Intro to Revenue Cycle Management

Presented by Rebecca Lamb, PedsOne Billing Specialist

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PRESENTATION AGENDA

1. Front Desk Team
2. Clinical Team
3. Billing Team

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TIMELY REIMBURSEMENT STARTS **LONG BEFORE** A CLAIM GOES OUT

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BILLERS HAVE MANY NEEDS...

Train the Front Desk to **scan** insurance cards into the patient chart, **verify** eligibility and **update** demographics at each visit.

Ensure Providers have charges ready to **bill within 48 hours** of time of service. Waiting to post creates unpredictable revenue and can affect timely filing.

The billing team should be expected to **drop claims within 72 hours** of time of service.

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UTILIZING YOUR FRONT DESK

Scan the front **AND** back of patient's insurance card.

Eligibility is one of the biggest denial reasons! Verify, verify, verify.

Correct plan begin and term dates increase efficiency.

Enter the correct subscriber's name & DOB. With 2 plans, this is essential.

Knowing if your office is "in-network" is the **family's** responsibility- encourage verification.

WHAT ELSE CAN PROVIDERS DO ASIDE FROM HAVING CHARTS READY TO BILL WITHIN 48 HOURS OF TOS?

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UNPOSTABLE CHARGES SPREADSHEET

PCC#	LAST NAME	DOCTOR	TYPE OF VISIT	REASON FOR NOT POSTING
12345	SMITH	JONES	WELL VISIT	NOT SIGNED BY PROVIDER
67890	WILLIAMS	JONES	SICK VISIT	MISSING SICK E&M CODE
51426	DOE	JOHN	SICK VISIT	MISSING INSURANCE CARD IN PATIENT CHART
21563	SMITH	MARY	WELL VISIT	MEMBER ID# NOT FOUND WITH PAYER; NO INSURANCE CARD
45124	SMITH	WILL	SICK VISIT	CHARGES INCLUDE A LEVEL 3 AND 4, NEED TO CHOOSE ONE
13452	GREEN	MIKE	WELL VISIT	NEW INSURANCE ADD TO CHART, BUT OLD PLAN WAS NOT TERMED
44112	WALLACE	MIKE	SICK VISIT	DX CODE NEEDED

BILLING SICK VISITS WITH A WELL

1. Significant – Would the presenting problem have required a separate encounter?

2. Separately Identifiable – Did the E/M service require the key components: history, exam and medical decision-making, or considerable counseling or coordinating care time?

3. Documentation – Is there *additional documentation* for the E/M service?

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PRIMARY DX DENIALS

External Cause Codes

- Primary Dx needs to be a symptom.
- Fall from bicycle (code laceration BEFORE coding bicycle fall).
- Same is true for coding auto accidents.

Asthma as primary

E/M code only needs the asthma Dx; some payers will deny the E/M if "wheezing" is the secondary Dx behind Asthma.

Other primary codes that may cause denials

- Common Cold
- RSV
- Strep
- Feared Complaint
- Follow Up

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BILLING G2211

"The Complexity Code"

CMS created the add on code G2211 to better account for the resource costs associated with visit complexity in primary care.

G2211 is for E/M visits that are part of an ongoing longitudinal care relationship that serves as the continuing focal point for all needed health care services.

G2211 may be billed for new or established patient office E/M Services. Refer to CMS Guidelines for more information.

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COMMUNICATE THE POTENTIAL FOR BALANCES TO PATIENT

Ensure Communication

Managing patient expectations about covered services can mitigate frustration and increase patient satisfaction.

Increase Understanding

Create a flier for parents explaining what constitutes billing a well with sick to reduce misunderstandings. G2211 code can go to deductible too

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ENROLL IN EFT AND ERA

Paper checks and EOBs, and Virtual Credit Card payments all slow reimbursements.

Corresponding denials are further delayed by relying on these forms of payment.

Ask the practice manager to complete EFT applications where possible.

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SAMPLE AGING REPORT

Insurance Group	Current	30-59 Days	60-89 Days	90-119 Days	120+ Days	Total	% of Total	% > 60 Days	60 Day Variance
Personal	35,607	10,055	8,631	3,223	11,965	69,481	38%	34%	**44%**
Amerigroup MCD	13,349	1,217	0	450	0	15,016	8%	3%	-84%
Medicaid	5,940	100	100	80	0	11,273	6%	2%	-82%
PeachState MCD	24,714	200	50	0	340	27,919	15%	1%	-63%
Aging Total ($)	**79,610**	**11,572**	**8,781**	**3,753**	**12,305**	**123,689**	**68%**	**20%**	**-13%**

Goal & Summary	Benchmarks	Total %	Insurance-Only %	Insurance-Only $
Current	> 77%	44%	24%	$44,003
30-59 Days	< 11%	6%	1%	$1,517
60-89 Days	< 6%	5%	0%	$150
90-119 Days	< 4%	2%	0%	$530
120+ Days	< 2%	7%	0%	$340
60+ Days	< 12%	14%	1%	$1,020

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EXAMPLE STAFF TASK LIST

Task	Status	Who	Frequency
Charges and Preptags	06/01	John	Daily
Hospital Charges	06/01	John	Daily
Payment Posting (BCBS, Cigna, Tricare)	06/01	John	Daily
Payment Posting (Aetna, UHC, Healthnet)	05/31	Sally	Daily
HCFA Batch and Secondaries	05/31	John	Weekly
Rejection/Error Report	05/26	John	Weekly
Aging Report	05/31	Jessica	Weekly
Ebills	05/28	Sally	Weekly
Zero/Full Pay Report	05/26	Sally	Weekly
A/R for BCBS, Cigna, Tricare	05/01	John	Monthly
A/R for Aetna, UHC, Healthnet	05/27	Sally	Monthly
Past Due Letters	06/01	Sally	Monthly
Underpayment Tracking	05/14	Jessica	Monthly to Quarterly

ENSURE ALL A/R IS BEING WORKED!

