Billing Best Practices for Audiology

By Christy Farrar

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Whether outsourcing a private practice's insurance billing or keeping it in house, all staff members must be well versed in the life of a claim and the best practices, policies, and procedures that surround it. Lack of this understanding and proper training will result in a frustrating and disjointed approach to billing that is inefficient and time consuming. It could also be one of the main reasons for a practice's accounts receivables to grow and ultimately become unmanageable.

The life of a claim begins at the time a patient first calls the office for an appointment. Besides a practice's providers, the patient care coordinators (PCCs) are the most important part of a private practice. Let me say that again: Besides a practice's providers, the PCCs are the most important part of a private practice! These staff members are the face of the business and often the first impression a patient will have about what they can expect from a practice as far as organization, courteousness, and quality of care. If a private practice owner does not invest in these key employees financially as well as through training and making sure they know they are important and valued, their work will undoubtedly reflect that. The unfortunate result of this is that patients may say, "Thanks but no thanks!" and choose another provider because their first impression of this practice was less than stellar.

COLLECTING & VERIFYING INSURANCE INFORMATION

Once a patient appointment has been scheduled, the staff must collect that patient's insurance information over the phone. This is where a current Insurance Verification Form comes into play. This form will be initially completed with the information given over the phone and then revisited once the staff verifies insurance a little later. However, practices may fail to collect accurate and complete insurance information from patients. Two of the most common reasons for this are that it was not convenient for the patient or the patient did not have the information handy. This information is essential and should also be collected and verified each subsequent year, without fail.

Next come preauthorizations and insurance benefits. Some practices may delay making the appointment until an authorization is obtained, if necessary; however, if your staff decides to make the appointment during the first call, make sure that they communicate to the patient that this appointment will be

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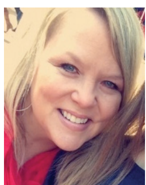
contingent upon obtaining this required approval. "No surprises" should be the mantra between patients, a provider, and the clinic staff. "No surprises" means that a practice's staff has effective communication skills and informs patients about their insurance coverage and patient responsibility throughout the course of their hearing care.

If a practice uses a paper superbill, the PCC, at the start of each day, will have a stack of superbills pre-populated for each provider and for each patient who will be seen that day so they are complete with all pertinent information and ready to go. If electronic superbills are used, processes for that should be in place as well, to alleviate extra administrative work for the provider and ensure that all necessary patient and insurance information is accurate and accounted for. This is vital so that whoever is doing that practice's billing does not have to hunt for this information. Once a patient enters the office, a copy of the front and back of their insurance card(s) and I.D. should be taken along with the other completed intake forms. Insurance policies should be clearly marked as "Primary," "Secondary," or "Tertiary."

The staff should also have the Cost Sharing and Confirmation of Delivery forms at the ready if hearing aids are dispensed. These will be signed before the patient is ever allowed to leave the office with a device. This is also the time when all co-pays will be collected. Providers will often say, "But what do we do if we aren't sure what the patient's co-pay is?" Your staff should have collected that information when they verified the patient's benefits. If you collect $10 or $20 more than what's owed, this is easily remedied by creating a patient credit or issuing a refund check once the claim is processed and reconciled. Collecting funds up front and settling later means far less is outstanding at the end of the day.

Once collected, this information is then uploaded into the patient's chart, so that it is readily accessible to all staff members. Once the patient is seen, all Confirmation of Delivery and Cost Sharing forms should be completed and signed along with any other necessary forms. These should be as



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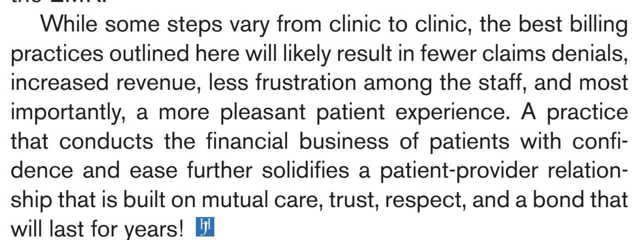
detailed as possible so that, again, there are no surprises regarding patient responsibility once insurance payment has been collected. This also serves as proof that the patient was aware of the patient obligations should he or she decide to complain to their health insurance plan.

PROCESSING BILLS & CLAIMS

The organization of patient superbills in a practice's electronic medical record (EMR) system is critical to ensuring that each patient encounter is filed to insurance and not overlooked. Clear and concise policies and procedures should be created so that each staff member and/or outsourced party knows exactly what their job is. Superbills should be clearly marked as "To be Billed" and ready to be collected at the close of business each day. In addition, they should be marked as "Billed" or "Completed" once they have been sent out to the billing clearinghouse. There should also be a bucket for communicating when additional information is needed by the biller, such as a primary care physician referral or additional medical records. This alleviates clogged email inboxes ("Mrs. Smith is coming in today. Has her claim been filed? Has insurance paid?") and lessens the chance that something is overlooked.

The workflow from here will differ depending on whether a practice outsources its billing or handles it in house. However, the result is the same. Once a claim is paid and posted and the payment deposited, each Explanation of Benefits (EOB) must be entered into the practice's EMR, where payments, write-offs, and patient responsibility are accounted for. It is important to catalog these EOBs by date and in a manner that makes them easily cross-referenced to the patient's date of service and insurance payment listed in that patient's chart, especially since these forms most often contain information on more than one patient. Creating a dummy chart called "Insurance EOBs" works well for this. After that, patient invoices are sent out and tracked, and bank statements can be reconciled against what has been received in the EMR.



While some steps vary from clinic to clinic, the best billing practices outlined here will likely result in fewer claims denials, increased revenue, less frustration among the staff, and most importantly, a more pleasant patient experience. A practice that conducts the financial business of patients with confidence and ease further solidifies a patient-provider relationship that is built on mutual care, trust, respect, and a bond that will last for years!