A SIMPLE GUIDE

Practice Management and Medical Billing

Boost practice efficiency, enhance patient convenience, and optimize practice revenue

nextgen® healthcare

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The revenue cycle journey—let's begin

Your revenue cycle affects every aspect of your practice—financial outcomes, patient satisfaction, provider experience, and clinical outcomes.

When errors occur anywhere in the revenue cycle, you increase your administrative workload—and may even lose revenue.

This e-book can help you optimize your revenue and make billing more convenient for both staff and patients.

LIFECYCLE OF A CLAIM

Know the links in your revenue chain

Accurate billing and timely follow-up is essential. Most states require health insurers to pay claims within 30 or 45 days.[1] Time frames depend on the insurance payer. Understanding this process can help you identify broken links and resolve issues that may lead to denials.

Every stage of the revenue cycle must be managed to ensure doctors are fairly compensated and patients who received services get their allowed insurance coverage.

PRE-ADJUDICATION	ADJUDICATION	POST-ADJUDICATION
Eligibility		Remittance
Demographics		Correspondence
Estimation		Denial Management
Charge Capture		Payment Posting
Claims Creation & Scrubbing		Patient Transfers
Claims Submission		Receivables Management
Clearinghouse Edits		
Payer Acceptance		

REPORTING AND ANALYTICS

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Get eligibility information at appointment scheduling

Verification with the RTS can occur days in advance. Have office staff verify the information again at check-in.

Understand your practice's payer mix

Know your payer mix so you can accurately identify patient plans and insurance eligibility. Take a proactive approach to communication with patients—letting them know up front which services are not covered. It's also crucial to know which insurers require preauthorization before services are billed.

Pinpoint the patient's insurance plan

When the patient registers and identifies their insurance provider, make sure you identify the exact plan. Failing to pinpoint the specific plan may cause you to miss timely filing deadlines and can create significant roadblocks to payment. For example, if the patient has Medicare, ask if they have a red, white, and blue Medicare card, or is Medicare written on another insurance card (for example, UnitedHealthcare). If the patient has Medicaid, determine if it's a Medicaid managed care plan.

Manage policies and procedures

It's important to maintain standard operating procedures for patient eligibility and registration.

Utilize automated outreach

Take advantage of automated outreach solutions integrated with your EHR and appointment-scheduling technology. Schedule automated patient reminders using text alerts, emails, or voice messages according to each patient's preference.

ELIGIBILITY AND DEMOGRAPHICS

Collect information at every patient visit

The first step in the revenue cycle is for the front office staff to collect patient data and a reason for the patient's visit. Errors made when collecting demographic information are among the most common reasons for claim denials by insurance payers.

Front office staff also need to verify insurance coverage. To support this effort, your PM solution should incorporate a remote transaction server (RTS) that connects with payer systems, allowing you to validate patient benefit eligibility, determine coverage, and estimate patient responsibility via online access. This eliminates the need to call payers individually or log in to separate payer websites. It can also help you collect the patient's co-pay, up front.

Preauthorization is an important part of registration. Insurance payers commonly require preauthorization for medical procedures other than a primary care physician visit. If you don't obtain it, the physician will not be paid.

90% of claims errors can be prevented with better processes and technology.[2]

CHARGE CAPTURE AND CODING

Create the record that will become a claim

Charge capture is the process that physicians, other healthcare providers, and medical office staff use to record information about services provided. Once recorded, this information is translated into a claim and sent to third-party payers for reimbursement. Several types of code sets are used for different purposes during this process, including:

- **ICD-10 diagnose codes** – describe a patient's condition or injury, as well as social determinants of health and other patient characteristics
- **Current procedural terminology (CPT) and healthcare common procedure coding system procedure codes** – indicate what actions were performed by the provider in administering care during an encounter
- **Charge capture codes** – connect physician order entries, patient care services, and other clinical items with a chargemaster code, a list of the prices for each service
- **Professional codes** – capture physician and other clinical services delivered and connect the services with a code for billing
- **Facility codes or place of service codes** – account for the cost and overhead of providing healthcare services, such as charges for using space, equipment, and supplies[3]

TIPS

Go digital—all the way

Encourage clinicians and staff to enter all billing data into the EHR.