Divide work based on team member strengths.

Require approval for all large write-offs.

Know timely filing guidelines and work payers with the shortest limits first.

Use calendar reminders to ensure proper follow-up.

Review A/R regularly to ensure all accounts are being touched.

Set goals and benchmarks for both personal and insurance A/R .

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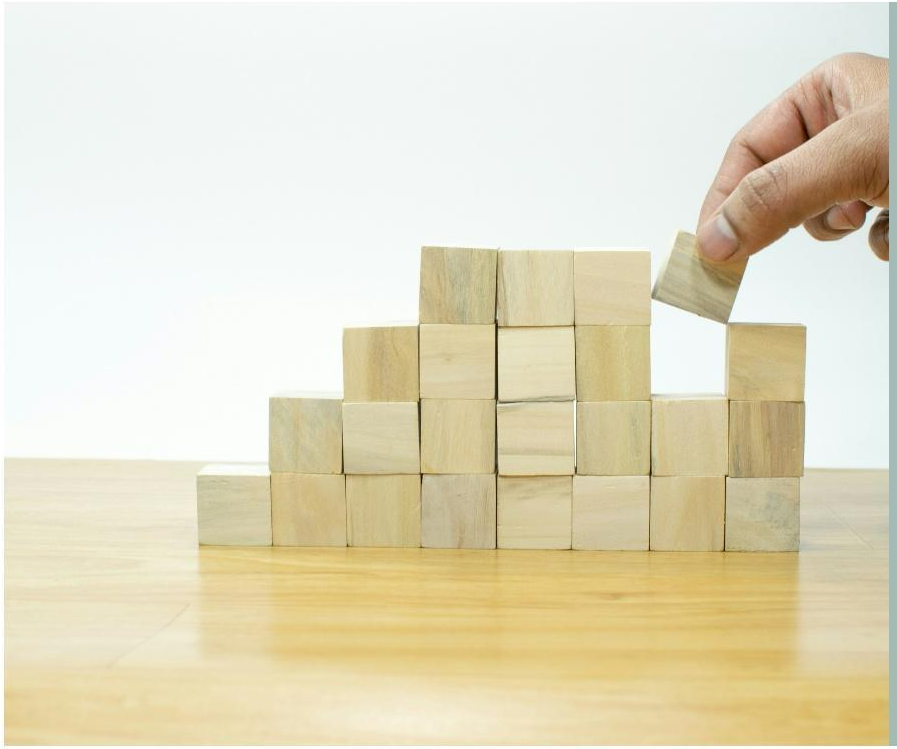
BENCHMARKS



AR/Days **<28**

60+ Insurance Only A/R **<9%**

60+ Total (Pers. and Ins.) A/R **<11%**

Collections % = **95-99%**

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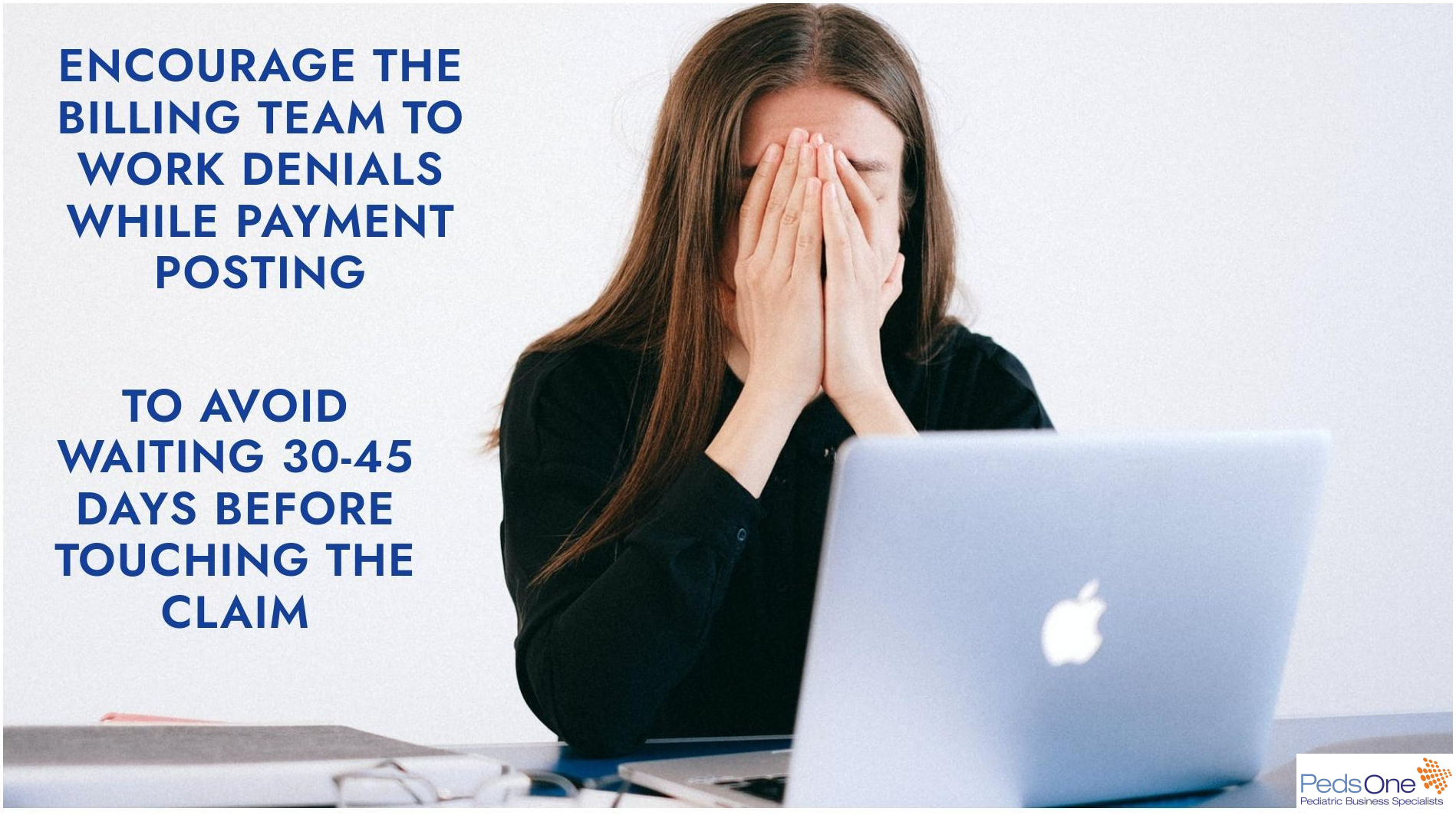
ENCOURAGE THE BILLING TEAM TO WORK DENIALS WHILE PAYMENT POSTING

