



Medical Billing

Revenue Cycling Brochure

Services provided to your practice

PATIENT ACCOUNT SERVICES | PAYMENT POSTING | BILLING | COLLECTIONS

SAFE Associates



Introduction- What is the Medical Billing Process

- - - - X

The medical billing process is a series of steps completed by billing specialists to ensure that medical professionals are reimbursed for their services. Depending upon the circumstances, it can take a matter of days to complete, or may stretch over several weeks or months. While the process may differ slightly between medical offices, here is a general outline of a medical billing workflow.

Patient Registration

Patient registration is the first step on any medical billing flow chart. This is the collection of basic demographic information on a patient, including name, birth date, and the reason for a visit. Insurance information is collected, including the name of the insurance provider and the patient's policy number, and verified by medical billers. This information is used to set up a patient file that will be referred to during the medical billing process.

Financial Responsibility

The second step in the process is to determine financial responsibility for the visit. This means looking over the patient's insurance details to find out which procedures and services to be rendered during the visit are covered. If there are procedures or services that will not be covered, the patient is made aware that they will be financially responsible for those costs.

Superbill Creation

During check-in, the patient will be asked to complete forms for their file, or if it is a return visit, confirm or update information already on file. Identification will be requested, as well as a valid insurance card, and co-payments will be collected. Once the patient checks out, medical reports from the visit are translated into diagnosis and procedure codes by a medical coder. Then, a report called a "superbill" may be compiled from all the information gathered thus far. It will include provider and clinician information, the patient's demographic information and medical history, information on the procedures and services performed, and the applicable diagnosis and procedure codes.

Claims Generation

The medical biller will then use the superbill to prepare a medical claim to be submitted to the patient's insurance company. Once the claim is created, the biller must go over it carefully to confirm

that it meets payer and HIPAA compliance standards, including standards for medical coding and format.

Claims Submission

Once the claim has been checked for accuracy and compliance, submission is the next step. In most cases, the claim will be electronically transmitted to a clearinghouse, which is a third-party company that acts as a liaison between healthcare providers and health insurers. The exception to this rule are high-volume payers, such as Medicaid, who will accept claims directly from healthcare providers.

Monitor Claim Adjudication

Adjudication is the process by which payers evaluate medical claims and determine whether they are valid and compliant, and if so, the amount of reimbursement the provider will receive. During this process, the claim may be accepted, rejected or denied. An accepted claim will be paid according to the insurer's agreements with the provider. A rejected claim is one that has errors that must be corrected and the claim resubmitted. A denied claim is one that the payer refuses to reimburse.

Patient Statement Preparation

Once the claim has been processed, the patient is billed for any outstanding charges. The statement generally includes a detailed list of the procedures and services provided, their costs, the amount paid by insurance and the amount due from the patient.

Statement Follow-Up

The last step in the medical billing process is to make sure bills are paid. Medical billers must follow up with patients whose bills are delinquent, and, when necessary, send accounts to collection agencies.

CLAIM DENIAL REDUCTION MANAGEMENT



How to handle Insurance Claims Denials...

Even practitioners who take precautions to avoid insurance payment pitfalls sometimes find themselves faced with a claims denial. Handling denied insurance claims can be a frustrating, time-consuming and complicated process for practicing psychologists and their administrative staff.

Knowing some basic strategies for resolving claims denials can save practitioners time and improve their practice's cash flow. Some basic pointers for handling claims denials are outlined below.

1. Carefully review all notifications regarding the claim

It sounds obvious, but it's one of the most important steps in claims processing. When you receive remittance advice, explanation of benefits, or other notification from an insurance company regarding a claim, review it carefully.

The notification should indicate whether the claim was paid in full, delayed, partially paid or denied. If the claim is determined to be "unclean" or contested, follow the carrier's instructions for resubmitting the claim along with any missing or corrected information. (Tip: For pointers on submitting clean claims, read "Insurance Claims 101: Avoiding Common Payment Pitfalls.") If the claim is partially paid or if payment is denied, the notification should specify the reason(s) and outline the specific procedures and documentation required to resubmit the claim or file an appeal.

If the notification is not clear, call the carrier for more information. In addition to eliciting a stated reason for denying a claim, you may find

out that the claim was adjudicated incorrectly because of an administrative error on the part of the payer. You might also discover that your submission procedures do not match the company's requirements but that you can make some simple adjustments to your procedures to streamline future claims submissions.

2. **Be persistent**

If your resubmitted claim is denied and you believe the denial was improper, you may appeal the decision according to the carrier's guidelines. Make sure you know exactly what information you need to submit with your appeal. Keep in mind that appeal procedures may vary by insurance company and state law.

Your appeal should include an explanation of your reconsideration request, along with any necessary supporting documentation, such as a copy of the claim in question and copies of earlier communication to the company about the matter. If your claim is denied on the grounds of "medical necessity," you may need to submit additional information to demonstrate necessity. Be aware that it is crucial to meet your obligations under the Health Insurance Portability and Accountability Act (HIPAA) to protect psychotherapy notes and to provide only the "minimum necessary" information.

You may need to resubmit the claim or file an appeal more than once to reverse a company's decision, but don't give up. Your persistence can demonstrate to the insurance company that you are serious about resolving the problem and getting paid.

3. **Don't delay**

It is important to submit and resubmit claims in a timely manner, within the timeframe specified by the company or the applicable laws in your

state. Otherwise, the claim may be adjudicated based only on the information you already provided, or any requests for reconsideration or appeal may be denied as untimely.

