How Much Inefficient Dental Billing Is Costing You?

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The changing landscape of the Dental Industry is forcing Dentists to be more efficient with the financial aspect of their practice. Healthy cash flow has never been as important as today. This article will explore and demonstrate the loss in revenue that inefficient dental billing is costing a practice and proposes solutions to help the operations get back on track.

The average one provider dental practice operates on $48,000 net production. Out of this production, it is expected, on average, that the insurance will be responsible for 50% reimbursement and 50% is expected to be collected at time of service from patients. Therefore, the plan is that: 1) $24,000 will be submitted to the insurance and 2) $24,000 will be collected from patients at time of service.
Statistics show that 30% ($8,000) of the $24,000, in claims submitted to the insurance, end up unresolved and need to be followed up on. Once investigated, there are usually corrections that take place, more information is submitted, or the claim never made it to the insurance company, is not on file, and needs to be resubmitted.

The team is providing patients with estimates and collecting at time of service. The practice depends on the team to collect the $24,000 owed in patient balances. The practice also depends on the team to manage the $24,000 to the insurance in a timely manner. This means that the practice depends on the team to submit claims daily, to be following up on claims that are unresolved consistently, and collect patient's portion at time of service.

Let's explore closer the impact of the dental billing inefficiency.

Specific daily tasks affect getting paid by insurance. Being in this business, and dealing with this daily, we have discovered the average revenue that should be paid, if the tasks are worked, and average revenue lost, if the same tasks are not worked, as they should be on a daily basis.

1. Daily claims submission and review of the Electronic Remittance Advice (ERA), corrections of errors and claim resubmission. As stated, an average office has a net production of $48,000, based on a 4 day work week, and 50% (out of the $48,000 monthly net) going to insurance ($24,000). Therefore, if the task is worked daily, $24,000 is expected to be coming in as insurance income within 3 weeks of claim submission.

Solution: Batch claims daily, submit the claims at the end of the day, review the electronic remittance advice daily, make corrections immediately, and run your "unsubmitted claims report" weekly to make sure you did not miss any unsubmitted claims.

2. Daily follow up on unresolved claims. 30% of the $ amount that goes to insurance in claims ($24,000) is expected to be hung up due to various reasons, follow up is needed, and the claims need corrections to resolve the claims. Therefore, 30% of $24,000 is $8,000 monthly loss that will not be paid unless someone follows up on claims daily. The follow up on claims handles claim error corrections, resubmissions if not on file, submission of supporting documentation, appeal of denials, and submissions to secondary insurance.

Solution: Print reports weekly, follow up on all new claims that are on the report within that week, write down next follow up date on the report associated with each claim and follow up as needed, work report daily with a goal of touching each claim on the report within that week (maintenance mode). If you have a huge backlog, you will need help (temporary agency or billing service) getting through all the claims the

first time around. Once follow up dates are set, you can follow up as needed. Transfer information gathered about claim status from one report to the next week's report to prevent repeated research on claim status. Follow up on new claims on the report first to prevent the from aging further.

3. Patient Balances are not paid as expected due to unresolved claims. If claims are hung up in claims corrections, the statements are not sent out until the claim resolves, and the office loses money that the patient needs to pay after the claim resolves. Even though patients pay their portion at time of service, we found that:

a. Patient's portion is NOT consistently collected at time of service. We found that on average, 25% of patients portions are not collected at time of service. The main reason for this is lack of established treatment plan financial agreements, lack of effective communication to the patient of the financial agreement with set expectations, or lack of effort to actually collect from the patient due to time constraints and other reasons. That is a loss of $24,000 x 0.25=$6,000 per month.

Solution: Make sure that every patient has a sound financial agreement and treatment plan is clearly phased out into appointments with a $ amount that is due at each visit written on the agreement. Make sure that you review in the "AM huddle" what is to be collected from each patient and that you collect that amount at time of service. Review the next day if something was not collected with the Doctor and why.

b. Patient has a balance after the claim resolves. There will be a patient's portion after the claim resolves if insurance underpays, the estimation provided to the patient was too low, there is a claim denial or rejection based on various reasons including plan clauses, termed insurance, annual maximum reached, or lack of medical necessity. Even the best practices, that utilize the benefits verification information, experience underestimations. We found that 10% of claims have a patient's portion that is still due after the claim resolves. Therefore, $2,400 per month is the additional patient's portion that cannot be collected if the patient's claim is unresolved.

Solution: Follow up on claims daily so that you don't create a backlog of unresolved claims. Once the claim resolves, and you enter the EOB into the system, start the patient balance collection process by calling the patient and collecting over the phone. If the patient does not pay you, send a statement and continue the collection process with the first statement. The statement should have a 10 day response request. If you do not hear form the patient within 2 weeks, send an overdue letter with a 10 days response request. If you do not hear form the patient within 2 weeks, send a final notice letter with a 10 day response request. This collection process is a 2 months process and then patients go to collections. If you bill once per month your terms between the collection letters is too long and you are extending this process into 4-6 months duration. The patient balance recovery success decreases with time as follows: 75% at 30 days aging, 50% at 60 days aging and 25% at 90 days aging.

DELAYED PAYMENTS FROM INSURANCE ($1,500 per day and $24,000 per month)

$1,500 in payments is delayed if claims are not sent out daily and remittance report not corrected ($24,000 delayed payment of claims)

$ NOT COLLECTED AT ALL ($1025 per day, $16,400 per month, 34% loss in revenue)

$8,000 per month is hung up in unresolved claims increasing the AR, and
$6000 is the uncollected patient's portion at time of service increasing the AR, and
$2,400 is the uncollected patient's portion from unresolved claims increasing the AR
Therefore, an office that should be collecting $3,000 per day (between insurance payments and patient's portion) is actually collecting only $1975. This results in $31,600 monthly collections, instead of $48,000, with an overall delay in payment of $34,400 (if the claims are not sent daily, the remittance report is not

reviewed and corrected). These deficiencies result in an overall collection of 66% and revenue loss of 34%. Best practices have collections of 97% or higher. Offices that take pre-payments often have a negative accounts receivable.

Now you have a better understanding of how the accounts receivable accumulates if your billing department cannot keep up.

OFFICE SIZE	Office Net Monthly Production	**Delayed** Insurance Claim Submission Resulting in Delayed Payments Per month	**Unresolved Claims** Losses per Month	**Uncollected Patient Balances** at time of Service Losses	**Patient Balances Losses** from Unresolved Claims per month	**TOTAL LOSSES** Per month if tasks not performed daily
Small 1 provider	$48,000	$24,000	$8,000	$6,000	$2,400	$16,400
Medium 2 providers	$96,000	$48,000	$16,000	$12,000	$4,800	$32,800
Large 4 providers	$384,000	$96,000	$32,000	$24,000	$9,600	$65,600

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