TO AVOID WAITING 30-45 DAYS BEFORE TOUCHING THE CLAIM



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PROVING OUT

Date	Deposit Amt	Insurance	Check Number	Proved Out	Amount Auto Posted	% Auto Posted	SRS Total	Diff: Takebacks etc	Initials
01/01/24	**$106.15**	**Healthy Blue**	**327323**	✓	**$106.15**	**100%**	**$106.15**	**$0.00**	**jl**
01/01/24	**$108.2**	**UMR**	**CG74623108**	✓	**$0**	**0.00%**	**$108.2**	**$0.00**	**ls**
01/01/24	**$112.87**	**UHC**	**W32449**	✓	**$112.87**	**100.00%**	**$112.87**	**$0.00**	**ls**
01/01/24	**$128.08**	**UMR**	**CB632229**	✓	**$128.08**	**100.00%**	**$128.08**	**$0.00**	**ls**
01/01/24	**$146**	**UHC**	**UH486000**	✓	**$131.08**	**89.76%**	**$146.04**	**$0.00**	**ls**
01/01/24	$147.56	UHC	UH0700015	☐	$0.00	0.00%	$147.56	$0.00	ls
01/01/24	$106.16	UMR	CN56923	☐	$0.00	0.00%	$106.16	$0.00	ls

SAMPLE DENIALS MANAGEMENT REPORT

Transaction Date	Pat ID	Pat Date of Birth	Procedure Code	Responsible Party	Charge Amount	Worked	Notes	Review Date
01/01/23	1001	10/01/10	99394-25	Wellcare	$255	✓		Dec 9th
02/02/23	2001	04/09/09	96160	Wellcare	$25	✓	CC batched changed DX order	Dec 9th
03/06/23	3001	03/17/09	99213-25	Wellcare	$150	✓		Dec 9th
04/07/23	4001	10/01/10	91320-SL	Wellcare	$0.01	☐		
05/09/23	5001	04/09/09	91319-SL	Wellcare	$0.01	☐		
06/10/23	6001	03/17/09	90480	Wellcare	$120	☐		
07/12/23	7001	10/01/10	90658-SL	Wellcare	$0.01	☐		

INSURANCE RULES PER PAYER

Codes	Aetna	BCBS	Cigna	Medicaid	UHC
96160	Submit reconsideration with medical records	Limited to 1 per day	Multiple units on 1 line	Limit of 2 units per day	Not payable
96161	Submit a reconsideration with medical records	Needs 59 mod and dx code Z13.89	Payable with 59 mod	Paid without modifiers	Not currently allowed
96127	Submit reconsideration with medical records	Separate lines; 59 mod on 2nd line and after	Payable with 1 line and multiple units	Pays 2 per day	Separate lines and 59 mod
9940199403	Payable with Dx code Z71.89	Well-check dx code with 25 mod	No special requirement listed	Not on fee schedule	No special requirement listed

INSURANCE INFO AND TIMELY LIMITS

Sample only! This is info is to be used as an example on how to set up your own sheet

Insurance	Website	Phone	Provider Rep	Timely
Aetna	Availity	888-632-3862	N/A	Original claims 90 days from DOS/corrected claims 90 days from date of denial/appeals 6 months from date of last denial
BCBS	Navinet	866-688-2242 IVR	Faye H. (insert email or phone)	180 days for original and corrected from DOS/60 days for appeals from date of denial
Cigna	www.cignaforhcp.com	800-244-6224	Matthew F.	90 from DOS for original/180 days for corrected/appeals
UHC	w.unitedhealthcareonline.c	877-842-3210	Elaine R.	90 days from DOS for original/180 days for corrected or appealed claims from last date of denial
Tricare	www.mytricare.com	844-866-9378	N/A	210 days from DOS/210 days for corrections from DOS/90 day disputes from date of denial

CLAIMS NEVER SUBMITTED

Acct Last Name	Acct First Name	Pat First Name	Transaction Date	Charge Amount	Amount Due	First Billing / Submission Date	Last Billing / Submission Date	Number of Bills / HCFAS Sent	Number of Days since First Billing	Number of Days since Last Billing
Canning	John	Apple	01/01/23	$475	$475			0	Not Yet Sent	Not Yet Sent
Canning	John	Apple	02/02/23	$250	$250			0	Not Yet Sent	Not Yet Sent
Plain	Jane	Pear	03/06/23	$310	$35			0	Not Yet Sent	Not Yet Sent
Gatsby	Jay	Berry	04/07/23	$210	$60			0	Not Yet Sent	Not Yet Sent