4. Get to know the appeals process

When you submit an appeal, make sure you are familiar with the company's appeals process. When you know your carrier's policies, you are in a better position to respond to the carrier's actions. Keep current information regarding the claims adjudication and appeal processes for each carrier with whom you work. Carriers often include this information on their websites and, if applicable, provide hard copies of the information each time you sign a new contract with them.

5. Maintain records on disputed claims

When you call an insurance company for more information about a claim, keep a record of the information you are given, along with the full name of the representative with whom you spoke. Store this information with other key information about the claim, including: why the claim was partially paid, delayed or denied; the actions your office took to follow up on the claim; and the outcome.

These records can play an important role in future actions, such as taking your appeal to higher levels, submitting complaints to the state insurance commissioner and/or pursuing subsequent litigation. The records can also serve as a helpful file of sample appeals letters and documentation that can aid your office in avoiding or resolving future claims denials.

6. Remember that help is available

While handling claims denials can be a frustrating process, it can save you time and money in the long run by alerting you to the expectations and requirements of the insurance carriers you contract with. By

ensuring that your billing procedures are consistent with the company's requirements, you may be able to reduce the occurrence of rejections and denials in the future. However, if you continue to encounter reimbursement problems with a particular insurance company, contact your state insurance commissioner's office for assistance

HOW DO I COLLECT MONEY OWED TO MY ORGANIZATION??

All hospital organizations struggle to collect money owed to them. To better serve patients while minimizing losses, it is important for providers to understand recent changes to medical billing collections and patient payments.

To say that a lot has happened in the world of healthcare since the start of the COVID-19 pandemic in 2020 would be an understatement. Here are three changes/trends in the law since 2020 that have impacted healthcare billing and collections.

1. Medical Bill Collections Laws 2021

Medical bill collections laws are changing quickly, and there are cases where a medical bill wrongfully sent to collections can be a problem. With medical

debt forgiveness now a nationwide priority, it is critical to understand some of the legislative changes that have recently been proposed.

One such proposal is the [Medical Debt Relief Act 2021](#).

Introduced by Senator Chris Van Hollen (D-Md.), this legislation intended to prevent healthcare providers from taking extraordinary actions to collect money on the bills owed to them during the pandemic. Although not yet a law, many states are introducing similar measures, and there are a number of potential changes that healthcare providers need to be on the lookout for.

For example:

- *Providers might not be allowed to sell an individual's debt to another party.*
- *They may not be able to take actions that require a legal process.*
- *They may not be allowed to report adverse information to credit bureaus.*

With respect to credit, this proposal would require a one-year waiting period before medical debt can be reported on a patient's credit report, and all medical bills that have been paid in full or settled would have to be removed from credit reports immediately.

Similar legislation has already been passed in many states, including Maryland, California, Colorado, New Mexico, and Illinois.

2. Surprise Billing Laws

As stated above, legislative changes with respect to medical billing and collections have recently built momentum at the state level. Many new laws focus on the concept of "surprise billing" and "balance billing."

One such example is the [Texas Balance Billing Law 2020](#).

Surprise billing laws have been put in place to prevent patients from going to an ER or an ancillary service and ending up with a massive bill they cannot pay. Even though the way balance billing laws are structured can vary from state to state, it is still important for medical providers to be familiar with how these new laws work.

Surprise billing laws look to protect patients against surprise bills in situations where they don't have a choice of where to get care. Instead of passing the responsibility on to the patient, the healthcare provider and the insurance company must employ an arbitrator to help them decide how much to charge for the services provided.

To learn more about the implications of surprise billing laws at the state level, check out [this comprehensive resource](#) from The Commonwealth Fund.

3. Medical Debt Forgiveness: Recent Executive Orders

There are plenty of organizations that help pay medical bills, and there are multiple medical debt forgiveness programs available.

One notable development is the Biden Administration's [recent Executive Orders](#) focused on increasing consumer protections and easing the burden of medical debt. The orders look to hold medical providers and debt collectors accountable for harmful practices by requiring them to offer non-predatory payment plans or financial assistance to all eligible patients.

These orders also reduce the role that medical debt plays in determining access to credit.

RCM Flowchart

Revenue Cycle Management steps



WHAT ARE THE HEALTHCARE PROVIDERS THAT YOU WILL OUTSOURCE TO??

**HOSPITALS | SPECIALTY PRACTICES | PRIVATE PRACTICES | CLINICS |
OUTPATIENT FACILITIES | OB-GYN | RENAL CLINICS | HOSPICE | URGENT
CARE FACILITIES |**

CARRIERS YOU COLLECT INSURANCE FROM?

**SELF-PAY | AUTO ACCIDENTS | WORKMANS COMP | HMO | PPO | MEDICAID |
MEDICARE PART A & B |**

WHAT ARE YOUR EXPECTED REVENUE TURN AROUND PERIODS?

The industry standard benchmark for Insurance Payment Turnaround Time is **30 days**.

60 days- for denied/corrected claims

90 days- for Self pay

Healthcare providers should strive to meet this benchmark and monitor their claims to ensure timely payments from insurance companies.

For more information or to schedule a sales meeting with one of our Accounts Specialist, to see if our outsourcing services are the right fit for your organization please contact our Business Sales and Marketing Department at business.sales@smeassociates.org