Health Information Compliance Alert

Revenue Booster: Utilize Internal Audits to Nix 2022 Billing Woes

Tip: Use monthly data reports to nip problems in the bud.

With the Omicron variant on the rise, healthcare organizations may need to tighten their belts again this winter. And that's why it's critical that your billing practices are stellar to ensure that you're not leaving money on the table in 2022.

In a recent HEALTHCON session, "How to Perform Internal Billing Audits," instructor **Stephanie Thomas, CPC, CANPC**, shared helpful steps you can follow to ensure you're bringing in maximum revenue warranted by the work performed. For example, you should first know which common problems cause denials, as well as what data you should be pulling in your monthly reports.

Here's how to apply Thomas's insights to your practice.

Step 1: Know Which Problems Cause Denials

When you're performing self-audits, you can work in myriad ways. One method involves reviewing claims before they're submitted, which is how you would catch errors ahead of time, before giving auditors a chance to come after you.

Other practices self-audit claims after reimbursement to find out what was paid and what wasn't, and they learn from their denials. This can include finding mistakes on your end, or on the insurer's end. Some common issues can cause claims denials, according to Thomas. They are as follows:

Eligibility issues: Problems with Medicare Advantage plans are common, according to Thomas. "I probably fix on average 25 of these a day," Thomas said. For example, a patient will come in with two cards, and they think they have both Medicare and Medicare Advantage, but they don't. The front desk might just accept what the patient says and enter the information into the system because they don't want to argue.

Medical organizations need to educate their front desk staff and everyone involved so they don't continue to see those types of problems, since it's important to get claims out the first time, Thomas emphasized.

"We should check the patient's eligibility while they are there so we can deal with those issues up front and face-to-face," Thomas said.

Coding-related denials: Issues include non-covered services or services not deemed medically necessary. Other situations include that a procedure is incidental to the primary service or there is a missing/incomplete/inappropriate/invalid place of service (POS).

Coverage limitations: You should identify the problem, Thomas said. Is this a limited plan that only covers preventive visits? Educate your front desk staff about what to look for.

Step 2: Look at These Issues as Denials

In some cases, a claim won't even make it to your payer's processing system because an error holds it back, Thomas said.

You should treat these instances as a denial and work those claims daily. Some examples of common errors include the following:

PM front-end edits (Also known as scrubbers): These types of claims don't make it out of your software. Your scrubber will clean claims and try to send them to the clearinghouse. Your system should catch mistakes such as identification (ID) numbers that aren't there or ID numbers that don't look right, some simple coding errors, and eligibility errors.

Clearinghouse edits: These types of claims are trying to be pushed to your payer but are stopped at the clearinghouse level. Common problems seen at this level are electronic data exchange (EDI) errors, eligibility errors, and some simple coding errors.

Payer edits: These types of claims make it to the payer but not to their adjudication system. Common mistakes seen here include some eligibility errors, the wrong payer, coding errors, listing the wrong ordering/referring MD or problems with reporting multiple procedures subject to edits (or lacking the correct modifier).

Step 3: Enhance Your Internal Processes Via Denials

You should use denials in your practice to improve your internal processes when you are auditing, Thomas said. You don't want these issues to keep happening.

"If we get denials, we need to work hard and fast," Thomas said. Meet timely deadlines for appeals or corrected claims and remember that the denial time starts when your payer first denies the claim.

Documentation is key, according to Thomas.

"Document. Document. Document," Thomas said. "Anytime you touch a claim, you should document what you did to it."

Whenever you get a status on the claim, review something related to the claim, or talk to a physician about the claim, you should document your actions, according to Thomas.

"If the employee working on the denial was to leave and you had to figure out what was going on with those claims, it is a really hard situation you've put yourself in," Thomas added. "Tell your team and anybody who is touching claims to document what you do because we need to know everything that is being done."

You should also follow up consistently on denied claims, Thomas said. Do this at least every 30 days, if not more frequently, until you are paid.

Step 4: Find Specific Data in Monthly Reports

As an auditor, you should gather specific data monthly and compare it month to month, Thomas said. This data includes the following:

- Patient payments at the time of service: "How many payments are we getting and how can we improve?" Thomas asked. Are they coming in through the portal, in person, or through the mail?
- Payments by insurance: You should break out these payments into primary, secondary, and tertiary, Thomas said. Run a denial report. Is there a trend with certain payer? If so, educate and figure out how to decrease.
- Denials for reason codes (each type): If this isn't possible, you should keep a log somehow, Thomas added.
- Accounts receivable (AR) for patients
- Accounts receivable for insurance

When you audit and compile your monthly data, you should look for the following specific details in those reports, Thomas said:

- Coding and claims submission
- Responses from payers: "We should know what we are doing with the responses," Thomas said. When you areauditing, pull up a claim, even if it is a paid claim, and figure out when you received payment. Then you can look at when you got payment. "When did we post the payment?" Thomas asked. "How long did that process take?"
- AR work: You can pick an old claim and see what's been done. You want to know when the first touch was done on the claim, Thomas said. You also need to know when you heard from your payer and what you did with that information.