ERROR REPORT

Acct Last	Acct First	Pat	Pat First Name	Date of Current Billing Status	Current Billed Message	Transaction Date	Charge Amount	Amount Due
Plain	Jane	10001	John	01/01/23	Payor Rejected Claim #138736: [Pattern 4087] Per CMS guidelines, payment for pr	01/01/22	$210	$210
Plain	Jane	10001	John	02/02/23	Payor Rejected Claim #138736: [Pattern 4087] Per CMS guidelines, payment for pr	02/02/22	$35	$35
Plain	Jane	10001	John	03/06/23	Payor Rejected Claim #138736: [Pattern 4087] Per CMS guidelines, payment for pr	03/06/22	$175	$175
Plain	Jane	10001	John	04/07/23	Payor Rejected Claim #138736: [Pattern 4087] Per CMS guidelines, payment for pr	04/07/22	$60	$60

CLAIMS SUBMITTED OVER X TIMES

Acct:	3223										
Responsible Party	Transaction Date	Acct Last Name	Pat First Name	Charge Amount	Amount Due	Copay	First Billing / Submission Date	Last Billing/ Submission Date	Number of Bills/ HCFAS Sent	Number of Days since First Billing	Number of Days since Last Billing
Personal	1/1/24	Canning	John	$214.57	$214.57	$0.00	1/15/24	1/30/24	5	187	33
Personal	1/1/24	Canning	John	$29	$29	$0.00	1/15/24	1/30/24	5	187	33
Personal	1/1/24	Canning	John	$60	$60	$0.00	1/15/24	1/30/24	5	187	33
Personal	2/2/24	Canning	John	$200	$200	$0.00	2/15/24	2/28/24	4	179	33

ZERO PAY REPORT

Ins Co Name	Pat	Date of Service	CPT Code	Chg Amount	Ins Pmt	Ins Adj	Y/N	Notes
ABC Insurance	1001	1/1/2023	15853	$45	$0	$45	yes	Pended back to insurance
EFG Insurance	2001	2/2/2023	36415	$20	$0	$20	yes	
EFG Insurance	3001	3/6/2023	36416	$20	$0	$20	yes	
ABC Insurance	4001	4/7/2023	69209-LT	$41.5	$0	$41.5	yes	inclusive to 92567
Medicaid	5001	5/9/2023	81003-QW	$5.5	$0	$5.5	yes	
Medicaid	6001	6/10/2023	81003-QW	$5.5	$0	$5.5	yes	
Main Street Insurance	7001	7/12/2023	94664-59	$46	$0	$46	yes	Inclusive to 94640

FULL PAY REPORT

Ins Co Name	Pat	Date of Service	CPT Code	Chg Amount	Ins Pmt	Ins Adj	Y/N	Notes
ABC Insurance	1001	1/1/2023	91321	$300	$300	$0	yes	Informed PM
ABC Insurance	2001	2/2/2023	91322	$300	$300	$0	yes	Informed PM
EFG Insurance	3001	3/6/2023	92552	$55	$55	$0	yes	Informed PM
ABC Insurance	4001	4/7/2023	90471	$60	$60	$0	yes	Informed PM
EFG Insurance	5001	5/9/2023	99,393	$281.5	$281.5	$0	yes	Informed PM

BECOME PROS AT NAVIGATING PAYER WEBSITES

AND AVOID THE PHONE WHERE POSSIBLE

Sign up for Payer Bulletins

- Learn the latest changes in reimbursement rules.

Learn More about Denials

- Payer websites provide detail about specific denial reasons.

Utilize Online Dispute/Appeal

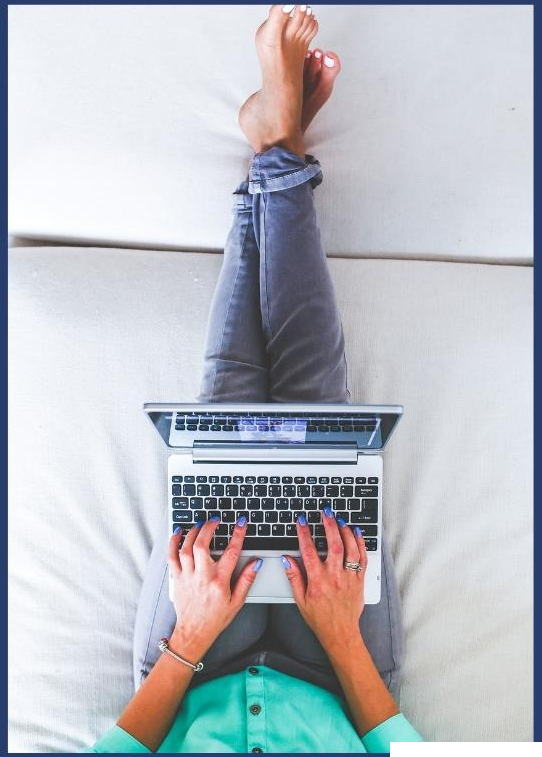
- Many payers offer the ability to dispute or correct a claim online.

Upload Medical Records Online

- When requested, submit them online and keep ref number in the notes.
- Follow up in 30 days.

Upload Proof of TF, Ins Term Dates or Primary EOB

- Can often be uploaded online. Keep ref number and follow up.



