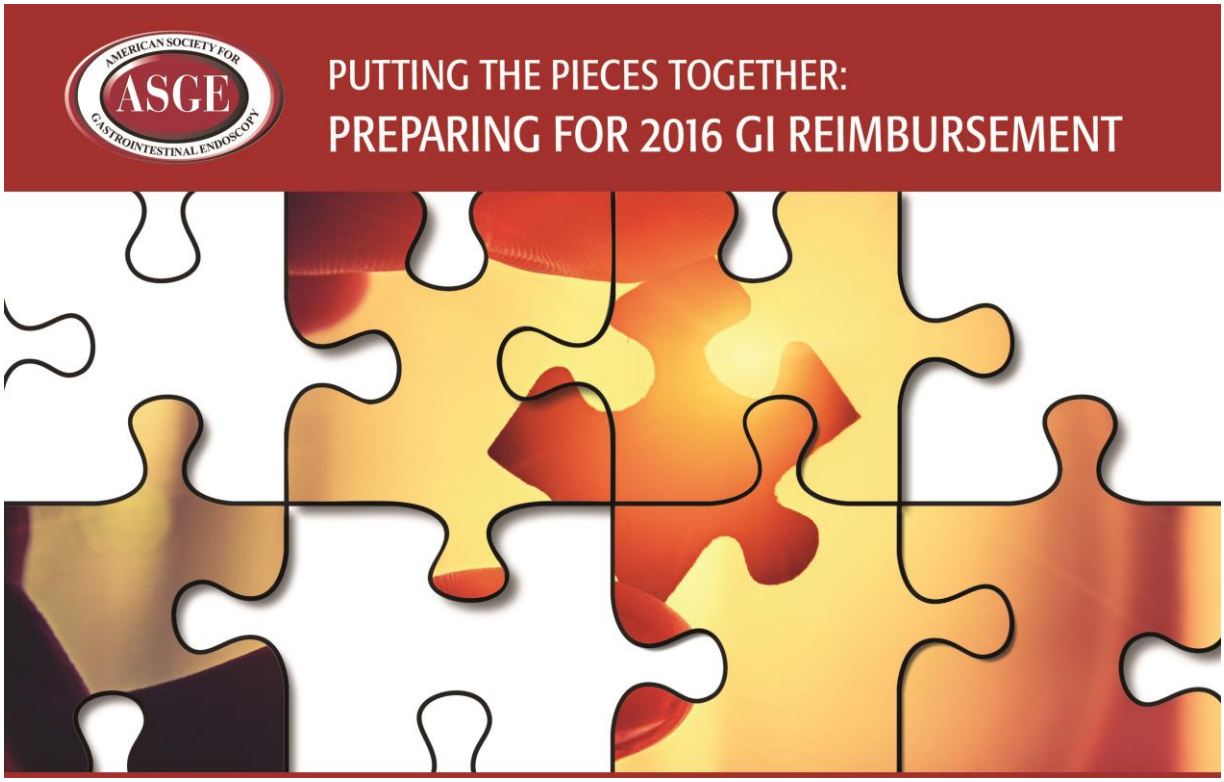

Optimize Your Coding, Billing, and Revenue Cycle Management

Paying close attention to your practice's revenue cycle can be a way to keep your business operationally and fiscally healthy. Just as you monitor the vital signs of your patients, assessing and monitoring key operational aspects of your practice will help you better understand the status of your practice's financial health. Optimizing your coding, billing and revenue cycle management is critical to the business side of your endoscopy practice.

Five Tips to Optimize Your Coding, Billing, and Revenue Cycle Management

1. **Arm your practice with qualified, experienced, and trained billers and coders**
   Your entire GI team, from the front-end staff to the coders and billers, has a role in ensuring that your practice is receiving appropriate reimbursement for the services it provides. Ensure that all the staff in your office is aware of the importance of the revenue cycle. Claims can be denied for errors ranging from incorrect demographic information to incomplete documentation from the physician. Create a culture that recognizes that every member of the team has a role in keeping a well-run revenue management system. The role of coding and billing staff in your practice is critical. On a daily basis, coding and billing staff performance has a direct impact on your revenue cycle. Therefore it is critical that your coding and billing staff has access to educational resources in order to stay current on all payer regulations, coding changes, and other important billing information essential to the success of your practice.

