Learn the Medical Billing Process Step by Step

Description

The medical billing process can be complicated. Converting patient notes to numbered claims may add human error, and insurers may be picky about how claims are prepared for approval. Even if your claims are accepted, insurers rarely pay you right away.

In the face of these problems, the best you can do is create uniform protocols for your claims and reimbursement processes. This step-by-step instruction can assist you.

1. Identify the patient.

When a new patient phones for the first time, your front-office staff will ask questions about the patient’s demographics, health insurance information, and other pertinent background information. The initial medical billing procedure stage is collecting all of this information. Many medical billing manuals indicate that after you’ve gathered the patient’s information, you never have to register them again. Although you do not need to ask previous patients a series of questions at every meeting, you should confirm your most recent records. You may update outdated contact and insurance information this way.

2. Confirm the patient's insurance coverage.

Insurance verification can be pretty straightforward. After gathering the patient's insurance details, call the insurer to validate the information. A patient's insurance card usually includes a phone number you can call to verify the information.

When you reach an insurance representative, please inquire about the patient's coverage and the benefits they receive. Inquire about deductibles and copays to determine how much to charge the patient. In rare circumstances, a patient's insurance plan will not cover all your treatments.

If the patient has secondary insurance, you should contact them to see if they will cover the rest of the amount. Otherwise, you must notify the patient of their financial responsibilities before their consultation. This manner, if your costs exceed their budget, they can cancel.

3. Take meticulous notes during the patient encounter.

For medical coding purposes, you must take notes during or immediately after the patient's visit. Make a list of the treatments, diagnoses, medications, and services you offer. This information should ideally be stored in your electronic medical record system.

4. Provide your medical billing team with your encounter notes.

Once you've finished your encounter notes, transform them into a proper medical script so that others can read them. If you use voice-to-text technologies to record your notes, you'll need to transcribe them before forwarding them to your medical billing staff.

You probably won't have time to handle this, so subcontract the task to your front-office personnel. You can also outsource this work to a medical transcribing service.

If you handle all of your billing in-house, your medical script will be sent to your front-office employees. You'll normally send your script to the billing service if you outsource your medical billing. There are a few exceptions: In our evaluation of athena Collector, an outsourced billing provider, we discovered that you must maintain an in-house medical biller to whom you will send your encounter notes.

5. Create ICD-10 and CPT codes from your medical script.

Your medical scripts will eventually make their way to medical coders. These professionals convert your treatments, diagnoses, medications, and other pertinent data into standardized ICD-10 and CPT codes. Insurers then use these codes to swiftly determine whether they will reimburse your services based on the patient's health plan. These codes, along with your charges and the patient's demographic information, will eventually appear on a medical claim.

Some firms hire in-house coders to work on claims coding full-time. Others use third-party medical billing firms to handle their medical coding needs. This decision frequently necessitates a cost-benefit

analysis. Medical billing and coding are time-consuming and error-prone, yet the percentage of your collections you will spend on outsourced billing can be substantial.

6. Include fees in your medical claims.

Although medical treatments are standardized through codes, payments are not. You must include your charges in your claims. For example, if you charge $300 for primary care appointments, you'll include $300 in your claims alongside the CPT code for primary care visits.

If your patient is responsible for any portion of your services, you must include the amount the insurer will cover alongside your costs. Payers will know how much to remove from their reimbursements, and you will not be paid twice for the same job.

7. Clean up and file your claims.

Errors are familiar with all the codes and numbers that go into claims. You can catch most, if not all, of these problems with claim scrubbers before you file your claims. These automated software systems are aware of the specifics of your claims.

It's time to file your claims after they've been cleansed. If your patients have Medicare or Medicaid, you can usually file your claims with these government payers directly. Direct filing may be easier if you have good relationships with only one to three payers. In all other circumstances, using a clearinghouse is preferable. These third-party businesses will reformat your cleansed claims for the proper payer. You won't have to deal with rejected claims because you filed a lawsuit in one payer's format to another.

8. Monitor payer adjudication.

The adjudication process begins after the payer gets your claim. The payer chooses how much of your claim will be paid and whether your lawsuit will be approved, rejected, or denied during this procedure. Rejections are frequently the result of coding problems rather than a payer's refusal to reimburse you.

Your rejections will frequently include recommendations on how to correct your mistakes. You can immediately refile your claims and (hopefully) be reimbursed if you follow these guidelines. Of course, even if your claims are flawless, insurers may reject them. In this instance, your billing staff should evaluate the payer's decision for potential mistakes, which will often be detailed. If you find any problems, you can start the appeals procedure, which can be costly and time-consuming.

You have two choices if your claim is refused because the insurer does not cover your services. You can notify the patient of the denial and inform them that they now owe you the money that was not reimbursed. Alternatively, if the patient has secondary insurance, you can claim their secondary plan for the uninsured expenditures.

9. Distribute patient statements.

If a non-zero debt occurs from a claim submission for a patient who does not have secondary insurance, you must send the patient a statement outlining their charges. You should also send a benefits explanation explaining what the patient gets and does not get with their insurance plan. This way, they'll understand why, despite having insurance, they still owe you money.

Payment instructions and due dates should be included with your patient statements. You can also offer information on how the patient can file an appeal if they so desire. Denials are frequently managed by medical clinics or their outsourced billing teams, but patients may still wish to file their appeals.

10. Seek payment.

If your claim were authorized, you would seek compensation from the payer. Remember that the wait between claim approval and reimbursement can be lengthy. Proper tracking of your accounts receivable can allow you to identify which claims have gone too long without being paid. You must follow up on these claims until you are paid.

The payment obligation for denied claims is on the patient. Your medical billing team should repeatedly contact the patient until they pay. If the patient continues to fail to pay, you may want to consider referring the patient to a debt-collecting agency.

Category

1. Finance

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