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UNITED HEALTHCARE

Claim Reconsideration, Correction, and Appeal

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USEFUL AVAILITY TOOLS

Eligibility

Confirm exact match for name, effective and term dates, as well as “other payer” name and ID# for COB denials.

Payer Chat

Work with claims rep on denials while multi-tasking and avoiding long phone calls.

Remittance Viewer

This feature allows you to find that one EOB for multiple payers that never made it to your office.

Dispute, Appeal, & Secure Messaging

Include a message for the adjuster embedded in the dispute, and uploading useful documentation.

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REGISTER FOR SMALLER PAYER WEBSITES TOO!

Quick Reference for:

- Eligibility
- Claim Status
- Date a Check Cleared and To Whom! (If subscriber was paid, bill the family for the allowable.)

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IF YOU MUST RESORT TO CALLING

Can't Get Past the Automated System? Get LOUDER!

Use the phonetic alphabet for prefixes that sound similar

Language Barrier? Ask for an On-Shore Rep

Note the name of rep and reference number from the call in patient account.

In complex cases, ask for a supervisor. Question Everything. Reps often learn what can be done from you!

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NO CLAIM ON FILE

Don't Just Resend Your Claim if Your System Shows It Went Out!
(Chances are it did!)

Verify Payer ID

- Is the payer ID (and claims address) a match to the patient insurance card?

Subscriber ID

- Is the subscriber ID a match to the patient insurance card?

Name and DOB

- Is the Name/DOB a match?
- Consider calling the payer to find out what they have on file.

If All Else Fails...

- Get a Fax Number for Claims!
- Follow up in 3-5 days to ensure it's been acknowledged.

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TELEMEDICINE CODE CHANGES

2025 Updates

New codes have been established but may not yet be recognized by your payers. Keep checking your state and payer guidelines for updates. Some payers are not yet adopting the new codes.

Telephone only codes have been deleted (99441-99443) and replaced by 98016 for 5-10 minute quick synchronous audio check-in

Document the place of service in patient chart (home or outside of home) for accurate reporting

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TIMELY FILING DENIALS

Know Your Payer's TF Limits

- **In invalid recoupment request that comes long past the TF appeals deadline resets the clock to 30 days from recoupment request date.**
- **Combat TF Denials with Proof of Submission.**
- **New Insurance Information, Past TF? No Problem; Submit proof of original electronic claim submission to wrong Payer.**

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NEWBORN DENIALS

Newborn Auto-Coverage

- Baby's not on the policy & claim denies for DOB.
- Call to confirm whether the policy includes automatic coverage for 31 days; if so, send back for review.

Subscriber Slow to Add Newborn to Policy

- After 30 days, if baby is not added to commercial policy, bill the parent.
- Include a letter explaining how to add baby to the policy to assist these exhausted parents!

And Finally...

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NEVER RESUBMIT A NEWBORN CLAIM OR COB DENIAL ONCE IT'S ACKNOWLEDGED THE FIRST TIME!

A RESUBMITTED CLAIM WILL DENY AS A DUPLICATE!

- Call payer to reprocess or dispute online once newborn added to policy
- Same for COB Denials

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DENIALS FOR PRIMARY EOB

BE RESOURCEFUL! DON'T WAIT ON PARENTS TO RESPOND

Pull eligibility on Payer Website. Often other insurance is listed with ID.

Next, verify elig with the other payer. If active determine which is primary.

With two active insurance, the "birthday rule" for married couples determines primary.

If other plan termed, download proof and dispute the original denial with it.

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OTHER DENIALS WORTH MENTIONING

No Preventative Benefits

- Keep a list of plans with limited benefits at Front Desk as cheat sheet for giving VFC.

PCP Denials

Update software by renaming plans that require PCP so that Front Desk is prompted to remind parent at Check-In of PCP requirement.

Medicaid Plans and PCP Designation

- Don't miss out on PCP designation on medicaid plans which affect your Monthly Capitation Payments.

