

Medical Office Workflow

We all know that successful claims reimbursement is increasingly challenging with payers becoming more detail-oriented in their focus to ensure that every aspect of the claim filing process is completed exactly as the payers require.

In this white paper, we will offer pointers which may help you tightly organize your office procedures to reduce the opportunities for payers to deny your claims. By outlining these processes, we hope to help you increase your reimbursement and improve your cash flow by putting steps in place to achieve maximum reimbursement the first time each claim is filed.

Step 1: New Patient Check List

When scheduling a patient for their first visit to your practice, you should advise them of what they need to bring to help ensure a smooth registration process and to assist your physician in making that first visit as thorough as possible.

Follow this check list as a guide:

- ✓ Picture identification and current insurance card(s)
Hint: Once provided with this information, you need to verify insurance coverage and benefits. This is the optimum time to collect copayments from the patient.
- ✓ Contact information for emergency contact and/or healthcare surrogate
Hint: Make sure the patient indicates the name(s) of any authorized persons on your HIPAA notification form.
- ✓ Contact information for all current healthcare providers
Hint: Please have the patient add to the HIPAA form, the names of any physicians they would like your physician to communicate with or share their medical records.
- ✓ Copies of any applicable medical records and recent diagnostic testing results
Hint: If you are handed records that are the patient's only copy, make your own copy and return the "originals" to the patient. They may need them for another provider. X-rays or radiology "films" stored on computer discs, should be logged in the patient's record if they are left behind after the visit.
- ✓ Complete list of current medications, both prescription and over the counter.
Hint: Adding the pharmacy name and phone/fax number into the patient chart facilitates issuing any required prescriptions.



Step 2: Verify Patient Insurance Coverage

For successful claims processing and payment, it all starts with the proper verification of each patient's insurance coverage and benefits.

Follow the guide below to ensure you are gathering all the necessary information to create a complete and accurate patient benefit profile.



Basic information needed before contacting the insurance company:

1. First and last name of patient and the subscriber (if other than the patient)
2. Patient's date of birth
3. Policy number as shown on the insurance card



(The insurance card is one piece of essential information your patient should bring on their first visit. Please see this [New Patient Checklist](#) other important documents, etc.)

4. Diagnosis or chief complaint
5. CPT codes for anticipated procedures



Ask these questions to build your patient benefit profile:

1. What are the effective dates of the current policy?
2. Are there any pre-existing conditions limitations?
3. What are the benefits for the anticipated service?
 - a. Does a deductible apply (see b) or only a copayment (see d)?
 - b. If there is a deductible, how much is the deductible and how much is met?
 - c. After the deductible, what is the co-insurance amount?
 - d. How much is the copayment?
 - e. What is the annual out of pocket maximum and how much is met?
 - f. Do the deductible and copayments apply toward meeting the out of pocket maximum?

4. Does this policy require any type of authorization of the anticipated service(s)? If yes, make sure to obtain the proper contact information for that internal department or outside agency.
5. Is there an annual, lifetime or per illness/diagnosis maximum benefit? If so, how much has been met?



If some of the above terms seem confusing, refer to the table below for helpful explanations.

Q:	A:
Pre-existing Condition	Most often occurs with a lapse of insurance coverage. The new insurer can refuse to cover a condition that was diagnosed before the effective date of the policy.
Deductible	Amount the subscriber is responsible to pay before insurance will pay their portion.
Copayment	A flat rate assigned to specific procedures that the subscriber is required to pay. Most commonly to office visits and outpatient diagnostic procedures.
Coinsurance	The percentage of the charge that is the subscriber's responsibility. Refers to benefits like "80/20", the insurance pays 80%, the patient pays 20%.
Out of pocket Maximum	This is the total patient's out of pocket financial responsibility designated by the payer. Once the subscriber has met this amount, services then become covered at 100% by the payer.
Benefit Maximum	This is the monetary payment limit set on the subscriber's policy. Once this maximum is reached the payer has no more financial liability and the subscriber must pay for the rendered services.

Iridium Suite medical billing software from **Medical Business Systems** has an integrated insurance **Real Time Eligibility** function that can do most of this work for you. See how Iridium Suite can help you "work smarter not harder".

Step 3: Obtain Proper Authorizations, When Required

During your insurance verification process, you became aware that one or more of the services you will be either providing or ordering for your patient require an authorization.



For a guide on Proper Insurance Verification follow this link: xxxxxxxxx.

If you have no current method in place for obtaining authorizations, use the following suggestions to create your office process.