Ensure physicians sign off in a timely manner

Until an encounter is signed off in the EHR, you can't start the billing process. A friendly reminder to providers to sign off can help.

Save time with a mobile solution

Capture information about diagnoses and procedures faster and more accurately with a mobile solution that allows physicians and other staff to dictate notes on-the-go using a smartphone. Built-in voice dictation and transcription make it easier and more convenient to record details about patient visits and capture charges. Look for a mobile solution that integrates with your EHR.

Increase accuracy with a certified coder

Medical coding standards are increasingly complex. A certified medical coder is trained in these regulations and requirements and is better prepared to translate physicians' reports into accurate medical codes.

CLAIMS CREATION AND SCRUBBING

Get it right the first time

Coding requires staff to gather information from the medical record and other documentation for billing. The codes are used to generate insurance claims, which go to third-party payers. Claims creation is where coding is transformed, manually or electronically, into billing.

Superbills

A superbill is the primary source of data for creating claims—an itemized list of services provided to a patient.

Forms for submitting claims

Medical billers create claims by pulling information from the superbill, either by hand or electronically, using the PM system. The CMS-1500 form (created by Medicare) is accepted by most third-party payers. Medicaid and other third-party payers may use different claim forms based on their specific requirements.

Claims scrubbing

During claim preparation, medical billers or coders check for errors—claims scrubbing. This helps ensure that all information is complete and correct, including: patient, provider, and visit information, as well as procedure, diagnosis, and modifier codes. The goal is to generate a clean claim and prevent denials. Much of the claims scrubbing process may be automated.

TIPS

Use a charge review rules engine

A charge review rules engine allows you to automate the comparison of your charges against standards set by Medicare, Medicaid, and private payers. Before the import of charges from the EHR into the PM system, the rules engine applies millions of coding rules to the submitted charges to ensure billing accuracy. It alerts you to errors, so you can correct them before a claim is submitted to the payer. A charge review rules engine reduces the need for time-consuming manual review of charges.

Correct repeated coding errors

If you find certain claim edits keep coming back, identify the issue that's causing the repeated error.

Claims editing tools help detect errors such as missing CPT code modifiers or incorrect diagnosis codes that will likely result in denials. Expect to check your claims against National Correct Coding Initiative edits, implemented by CMS to promote proper coding.

Claims scrubbing software that integrates with your EHR and PM helps ensure claims are billed at the actual contracted amount, coded accurately, and processed as quickly as possible.

CLAIMS SUBMISSION

A clean claim saves time

Be aware that payers have specific deadlines to submit claims—timely filing limits. If a claim is denied because you missed the timely filing deadline, you have no appeal rights.[4] Your practice forfeits all money that potentially may have been collected.

For example, Medicare claims must be submitted within one year of the date of service. Timely filing deadlines for other payers vary; they may be 90 days from the date of service, depending on your contract with the payer.

The first phase of submission occurs when a claim leaves your practice for review, usually by a clearinghouse service. The clearinghouse aggregates mountains of electronic claim information, almost all of it managed by software. The clearinghouse sends this information to third-party payers.

Once your practice's claims are ready to be submitted, your system will generate an 837 file, a HIPAA-compliant electronic format used to transmit healthcare claims and upload them to the clearinghouse.