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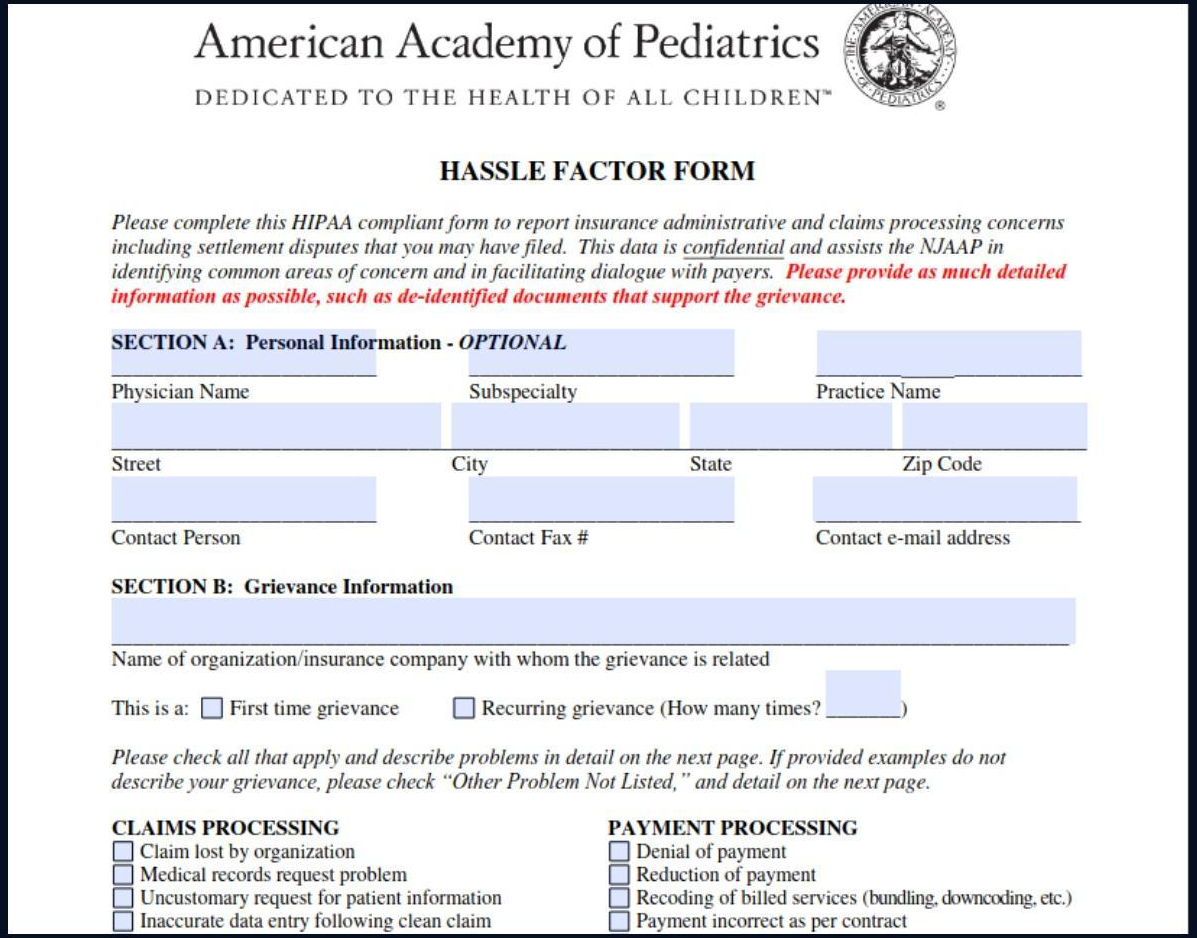

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HASSLE FACTOR FORM

Please complete this HIPAA compliant form to report insurance administrative and claims processing concerns including settlement disputes that you may have filed. This data is confidential and assists the NJAAP in identifying common areas of concern and in facilitating dialogue with payers. ***Please provide as much detailed information as possible, such as de-identified documents that support the grievance.***

SECTION A: Personal Information - *OPTIONAL*

Physician Name _____ Subspecialty _____ Practice Name _____

Street _____ City _____ State _____ Zip Code _____

Contact Person _____ Contact Fax # _____ Contact e-mail address _____

SECTION B: Grievance Information

Name of organization/insurance company with whom the grievance is related _____

This is a: ☐ First time grievance ☐ Recurring grievance (How many times? _____)

Please check all that apply and describe problems in detail on the next page. If provided examples do not describe your grievance, please check "Other Problem Not Listed," and detail on the next page.

CLAIMS PROCESSING

- ☐ Claim lost by organization
- ☐ Medical records request problem
- ☐ Uncustomary request for patient information
- ☐ Inaccurate data entry following clean claim

PAYMENT PROCESSING

- ☐ Denial of payment
- ☐ Reduction of payment
- ☐ Recoding of billed services (bundling, downcoding, etc.)
- ☐ Payment incorrect as per contract

IF ALL ELSE FAILS, WE GET TO HASSLE THE PAYER!!

THERE IS JUSTICE IN THE INSURANCE WORLD…

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A QUICK WORD @

Personal Balances Due...

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DECIDE ON A COLLECTION PROTOCOL

CCOF

Run upon receipt of the EOB or at the 30 day mark to keep your personal balances in check.

TOS Payments

Self Pay at TOS and the Good Faith Estimate. For High Deductible Plans, consider a flat fee to be paid at TOS.

Budget Plans

Decide whether you want these balances paid in 3-6 months and keep a CCOF to run automatically.

Fees

Missed appointment fees and late payment fees. Do they help?

Collections

To send or not to send.

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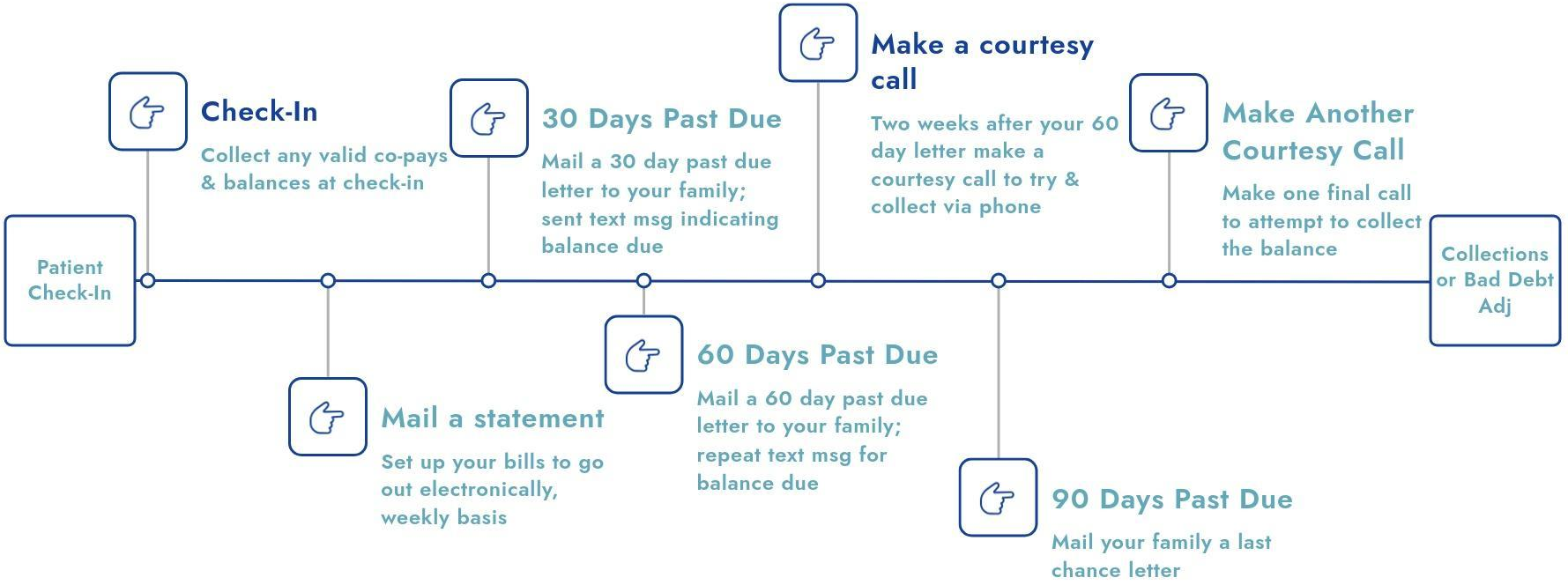