   Resources
   - Attend the ASGE Annual GI Coding Update
     Trifecta

- Purchase the ASGE Coding Primer: A Guide for the GI Practice
  Coding Primer
- ASGE ICD 10 Modules
  ICD-10 GI Coding Modules

2. **Communicate often with your billing and coding team**
   The revenue cycle starts at the time an appointment is scheduled and ends when the patient account is at zero. Billing and coding is not just a back-office function but a whole team effort. Continual communication with the staff that oversees your revenue is necessary so that problems can be resolved in a timely manner. Emphasis should be placed on getting appropriate patient information such as verifying the patient birthdate and the correct insurance information. Be aware of and obtain preauthorization for any visits or procedures before the visit is scheduled. Make sure documentation in the medical record is thorough. Understand reasons for any denials you receive for submitted claims. Each rejected claim can cost up to forty dollars in staff time to resubmit.

   Encourage the staff that is responsible for working and submitting claims to be comfortable seeking clarification or requesting additional information from providers. Track why there are denials. Adopting these best practices will increase the efficiency and success of your revenue cycle management.

3. **Timely attention to denied claims and accounts receivable**
   The number one reason for a denied claim is missing or incorrect information. Claims can be denied because of clerical mistakes or even an illegible provider signature. In order to decrease the number of denials your practice gets, it is important to understand why your claims were denied. Urge your office manager to provide you with a weekly report on denied claims and their reason for denial. This will help you pinpoint the reasons for denial and provide education or counsel to your team on how these denials can be minimized and collections can be improved. Institute and maintain a consistent claim review process and policy. Assigning a staff member to review the status of submitted claims and their payment status on a daily basis is important.

   Don't hesitate to appeal denied claims when it has been determined that it was submitted correctly. Staff should gather the pertinent information that supports the service that was provided and resubmit the claim. Check with your third party payers if you are unsure how to resubmit a denied claim or how to appeal an appropriately billed claim that has been denied without valid reason.

   Resources
   - Medicare forms and information to resubmit or appeal a denied claim
     CMS Forms for Medicare

4. **Capture all of the charges for the services you provide**
   Threats of audits and medical record reviews potentially can tempt you to under-code for your services. According to the Centers for Medicare and Medicaid Services, just as with over-coding, it is improper to under-code for a patient encounter. Documentation of the encounter is key to ensuring the correct level of service is chosen and submitted for payment.

   Another recurring problem in a medical office is when the staff does not receive all of the information on encounters. The provider may have seen a patient outside of the main practice site and failed to give staff the information necessary to enter a charge. Implement a process to capture

patient information and the service rendered so charges can be submitted. Find a way to communicate the information to the billing staff in an easy format. One way to make sure all outside charges have been captured is to ask your office manager to provide you daily with the charges submitted. This will allow you to identify missing visits more readily.

5. **Explore using electronic transactions**
   Using standard electronic transactions can speed up the claim processes and save your practice time and money. Receiving electronic remittance advice (ERA) and electronic funds transfers (EFT) is much faster than using the mail. ERA is an electronic format that provides details about claim payments and claim status from health plans. EFT is an electronic transfer of funds directly to your bank account. It is likely that you already submit your claims electronically through your medical records system, so adding other electronic transactions is the next step to streamline the revenue cycle. Another advantage of using electronic information is that it will reduce the amount of paper in your office.

   Resources
   - **Medicare HIPPA Facts**
     Medicare Billing: 837P and Form CMS-1500 Fact Sheet
   - **Medicare EFT and ERA Information**
     Medicare ERA Information
     EFT information