- 1 Gather all pertinent patient information: name, date of birth, insurance policy number and contact information for the **authorizing entity**.



The **authorizing entity** can be the insurance company, but more and more frequently payers are contracting out to third party organizations to perform this function.

- 2 Obtain the following data: accurate diagnosis including the ICD9 or 10 code, copies of related medical records, the history and physical report from your physician, and the procedure(s) ordered with the appropriate CPT code(s).



Because you will need accurate medical data on your patient and in some cases actual office notes to provide to the authorizing entity, your hands may be tied in regards to the speed in which the authorization can be obtained. For this reason, it is always helpful when possible to schedule the services enough into the future as to allow for processing time.

- 3 Now that you have the basics you are ready to begin the authorization process. Follow the guidelines indicated by the authorizing entity to complete your authorization request. This can vary from phoned in requests, to online or faxed submissions. Make sure to complete any forms as accurately and thoroughly as possible.



It is helpful to compile a file on authorization processes for each authorizing entity you encounter. This allows you to have the information readily available again and again.

- 4 Now you wait. With online submissions, you may have your authorization within seconds or minutes. Other authorizing entities may take 24-48 business hours as their standard turn around. You may even on occasion experience a week or more time between the request and the response.



If you fail to get a response in the time specified by the entity, do not wait idly by. Call or email as follow up. You may discover the request was incomplete so you are

able to provide the additional needed information. Unfortunately, sometimes it is just floundering around on someone's desk and you have to make sure it is brought to their attention.

5 Once you have received your authorization make sure to pass it on to the appropriate party: the billing staff in your office for an in office procedure, the hospital or outpatient facility, or the diagnostic center.



You are . Hopefully we have taken some of the mystery out of obtaining authorizations for your patients.

Step 4: Collecting Your Charges and Filing Claims

By properly registering your patient and verifying their benefits, you have laid the groundwork for correct claims reimbursement.



You now need to establish a reliable process for collecting charge date and filing claims. One of the best ways to accomplish this is to utilize your Practice Schedule. You will want to verify you have received a charge slip or “superbill” for each patient that has been marked as seen on your schedule.



Integrating multiple systems can enhance your work environment and improve efficiency. A **billing and coding software** that is able to directly import charge data from your EHR will eliminate the need for manual charge entry from “superbills”.



Iridium Suite **medical billing software** now comes with the [Connectivity Clearinghouse](#) enabling connections to multiple EHR systems.



To prevent denials and receive proper reimbursement:

- Be aware of any services/procedures you provide that may conflict with others or be bundled together according to **NCCI (National Correct Coding Initiative) edits**.



[Iridium Suite](#) features a built-in **claim scrubber** that has many capabilities, so a biller can be confident that coding violations will be caught before the claim is generated.

- Stay informed of your commercial payers' Medical Policies and government payers Coverage Guideline.



These two articles can provide more detailed guidelines on payer's policies: [Reviewing Commercial Carriers Medical Policies/Clinical Guidelines](#) and [Understanding Medicare Fiscal Intermediaries](#).

Now that you have entered your "clean claims", it is time to get them off to the payer. Filing your claims can be done:



via paper on the standard HCFA-1500 claim form, or sent electronically.



Sending claims electronically utilizes **Electronic data interchange (EDI)**. EDI is the structured transmission of data between organizations by electronic means. Claims are batched in the **medical billing software**, and then transmitted in an electronic format directly to the payer or to a clearinghouse.



Iridium Suite utilizes EDI to improve your claims processing in the following ways:

- Ability to track the [Electronic Claims](#) from receipt by the clearinghouse to the acknowledgement and acceptance by the payer.
- Electronic claims are pre-screened for certain errors with notices being sent back to the medical practice within days for quick correction and resubmittal.
- Due to their formatting, electronic claims are much more quickly processed by the payer, reducing the wait for reimbursement in some cases from weeks to days.

Step 5: Payment Posting

Once your charges have made it out the door, you should expect to see payer responses in as little as 5 days for electronic claims transactions and 3 weeks for paper claims. You may receive these responses

electronically, which is commonly referred to as an Electronic Remittance Advice (ERA) or on paper. The appropriate payments can also be received electronically via Electronic Funds Transfer (EFT) or by paper check.



[Iridium Suite Practice Management software](#) imports the ERA and often can adjudicate the payments automatically in the indicated patient's account.



Information regarding denials is attached to the designated services with complete details allowing medical office staff to research and choose the best action in order to resolve the denial with the payer.



[Click here](#) to get the white paper “Understanding Explanation of Benefits Statements.”