Collecting Patient Balances

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LEVERAGE THE FRONT DESK STAFF

Educate

Provide general understanding of commercial insurance plans with deductible, cost share, and co-pays to help FD staff field basic questions about a bill.

Train

Teach FD to respond to flags/alerts in the EHR.

If there is a balance or insurance information needed, FD can address it at check-in/ scheduling.

Prioritize

Morning is a chance to huddle to run eligibility and an authorization on CCOF before the parent arrives for check-in.

Consider calling to update either to speed check-in.

Plan Ahead

Have FD staff make appointment reminder calls or texts and include information about a balance due.

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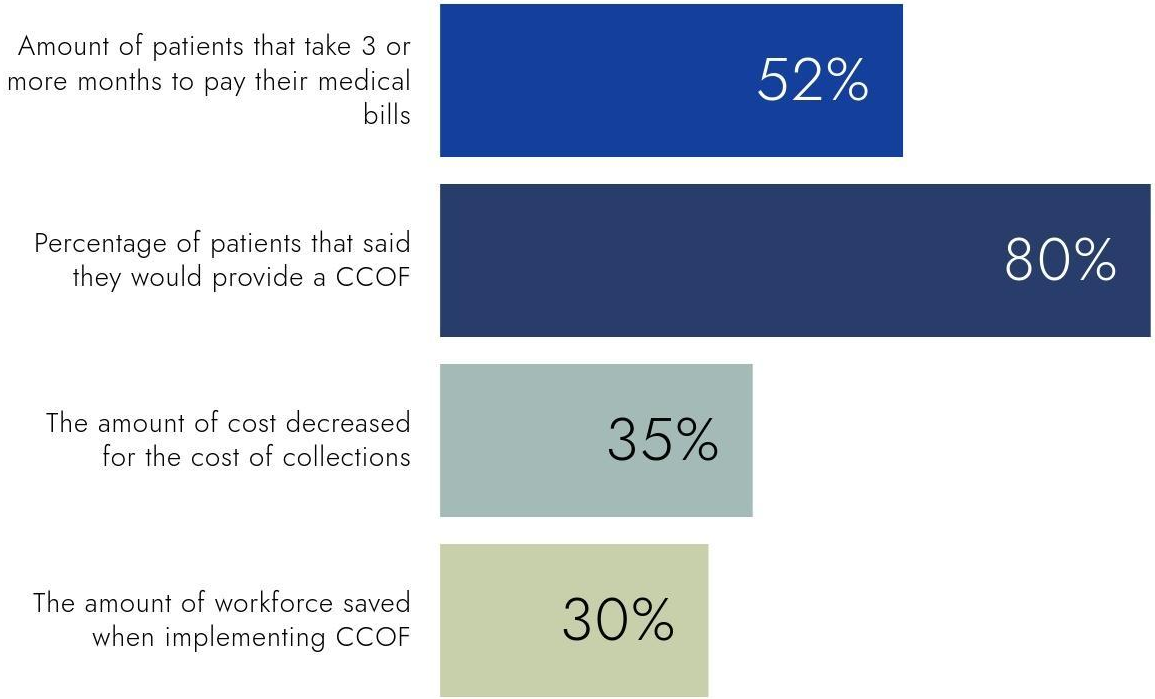
CCOF AND BUDGET PLANS



BUDGET PLANS

Is your staff offering budget plans and how are they being monitored? Do you have a set allowed amount or will you accept anything?

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SAMPLE FINANCIAL POLICY PT. 1

Payments: Payment, in full, is due at the time of service. This includes applicable co-pays, co-insurance and deductible balances. (Practice name) accepts cash, personal check, debit cards, and all major credit cards. _____ (initials)

Self-Pay Accounts: If you do not have insurance, please prepare to pay for the visit in full upon check-out. We offer a discount for all self-pay services paid at TOS. _____ (initials)

Missed Co-Pays: (Practice name) is required by our insurance contracts to collect all co-pays at the time of service. A $25 service fee will be charged in addition to your co-payment, if the co-payment is not paid by the end of that business day. _____ (initials)

Missed appointments: Cancellations are required 24 hours prior to any well visit appointment and two hours prior to any sick visit appointment via phone call to the practice. A "no show" fee of $50 will be applied if an appointment is not cancelled within the stated time frame. _____ (initials)