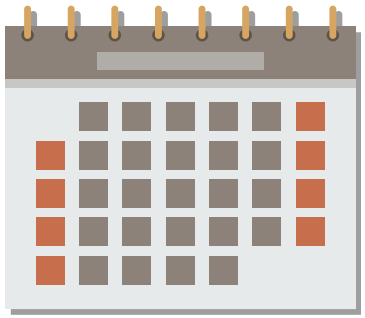
TIPS

Check daily for the status of your claim file

Usually clearinghouse services provide a dashboard that checks for updates on the status of submitted claims. Note that they enroll new insurance payers in their services on an ongoing basis. Therefore, new payers are continually being added to the dashboard. A clearinghouse also provides digital proof of timely filing, which can be more difficult with paper-based claims.

Set expectations for payment timelines

Medicare commonly pays within 14 days and many Blue Cross/Blue Shield payers pay within 14 or 21 days, as does UnitedHealthcare. But worker's compensation or Veteran's Affairs claims can take 45 to 90 days before you receive payment.



Know your payers so you know how long it's likely to take to get paid.

CLEARINGHOUSE EDITS

Last chance to prevent a denial

A claims clearinghouse acts as an intermediary between your practice and third-party payers. The 837 file you generated during claims submission gets uploaded to a computer platform and the clearinghouse performs its own series of edits. After this review, the clearinghouse forwards your claims information to insurance payers.

Clearinghouse edits present a last opportunity to ensure the integrity of a claim before it gets to the payer—and prevent a denial. If the clearinghouse finds a problem with your claim, they will reject it. Although a rejection from a clearinghouse doesn't have the same impact as a denial from an insurance payer, these rejections should be minimized.

To reduce clearinghouse rejections, be conscientious about scrubbing claims and correcting errors in charges—especially errors that repeat themselves.

TIPS

Understand reasons for clearinghouse rejections

Be aware of seasonal trends that may affect the number of claims coming back from the clearinghouse. For example, January can be a challenging month for coders and billers because payers tend to make coding changes in the new year. These changes can trigger an unusually high number of clearinghouse edits.

Address clearinghouse rejections

Clearinghouse rejections should be handled as soon as possible. Many practices have a policy that most clearinghouse rejections will be addressed within 24 hours.

TIPS

Use automation to pull info from the 277 file

Find a billing and PM solution that can automatically pull clearinghouse information to check whether or not a claim was accepted.

Be prepared for information requests

You may need to respond to a request for information from the insurer or a denial indicated in the 277 file. In some instances, a registered nurse or physician employed by the insurance payer may review related medical records to help adjudicate the claim. If manual review is required, you can face a significant delay. Provide any requested information quickly to accelerate payment and reduce aging of your accounts receivable.

Monitor results

Tracking is vital when it comes to payer adjudication. You'll want to know the percentages of your claims that are being denied, which will also let you know the percentage of clean claims. You'll also want to track the effectiveness of appeals to determine the denials that are worthy of the appeal effort.

PAYER ADJUDICATION

Review and decision

When a third-party payer receives your claim and starts the review process, it's known as adjudication. The payer decides, based on the information you provide, whether the claim is valid and should be paid. Expect payers to review claims meticulously. They want to be assured that you have all the records needed to back them up, especially for high-dollar claims.

Healthcare payers use a specific file format—the EDI 277 Health Care Claim Status Response transaction set—to report on the status of claims. The 277 file generated by the clearinghouse indicates whether the payer has accepted your claim and can be automatically loaded into your PM system. If a claim is denied, the 277 file will usually tell you the exact loop and segment where errors or omissions were flagged, as well as the reason for the denial.

Note: A loop is a section or block of an EDI file; each loop contains multiple segments.

REMITTANCE AND PAYMENT MANAGEMENT

Take control of your cash flow

Remittance refers to the process of getting paid. The Electronic Remittance Advice (ERA) or 835 file, is an electronic transmission of claim payment information. ERA or 835 files can be uploaded directly into your PM system. This file provides an explanation of the claims you've submitted—the reasons for payment, adjustment, or denial.

Insurers provide two types of statements to explain payment or denial of claims—(1) remittance advice and (2) explanation of benefits (EOB) statements. Usually, the remittance advice is provided to the healthcare provider and the explanation of benefits statement is sent to the patient.

