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Clean Claims: Smooth Processing of Payment

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Isn't it obvious what makes a dental claim process smoothly? And don't we assume that the claims should go through the electronic claim submission clean resulting in fast payment? I mean, that is the reason we invest in the electronic claim submission technology and we pay monthly service fees. The goal of electronic claim submission should expedite the claim delivery and insurance payment as well as serve as a digital record that can be tracked during the billing process. Yet, on average, 20% of claims are rejected by the dental software almost as soon as the 'Send' button is clicked, and of those that successfully pass the software and move to the next phase, 30% are rejected by the insurance and remain unresolved after 30 days, unpaid. Using those numbers, we can mathematically determine that about 44% of claims don't make it through the first time. In other words, a large number of claims that we send electronically need to be followed up on as they don't go through smoothly to payment.

We've found that rejections tend to fall into two categories: 1) IT issues and 2) benefits verification issues

Let's explore what is included under the 'IT issues' umbrella.

1) **The insurance company is not an electronic payor.** This is a big issue because the clearinghouse will drop the claim to paper and mails it, and those claims have a good chance to be "lost" and not on file for processing. It's laughable that insurances, we suspect, have a batch claims "trash day", and somehow those mailed claims "never make it". The US mail system is pretty reliable in this day and age, but not when it comes to the dental insurance claims, I guess.

2) **User software steps during claim submission are incorrect.** The omission of key information such as proper settings, flowchart/sequence of events to properly submit a claim, necessary items like properly created attachments or narratives, or other specific technicalities required to correctly submit claims will cause repeated errors and wasted time. Some mistakes may result in immediate feedback alerting the user that attention is required, but most of the time they're not revealed for weeks. These issues go undetected. The team will spend hours researching claims that are not on file and fixing the errors, when in fact, if the team was aware of the correct process the claim would instantly be delivered and on file.

3) **Claims that need to be filed specifically through the carrier's website:** The experienced team will be familiar which insurances should be filed online for more successful filing. Each insurance will have their own protocols, and with each come unique challenges and pitfalls to watch out for. Medicaid claims are a good example of this. Also, insurances which do not accept EDI and do not have electronic payor IDs are another. Clearinghouses will create a paper claim and mail those as you would. To ensure the proper filing, it is better to file them directly online, but you need to be familiar which insurances and what process to use. Very often, faxing is the only modality to get a claim on file.

Identifying 'IT' problems can be difficult, or at least slow to come about. As mentioned before, you don't often receive immediate error feedback alerting users to a problem. The simplest way is to mitigate this category of claims problem is diligence. When you call on insurance claims to verify demographics and payor and provider information, if these are all correct and the claim is still not on file, then there is a glitch in e-claims submission. If you identify that there is an IT issue, you need to immediately contact the electronic claim submission software company or your dental software company. This can be detrimental to your cash flow. It is assumed that some claims will be held up during the claim filing process, but most claims should process within 3-4 weeks. If there is a true IT problem, claims that normally pay within 3-4 weeks will not pay and you will be down in operating funds that you normally are used to.

On the other hand, if the claim is not on file and the patient, subscriber, insurance, or provider information is incorrect, then there is a benefits verification issue. Benefits verification is a large category for all informational data relating to the insurance company,

patient, subscriber, and provider. For a patient to be able to use the insurance benefit, the insurance will only pay out if the information about the insurance company, patient, subscriber, and provider is ABSOLUTELY CORRECT. We are dealing with a claim which is a legal document. Any error will cause a mismatch in the information the insurance has on file and will reject the claim automatically, as those things are managed by computers and software. The claim rejects and is not on file for processing as we assume it is and we wait for it to process.

Let's explore what is included under the category of benefits verification issues. Good news is that we have full control of the information intake and have access to insurance websites to verify the information the patient provides us. When we find out through eligibility verification, that the eligibility did not pass, we can request new information from the patient. Most dental software or third party software provide this eligibility process. Or the team may have to call the insurance company and verify the information on the phone. It is time-consuming but well worth the smooth and fast processing of the claims.

1) **Information intake must be accurate.** Staff must be careful about obtaining information, which includes proper spelling of personal information and street names and verification at the time it is collected. Relationship of the subscriber to the patient, dates of birth, complete subscriber information with address, date of birth, gender are all items that play a key role in claim processing verification. Provider address, rendering provider NPI number, facility NPI number, billing NPI number need to match what the insurance company has on file. Also, make sure the insurance address and electronic payor ID is accurate or it will not match the clearinghouse. It's easy to get lazy here; staff members do this several times daily so it's not difficult to become complacent and lose attention to detail. Any rejections based on rendering provider NPI # point to credentialing issues. This is crucial to know, as you may be proceeding for months with a rendering provider that will never get paid for services submitted and you may be in a pickle if it is an associate that you paid a salary to based on money you thought is coming to you from insurance.

2) **Information must be correctly inputted into the system.** This is another place where staff mistakes can result from the drudgery of daily, tedious work. Ideally, each staff member discovers what they need to do to stay alert and revise mistakes as soon as they discover them. Distractions of answering the phones, patients at the desk, personal conversations with team members allow room for human errors.

3) **Benefits verification must be performed diligently.** Presence of active coverage must be confirmed, and the staff must be familiar with the plan and how it is handled by the software. Training and experience will help alleviate this. Time is money, but leaders must be patient with staff to encourage diligence. When the staff knows that accuracy is important, they have clear goals with understandable outcomes, and their diligence is rewarded. In the end, the team works with more confidence. We developed a sound benefits verification protocol. We work the schedule 3 days out. All patients in the schedule get insurance eligibility checks to ensure active coverage. We call on all new patients, emergency patients, and patients with new insurance or failed eligibility, and obtain a full breakdown of insurance coverage. The

information is updated in the system so that the patient is ready for treatment planning and a financial estimate of treatment proposed. As a side note, make sure that you update the fee schedules for the insurance plans you participate in annually. It will allow you to be as close as possible to the patient portion estimate and responsibility. A sound financial agreement is created, signed by both parties, and the patient portion HAS TO BE collected at the time of service.

Complete knowledge of billing is necessary when it comes to coordination of benefits, billing types, assignment of benefits, indication for narratives and supporting documents to be submitted, and proper dental coding. Standardized processes also help, not only streamlining but also maintaining a flow of information that allows identifying gaps when issues arise and make corrections.

While on the surface it looks like more work for office staff who are already busy, what we're really talking about is putting time and effort into hiring and training reliable staff who put the focus on the front end of the process. In addition, ensuring that the existing team understands attention to detail and is trained properly is key. These things do take valuable time, but the result is savings on the back end in terms of time, money, and hassle—for the office and the patient. Reduction in roadblocks helps maintain good attitudes in patients as well as staff. This is, of course, an ideal. There will always be speed bumps, but a smooth process handled by well-trained, knowledgeable staff is like a well-oiled machine that can easily be maintained when inevitable mishaps occur.

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