The Top 8 Missed Reimbursement Opportunities and How to FIX Them!

Could your medical practice use some improvements, but the money just isn't there? Maybe you have an exam table that has seen better days or your IT software desperately needs an update? It can be frustrating to look at other healthcare organizations that seemingly want for nothing and wonder how they do it. You can drive yourself crazy with questions like:

- *Do they see more patients than we do?* Nope.
- *Have they been in business longer than we have?* Also, no.
- *Are they better practitioners than we are?* Don't even go there!

Then WHAT is going on?! That is the right question and we may have the answers for you. Chances are, you're not getting reimbursed from your healthcare payors at the rates you should be. That means you could be treating just as many patients as your competitors yet bringing in substantially less revenue. The truth is, this is not an uncommon predicament for medical organizations nationwide. The good news is, you don't have to keep settling for less! Let's dive into this deeper.

First of all, it's important to recognize there are few businesses more difficult to manage than a healthcare practice. Whether you run your little hometown doctor's office or an independent medical conglomerate with multiple clinics, reimbursement pitfalls are plentiful. The number of ways you can lose revenue far exceed those intended to generate income. That is why it is so crucial to understand your payor reimbursement information inside and out. Of course, this is no easy task and may feel overwhelming, especially when you are starting from scratch. It's critical to keep in mind that this process is a marathon, so don't try to sprint your way through it. If you are already panicking, not sure where the time will come from to get this done; relax. We'll get to that a little later.

Below are the ten most common ways healthcare practices leave money on the table, in no particular order. They're all pretty bad.

1. **Payor Negotiation Traps:** Prior to seeing any patients, every practice is required to engage in a payor contract negotiation process with commercial insurers, Medicare, and Medicaid. Of course, this takes quite a while and by the time the first offer comes in, most practices are quick to accept. Don't do it!

   Solution: Payors are always going to low-ball the initial offers hoping you don't do your homework, which is why you should never accept the first offer. But, let's back up a moment. Don't even start negotiating without a value proposition prepared to show payors why you deserve fair reimbursement rates. That way they know they're dealing with a provider who has a lot to offer their community. You'll be surprised how much more willing to hear you out they'll be suddenly.

2. **Outdated Fee Schedule:** Without regular updates, the fee schedules you're referencing can be rendered practically useless. That can lead to using the wrong CPT codes for billing and can throw off your accounting records if you are expecting a higher reimbursement than is coming your way. What a nightmare!

   Solution: This can be grueling process but more than worth the effort in the long-run. You can request your payors' current fee schedules if they're missing but rather than just shove them in a file somewhere, look at them. Take the time to review how much each payor is reimbursing you for various services and procedures. The starting goal is to make sure no commercial insurer is compensating you less than Medicare for any one billable service.

3. **Ignored Payout Disparities:** It's no secret that payouts for the same services can vary significantly, especially when comparing Medicaid and a commercial insurer. That said, if you see a major gap between different payor reimbursement rates, you should be proactive and get to bottom of that right away!

   Solution: Just as we noted above, if an insurance company can pay less for a certain treatment or procedure, they will. It isn't personal, it's just numbers. You can combat this disparity by first knowing what the reimbursement rates are for your top billed CPT codes by all your contracted payors. A pattern should emerge and any insurer falling well below the average payout amount should be at the top of your list for future renegotiation deadlines. More on that next!

4. **Missed Termination Deadlines:** When contracting with 50-60 individual insurance payors, it can be difficult to keep track of agreement termination dates. If you're counting on getting notified in advance, don't. Unfavorable amendments can be imposed on an existing contract if you do nothing so…do NOT do that.

   Solution: Being aware of your contract termination deadlines enables you to proactively reach out to payors in advance and puts your practice in a very good negotiating position. It shows that your organization is paying attention and less likely to settle for unfair reimbursement rates. It also gives you the opportunity to reach out to payors on your terms. For example, if you can get their attention during their slow period, they will pay more attention to your requests. Win, Win!

5. **No Payor Matrix in Sight:** You can gather all the payor contract negotiation data mentioned above, but without a method of organization, it cannot help you one bit. The number of people who could commit all this information to memory is fairly low so, it's really best to just create a payor matrix instead. You've got this!

   Solution: Designing a payor matrix will give you a platform for organizing all of your core payout information. This includes a copy of the basic contract, strict reimbursement policies, submission and appeal timelines, current fee schedules and relevant contact information for each payor. An organization tool like this will

become your primary resource for all future payor contracting negotiations, which puts you on the offensive rather than having to launch an avoidable defense.

6. **Poor Denial Management:** Too often, payors deny claims with no follow-up from the healthcare practice who submitted the paperwork. Not only does this lose revenue, but if you don't understand why the claim was denied in the first place, it could happen again, and again, and again. Let's do something else instead!

   Solution: The first step is to organize denied claims by reason and payor. Some insurers routinely deny claims without merit and you will likely notice denial patterns if that's the case. However, if you find that multiple payors are denying claims for similar reasons, someone is probably making a mistake. It could be an insufficient documentation issue, submitting the claim too late, or some other payment policy not being met. It's in your practice's best interest to find out!

7. **Billing for Co-Pays:** Letting patients leave without paying their co-pay upfront is a common mistake and falls under the category of being way too nice. It is a lot of extra work to collect that $20 or $30 dollars after they head home, and more work means more of your hard-earned revenue. But don't worry, you're still nice.

   Solution: This is probably the simplest fix of all. All it requires is a change in policy and a system that allows your front desk staff to receive payments. Otherwise, all the players are already in place. Everyone is required to check-in even if they've been your patient for years, so that's the perfect time to get that co-pay. Sure, implementing any new policy can cause a hiccup or two, but you'll find that most people are happy to get it out of the way too.

8. **Failing to Verify Insurance:** It may seem like 'running a practice 101' but this is a more common problem than you might imagine and results in massive revenue loss each year. Sometimes this is a communication error or just knowing an established patient for many years and forgetting to double-check.

   Solution: Fortunately, this is another easy fix with a basic front desk policy change. Whether it happens at the time the appointment is made or at any point before it begins, someone in your practice should be verifying that the insurance information on file is correct. Further, you need to confirm every patient's eligibility with their insurers before they are seen by your practitioners. As a bonus, it will help you code for procedures more efficiently. Makes sense, right?

About that Time Issue…

We are well aware that practice managers and especially physician or dentist owners do NOT have the time to do all of this. You do have patients to care for after all. While it's true, there are a few in-house administrative actions you can implement pretty easily, others are much more involved. Payor contract negotiations and thorough reimbursement reviews are very specialized work that requires many long hours to get

right. Rather than stressing you and your staff out with a bunch of late nights and overtime, there is a far better option.

We're just going to say it, this is the kind of service you will want to outsource. The return on investment is phenomenal and once you have your payor matrix in place, your administrative staff can keep it going from there. Ultimately, the goal is to create a system of payor contract management that will keep your practice growing, your revenue flowing, and your people happy.

For more information on how to get the reimbursement you deserve, contact Health Professionals Alliance today.