to track to determine the effectiveness of their collection procedure. Tracking this amount from quarter to quarter and comparing these figures to those of the previous year are excellent ways to determine how efficiently a practice's revenue cycle is performing. Such an analysis can also help determine the impact of any newly implemented procedures.

- **Stay informed:** Medical billing rules are constantly changing and keeping up with these changes can require continuing education and training for staff, as well as software updates. Stay on top of any changes that may affect billing and coding protocols and seek training if necessary — this is less costly in the long run than repeatedly resubmitting claims.

- **Identify problem accounts:** Establishing clear procedures for handling patient accounts means that data will become available to aid in the identification of potential challenges. Implement ways of tracking problematic behaviors like late payments, regularly declined payments, or frequent changes in contact information to better target such patients for additional reminders and prepare billing personnel to outsource to collections.

6. Know When to Outsource

Medical practices must constantly worry about their patients, current trends in medicine and proper staff management. They must also stay current with the most recent rules about coding standards, insurance companies, and billing regulations. With so much to keep up with, details can slip through the cracks, resulting in rejections, denials, and underpayments that cost medical practices time and money.

Despite their best efforts to implement proactive billing practices, many healthcare providers still find themselves lagging behind. This is often due to the costly time and labor involved in tracking down debtors, submitting and editing claims, and staying on top of current regulation — duties often piled on top of the existing responsibilities of medical office staff.

In response to the multiplying rules and regulations and in an effort to cut labor costs, many practices have outsourced their medical billing and coding to third party specialists such as Tower Physician Solutions. For many, letting another party manage their medical billing is an effective way to increase revenue and regain control.

Some of the benefits of outsourced medical billing include:

- **Dedicated specialists:** Medical billing and coding companies have dedicated staff of medical billing specialists, whose sole job is to ensure that claims are filed correctly and denied claims are resubmitted properly. Because of their specialized experience and duties, they can pay attention to the minutiae medical office employees can miss in the bustle of their daily duties.

- **Fast submissions:** Highly trained staff members can submit claims much more quickly and with greater attention to detail.

- **Greater focus on patients:** Once they’ve eliminated the time spent on billing and staffing concerns, doctors and nurses can better focus on their patients.

- **Up-to-date standards:** Medical billing companies are compliant with the most recent health care laws, and they are required to stay up-to-date with the most current regulations in order to meet the changing demands of serving hospital-based specialty practices.