Payment

The insurance company deposits payment into the practice's account by means of electronic funds transfer (EFT). Your practice may still need to collect a copayment, coinsurance, or deductible from the patient.

Reconcile payment with the claim

After the practice receives the ERA or EOB statement, the medical billing staff matches payments to the respective patient accounts, reconciling each payment against the claim. They check whether data from ERAs and EOBs match actual payments. During this process, the practice can:

- Find denials and ensure they are reworked and resubmitted
- Review line items to identify reasons for denials, such as medical necessity issues, non-covered services, or lack of prior authorization
- Move balances to patient responsibility for patient billing
- Take write-offs and make adjustments
- Identify in-person patient collection issues, such as failure to collect co-payment at the front desk

TIPS

Post payments daily

To gain better control of your cash flow, consider posting claim payments daily and reconciling with the bank. This includes payments from 835 files, as well as paper checks from insurers, insurance credit card payments, patient checks, and patient credit cards.

Keep original claims files

Claim files, remittance advice, and EOB statements should be organized in a document management system to follow up on denials and subsequent appeals.

Post zero-dollar remittances

Zero-dollar remits should also be posted, because they usually include denial codes and other information. To capture zero-dollar remittances, it's helpful to know when payers send their remittances. Information from these remittances may help you rework denials and submit appeals.

Track correspondence related to transactions

Keep information that may affect your revenue, like correspondence regarding prior authorization or physician credentialing. These records can help with claims follow-up and may prevent loss of revenue.

CLAIMS FOLLOW-UP AND DENIAL MANAGEMENT

Understand denials

Follow up on denials to get maximum revenue earned by the practice. Most practices meet timely filing standards for the initial submission of a claim, but there are also deadlines for reworking and appealing denials.

Insurance payers communicate claim denials to providers using remittance advice codes that include brief explanations. Review these codes to determine whether to correct and resubmit the claim or bill the patient.

There are many reasons a claim may be denied. Payers may reject services due to a lack of medical necessity or because services took place outside of the appropriate time frame. Denials may also be attributed to non-coverage by the patient's insurance plan.

How Medicare communicates payment adjustment

After Medicare processes a claim, either an ERA or a Standard Paper Remit (SPR) is sent with final claim adjudication and payment information. Itemized information in the ERA or SPR helps you associate the adjudication with the appropriate claims or line items. The ERA or SPR reports the reason for each adjustment, and the value of each adjustment. Three sets of codes may be used:

- **Claim Adjustment Group Code** – assigns financial responsibility for the unpaid portion of the claim to the provider or the patient
- **Claim Adjustment Reason Code** – provides an overall explanation for the financial adjustment
- **Remittance Advice Remark Code** – may provide a more specific explanation for the financial adjustment

Know your options

A denied claim isn't the final word. For Medicare denials, you may resubmit the claim to CMS for redetermination or reconsideration. Commercial insurers have an internal appeal process.

Most insurers have multiple levels of internal appeals, external review, and a grievance process if you disagree with the outcome after you've exhausted the internal appeals process. Medicare denials can ultimately be appealed through the federal court system. For commercial insurers, grievances can be taken to your state insurance commission.

TIPS

Track and share denial information

As you review denials month-over-month, you may be able to identify patterns. Track denial volume, root causes, and appeal success rates.

Update your rules engine to mitigate future denials

If a high percentage of your denials are related to the same error or omission, you can use preprogrammed rules to avoid that error. Select an EHR and PM solution that allows you to update the rules engine, so you can avoid recurring denials.

Determine if a claim is processable

When a Medicare claim contains incomplete or invalid information, CMS may return it as "unprocessable." You must correct the claim and resubmit it—generally within one year of service. There are no appeal rights on claims deemed unprocessable and not followed up on by this deadline. Note that deadlines for appealing a claim after a denial are a different matter altogether.

