

Medical Billing Matters

By Andrea Barrett's always the smallest things that seem to make the biggest difference. The small things that matter for your practice could be costing you thousands. It is important that you have a sound process in place for your complete medical billing process. This process should include steps that start before the patient gets to your office, all the steps in between, to the time the patient checks out of your office. A few steps before and in between that you may think are small; really do matter are:

Your Encounter Form: Is your encounter form up to date?

Patient Registration: Are you verifying your patient's information properly?

Insurance Verification: Are you verifying your patient's Benefits and Eligibility correctly?

As a provider, you may think all I have to do is see the patient make a check and a circle and I am done. If only it were that simple. As a business owner, your practice will only succeed with a sound medical billing process in place allowing you to have a check and balance system to monitor your productivity and your cash flow. If your Encounter Form is not up to date then all of your checks and circles are decreasing your bottom line and not increasing it. CPT and diagnosis codes are added, deleted and revised every year. Make sure that your encounter form is reviewed annually to reflect any changes made. Staying on top of the current changes each year will make a difference in your practice's bottom line, eliminating denials for an invalid code. If you are not verifying your patient's information properly it is costing your practice time and money. Patient Registration should start at the point the patient calls for an appointment. Whether they are a new or established patient, all of the patient's demographic and insurance information should be verified for accuracy and any changes that need to be updated. One of the most common medical billing denials is registration related issues. It could be as simple as two numbers composed incorrectly for a patient's insurance identification number or date of birth; the claim will deny and need to be re-submitted. Therefore costing your practice an unnecessary delay in payment and valuable time spent correcting a claim with preventable errors. Insurance Verification should be done for each appointment to check the patient's benefits and eligibility. This is especially critical for mental health practices. Many insurance carriers carve out the mental health benefits of a patient's plan to a separate division. It is important to contact the appropriate division for the patient's mental health benefits for any pre-certifications, authorizations, referrals and/or treatment plans prior to the patient's appointment. No authorization is one of the most common medical billing denials for mental health practices. Not obtaining the authorization prior to the patient's appointment will cause more work on the back end. The insurance company may request notes with an explanation to try to obtain a retro authorization number for the visit. This may be difficult to get. Implementing a tracking system for authorizations is an essential tool. Documenting the number of visits authorized in your billing system will also flag the scheduler letting them know how many authorized visits are left before a treatment plan or a new authorization is required for any additional visits needed. Make your medical billing process a priority! Implement a sound process for your encounter form audits, patient registration and insurance verification and you will see your practice maximize your reimbursements and increase your bottom line for 2009!