Outstanding Balances: If you have a personal balance on your account, a monthly statement will be sent. Unless authorized in writing, payment is due upon receipt of statement or within 30 calendar days. _____ (initials)

Payment Plans: (Practice name) understands that full payment may not be possible in certain circumstances. As a courtesy, (practice name) may offer the assigned account holder a payment plan. Payment plans are approved on a case-by-case basis and may be discussed with our management team. Patients
with a payment plan must be in full compliance with all conditions of the agreement at time of visit. Failure to make scheduled payments on the payment plan, or not paying off a balance in full, may result in your account being turned over to a collection agency and your family being dismissed from the practice. _____ (initials)

Collection Accounts: If your account is submitted to a collection agency, all associated fees are the responsibility of the assigned account holder, including a collection fee equal to 50% of the collection balance. The assigned account holder will receive written notification by way of a dismissal letter and given 30 calendar days to find a new health care provider. If your account is sent to collections and then paid in full, the assigned account holder may request the practice to reinstate the account. _____ (initials)

SAMPLE FINANCIAL POLICY PT. 2

Returned checks: A $30 fee will be charged for any checks returned for insufficient funds. _____ (initials)

After Hours/Holiday Care: There is a $40 fee for non-preventative care visits that occur after 5:00 pm (EST), daily, on weekend days and federal holidays. If that fee is not covered by your insurance carrier, the account holder is financially responsible for the charges. _____ (initials)

Insurance: We accept most insurances including most Medicaid plans. Please contact your insurance to verify we are in network with your plan. Bring a copy of your insurance card to every visit. A scanned copy of the assigned account holder's current insurance card and driver's license is required to be kept on file. If you have an HMO insurance plan, please assign one of the physicians in our practice as your child's primary care physician (PCP) prior to your visit. _____ (initials)

Credit Card on File Policy: We require a valid credit card on file in order to avoid late payment fees and streamline the billing process, eliminating the time it takes to collect balances due. The card is stored electronically in encrypted form and cannot be read by staff. Your signature authorizes the card to be used when a balance becomes past due.

Review and consent of this policy is required prior to services rendered

Patient's first name: _____ Last name: _____ Birth date: ____/____/____

My initials above and signature below certifies that have read and consent to the outlined policies and procedures.

_____ _____ Date: ____/____/_____

Signature of parent/guardian **Printed name of parent/guardian**

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WRAPPING UP…

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INSURANCE REIMBURSEMENT ANALYSIS (IRA): VISION SCREENING

From:	01/01/24	To:	06/08/24				
Date	**Procedure**	**Patient**	**Charged**	**Due**	**Ins**	**Pers**	**Adj**
01/02/24	99173-59	Canning, John	$35.00	0	$5.07	0.00	$29.93
02/02/24	99173-60	Plain, Jane	$35.00	0	$5.07	0.00	$29.93
03/02/24	99173-61	Tall, Sarah	$35.00	0	$4.92	0.00	$30.08
04/02/24	99173-62	Potter, Harry	$35.00	0	$3.5		$31.5
05/02/24	99173-63	Weasely, Ronald	$35.00	0	$4.80		$30.20
06/02/24	99173-64	Granger, Hermione	$35.00	0	$5.07		$29.93

INSURANCE REIMBURSEMENT ANALYSIS (IRA): COMPARISON - EXPANDED FOCUS OV

From:	01/01/24	To:	06/08/24				
Date	**Procedure**	**Patient**	**Charged**	**Due**	**Ins**	**Pers**	**Adj**
06/02/24	99213	Canning, John	$199.00	$199.36	$5.07	$0.00	$29.93
05/02/24	99213	Plain, Jane	$199.00	$0	$92.72	$0.00	$106.64
04/02/24	99213	Tall, Sarah	$199.00	$0	$74.94	$50.00	$124.42
03/02/24	99213	Potter, Harry	$179.00	$0	$85.33	$0.00	$94.03
02/02/24	99213	Weasely, Ronald	$179.00	$0	$85.33	$0	$94.03
01/02/24	99213	Granger, Hermione	$179.00	$0	$85.33	$0	$94.03

VACCINE PER PAYER SPREADSHEET

DESCRIPTION	CPT	CHARGE	Aetna	BCBS	Emblem	Cigna	UHC
MenB Bexsero	90620	$325	$195.45	$190	$206.95	$214.76	$240
Hep A Vaqta	90633	$70	$35.16	$36	$37.23	$38.75	$43.65
HPV9	90651	$350	$243.95	$245	$258.3	$268.00	$300
Prevnar 13	90670	$305	$241.38	$213	$228.68	$237.28	$266
Rotavirus	90680	$130	$89.51	$93	$94.78	$98.43	$110.5

NEGATIVE IMPACTS

- Inconsistent A/R Work
- First of the year = deductibles & holiday closures
- Credentialing & enrollment issues
- Flu clinics
- High volume provider on vacation
- Payer edits, new codes not loaded, system errors

REVENUE CYCLE MANAGEMENT BEST PRACTICES

Front Desk

Train your Front Desk staff to complete Eligibility Checks, Update Demographics, and Collect Insurance Card at each visit

Enroll in ERA and EFT

Enroll in ERA and EFT to speed up the opportunity to work denials and limit time spent looking for paper/virtual card payments with their EOBs

Billing within 48 Hours

Providers should have visits ready to bill within 48 hours of Time of Service

Use Goals & Benchmarks

Define an A/R Plan

Pair goals with regular oversight

Implement CCOF

For Prompt collection of personal balances.

Train FD staff to collect balances at Scheduling and/or TOS.

Consider a reasonable PayPlan Policy with CCOF.

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QUESTIONS?

Feel free to email me: rebecca@pedsone.com

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