Make sure providers are identified as in-network by payers

Make sure each provider affiliated with your practice is properly credentialed and connected to the appropriate group for billing purposes, especially if your practice contracts out some professional services. Identification of the physician as out-of-network is a common cause of denials.

A national provider identifier (NPI) number is a unique 10-digit identification number issued by CMS to healthcare providers. The NPI is a required physician identifier for Medicare services and commercial healthcare insurers. Each individual physician has their own NPI. In addition, every group practice has its own NPI. Out-of-network denials may result if NPI and tax ID information is mismatched.

REPORTING AND ANALYTICS

Monitor the health of your practice

Accurate, timely reporting and analytics need to be formatted consistently. A strong foundation in data can help you:

- Measure practice financial performance, manage cost, and improve revenue
- Improve administrative efficiency and quality of care
- Mitigate the risk of revenue loss
- Analyze the effectiveness of claims management and evaluate AR

Reporting features should be built into your PM solution and should offer both ad hoc and automated reports.

Key reports

Timely reports give you a complete view of your revenue cycle. Use reporting to improve processes, spot trends, achieve key performance indicators (KPIs), and identify issues that may hinder revenue collection. Examples of revenue cycle reports:

- **Monthly changes in AR** – provides information on beginning aging totals, charges, payments, adjustments, and ending aging totals
- **Insurance aging less credits** – shows all open insurance balances without any credits (overpayments); also associates balances with their respective financial class—for example, Medicare, Medicaid, Blue Cross Blue Shield, UnitedHealthcare, Cigna, or other commercial payer
- **Patient aging less credits** – this report shows all open patient balances, minus any overpayments
- **Bad debt AR** – outstanding patient balances that have been referred to collections
- **Receivables analysis** – identifies accounts receivables according to category—insurance, patient, and credits
- **Charges by financial class** – identifies the amount of charges sent to Medicare, Medicaid, Blue Cross or other commercial payer; provides information on where charges are sent for processing
- **Payments by financial class and date of service** – shows how quickly you receive payments from major payers after charges have been submitted
- **Service item summary** – services billed, organized by CPT code
- **Denials by reason code** – provides details on reasons for denial according to payer
- **Standard monthly reports** – any other reports that the board, practice management, clinical management, or other departments may need for monthly review and tracking

TIPS

Run reports on a regular schedule

Establish a schedule to run daily, weekly, and monthly reports to see financial trends. This will help establish KPIs and meet long-term financial goals.

- **Daily reports** may include a reconciliation of claims generated and submitted.
- **Weekly reports** may include a review of RCM system and clearinghouse edits, AR aging, and denial management activities.
- **Monthly reports** include charges, payments, and adjustments; AR balance trends; gross collection rates; and provider productivity.

BETTER STARTS HERE.

Contact us at 855-510-6398 or results@nextgen.com.

Optimize your revenue cycle with a trusted advisor

NextGen Healthcare offers many options for assistance with medical billing and practice management. We can help you manage claims and payment posting with revenue cycle technology and client services. You earned the money—now optimize collections with a faster, more efficient revenue cycle.

1 Health Care: Resolving Billing Problems and Claim Denials, United Policyholders, 2020, https://www.uphelp.org/pubs/health-care-resolving-billing-problems-and-claim-denials. **2** "How to Maximize Revenue with Improved Claims Denials Management," Rev Cycle Intelligence, November 4, 2016. https://revcycleintelligence.com/features/how-to-maximize-revenue-with-improved-claims-denials-management. **3** Jacqueline LaPointe, "Exploring the Fundamentals of Medical Billing and Coding," Rev Cycle Intelligence, June 15, 2018, https://revcycleintelligence.com/features/exploring-the-fundamentals-of-medical-billing-and-coding. **4** P.J. Cloud-Moulds, "Medical Payers' Timely Filing Deadlines," MJH Life Sciences Physicians Practice, January 17, 2015, https://www.physicianspractice.com/blog/medical-payers-timely-filing-deadlines.

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