Whether or not your medical billing software has the ability to automatically post your ERA's, you will need to have a full understanding of the terminology used on any format of payer remittance. The “Amount Paid” column is of course the most self-explanatory; it is the details that accompany the non-payment amounts that are much trickier to navigate.



The explanations for non-payment amounts are indicated by using a combination of the **Claim Adjustment Group Code** (two alpha characters) and a **Claim Adjustment Reason Code** that can be numeric or alpha-numeric. There are 5 **Claim Adjustment Group Codes**:

- CO** Contractual Obligation – most commonly refers to un-allowed amounts based on the payer's contractual fee schedule amount.
- CR** Corrections and Reversal – used to indicate a reprocessing of a claim that was overturned on appeal or denying a previously approved service
- OA** Other Adjustment – default code used when others may not be applicable
- PI** Payer Initiated Reductions – may reflect a penalty imposed by the payer
- PR** Patient Responsibility - typically applies to amounts for deductible, copayments and coinsurance per patient policy



For more details on Claim Adjustment Group Codes follow this link:
<http://www.iridiumsuite.com/mbs-blog/what-are-eob-claim-adjustment-group-codes>

Claim Adjustment Reason Codes range from 1 to W2 and help to define the adjustment, by communicating why a claim or service line was paid differently than it was billed.



For a complete list of claim adjustment reason codes, visit Washington Publishing Company's website by [clicking here](#).

Now that you understand the terminology, you can begin to post your remittance:

As you match on the service date and procedure, you will enter the appropriate indicated amounts for payments, contractual write off amounts, and patient responsibility. The patient responsibilities, such as co-pays, co-insurance and deductibles, are allocated to the next responsible financial party; this may be the patient or another insurance company.



Once you have completed entering the data for the service line, the remaining balance should be \$0 for the payer you are processing. Any allowed amount, but not paid, would now be showing as the responsibility of another party, either patient or an additional payer.



Identify a **DENIAL** by a \$0 allowed amount. You should never assume without verification that a \$0 allowed amount has been processed correctly by the payer. Carefully review the adjustment code against payer payment policies, NCCI edits, your billing records for the account and the patient's medical record. Only when you are convinced the service has been denied appropriately should you accept this write-off amount.

Step 6: Aggressively Work your Accounts Receivables

If you followed the advice given in the previous articles, you have properly identified the patient benefits, obtained the necessary authorizations, and carefully produced clean claims. If you missed the blogs discussing these important steps, follow these links: [Step 2](#), [Step 3](#), [Step 4 links](#)



Each one of these steps is an integral part of keeping a "young" Accounts Receivables (ARs) balance. They ensure the quickest turn-around time for your claim payments which keeps your cash flow smooth and predictable.

You may wonder why I use the reference "young" when speaking of ARs. One of the most common ways to evaluate your practice cash flow situation is by analyzing the open balances by their aging. The aging is most often broken down into "buckets" of 30 day increments: 0-30 days, 31-60 days, 61-90 days, 91-120 days, 121-150 days and 151 days and over. As the aging increases, the balances should decrease with the highest amounts, hopefully, always in the 0-60 days' categories.



An optimum strategy for keeping your ARs the most current involves two main tasks:



Reviewing all rejected/denied claims **as soon as received**. In the case of electronic transactions, claims that contain bad data are pre-screened at the claims clearinghouse and are often seen back in your **practice management** software within 24 hours for quick correction and resubmittal. Electronic claims that pass on to the payer can be processed within just a few days by receiving an ERA right into your **medical billing system**.



[Iridium Suite Practice Management software](#) optimizes the advantages of electronic claims responses and remittances with unique warning system. The user will see visual alerts when claims have been rejected or an ERA contains a denial. These tools assist office staff to be continually aware of situations that negatively affect your Accounts Receivables.



Regular monitoring of all claims dated over 61 days for activity by office staff or payer. Whether you have just had no payer response or you are waiting on a reply to some type of re-submittal, you must evaluate your aging Accounts Receivables for proper activity. For instance, a claim sent with records for appeal should prompt a call to the payer at least every 4 to 6 weeks for a status update.



[Iridium Suite Practice Management software](#) is designed for paperless AR follow up with an entire module in the software dedicated to sorting and prioritizing your ARs the way you like to see them. Specific payers or issues can be divided up and assigned to individual office staff allowing for tracking of progress and positive resolutions.

The best plan for an efficient and productive medical office is to have a workflow process in place. Hopefully you can implement the recommendations from this 6 part series to help you and your staff to create an office environment where each person can fulfill their duties with ease and confidence.