

P.R.O.A.C.T.I.V.E.

Carra Benson, MS, CPC, CDEO, CPMA, PPMC, PACS
Director, Physician Payment Services
Texas Medical Association

Carra Benson, MS, CPC, CPMA, CDEO, PPMC, PACS, Doctoral Candidate in Healthcare Administration serves as director of physician payment services and has approximately 20 years of experience in health care, working with physician practices and in hospital systems. Her expertise includes revenue cycle management, coding and documentation audits, credentialing, dispute resolution, and business office operations. She holds a master's degree in interdisciplinary studies from Oklahoma State University and is certified as a professional coder, medical auditor, and documentation expert for outpatient services by the American Academy of Professional Coders. Ms. Benson also received her certification in principles of practice management from the Medical Group Management Association and her prior authorization certification from the Accreditation Council for Medical Affairs.

Carra is also a member of the AAPC National Advisory Board for the 2025-2027 term.



TMA



CME Objectives

Upon completion of this program, participants should be able to:

1. Differentiate between proactive and reactive billing and coding activities.
2. Identify what proactive techniques can be written into the practice's policies and procedures.
3. Use applicable proactive techniques to minimize payment delays and claim denials.

The TMA designates this educational activity for a maximum of 1 *AMA PRA Category 1 credit*[™]. Physicians should only claim credit commensurate with the extent of their participation in this activity. This activity has been designated as 1 hour of ethics and/or professional responsibility education.

Notice

The Texas Medical Association (TMA) provides this information with the express understanding that (1) no attorney-client relationship exists, (2) neither TMA nor its attorneys are engaged in providing legal advice, and (3) the information is of a general character. **This is not a substitute for the advice of an attorney.**

While every effort is made to ensure that content is complete, accurate and timely, TMA cannot guarantee the accuracy and totality of the information contained in this presentation and assumes no legal responsibility for loss or damages resulting from the use of this content. You should not rely on this information when dealing with personal legal matters; rather legal advice from retained legal counsel should be sought. Any legal forms are only provided for the use of physicians in consultation with their attorneys.

The information and opinions presented as part of this presentation should not be used or referred to as primary legal sources, nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. The standard of care is dependent upon the particular facts and circumstances of each individual case, and no generalization can be made that would apply to all cases.



StoryTime

Be **PROACTIVE** not Reactive

Pre-service Verification:

Implement thorough patient insurance verification and eligibility checks before appointments to confirm coverage and anticipate potential out-of-pocket costs.

Accurate Coding & Documentation:

Ensure clinical documentation fully supports billed services, and coders are up-to-date with the latest ICD-10 and CPT guidelines to prevent claim denials.

Timely Claim

Submission: Establish workflows for prompt and accurate submission of claims to payers, reducing delays and improving cash flow.

Financial

Counseling: Offer transparent financial discussions with patients about their estimated costs and payment options to set clear expectations and reduce payment hesitancy.

P

Preventive

Policies/Procedures

Patient Information Accuracy

Physician Champion

Parameters

Provider Numbers

Payment

Provider Manuals

Patient Information Accuracy

Verify Photo ID:

Confirm patient identity to prevent fraud and ensure services are rendered to the correct individual. This also helps in cross-referencing records

Update Contact

Information: Collect current addresses, phone numbers, and email addresses. This is crucial for appointment reminders, lab results, patient statements, and critical health communications.

Complete Insurance Details:

Obtain full policy numbers, group numbers, subscriber IDs, and the payer's contact information. Note any changes in coverage, deductibles, or co-pays.

Medical History &

Consent: Ensure all relevant medical history, allergies, and signed consent forms are current and readily accessible, as these can impact coding and medical necessity documentation.



R

Reports

Root Cause

Resources

Revalidation

Recredentialing

Revenue Cycle Management

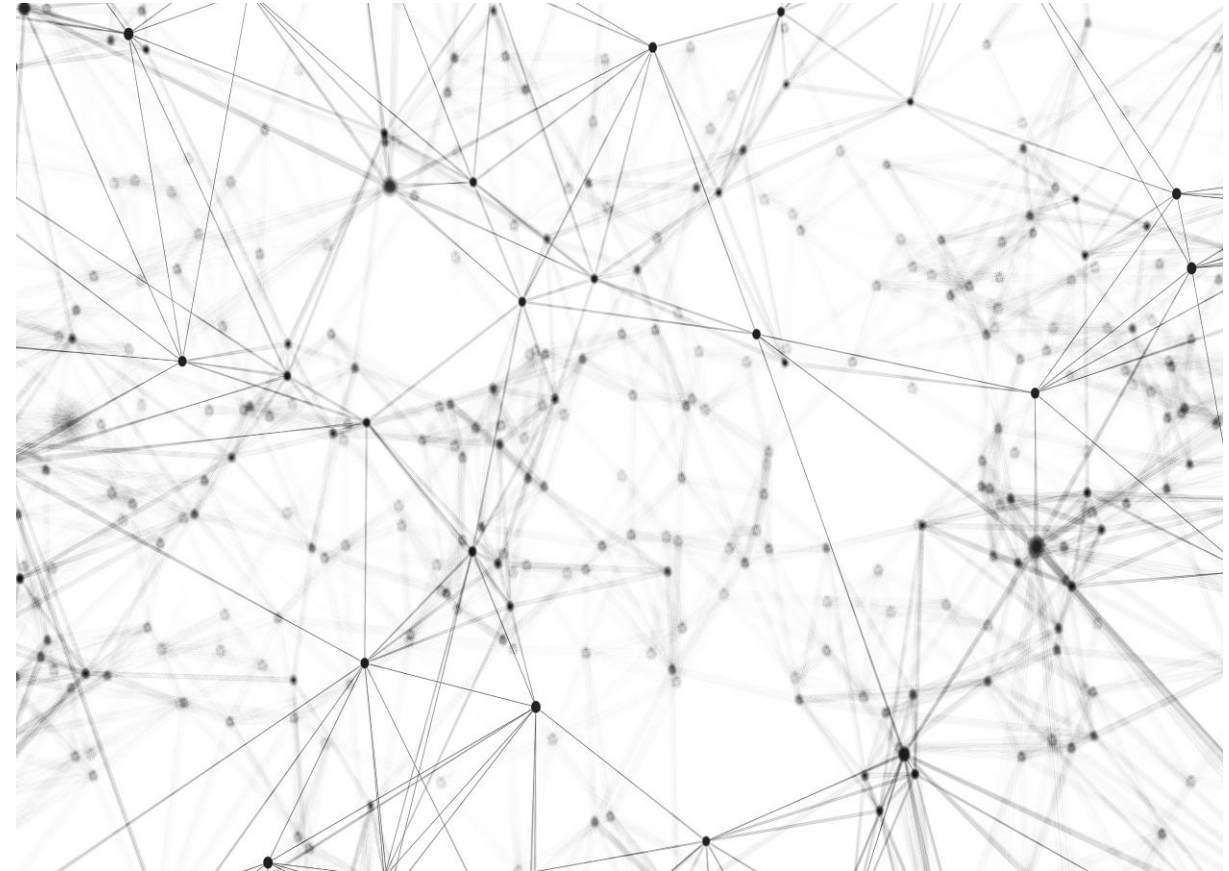
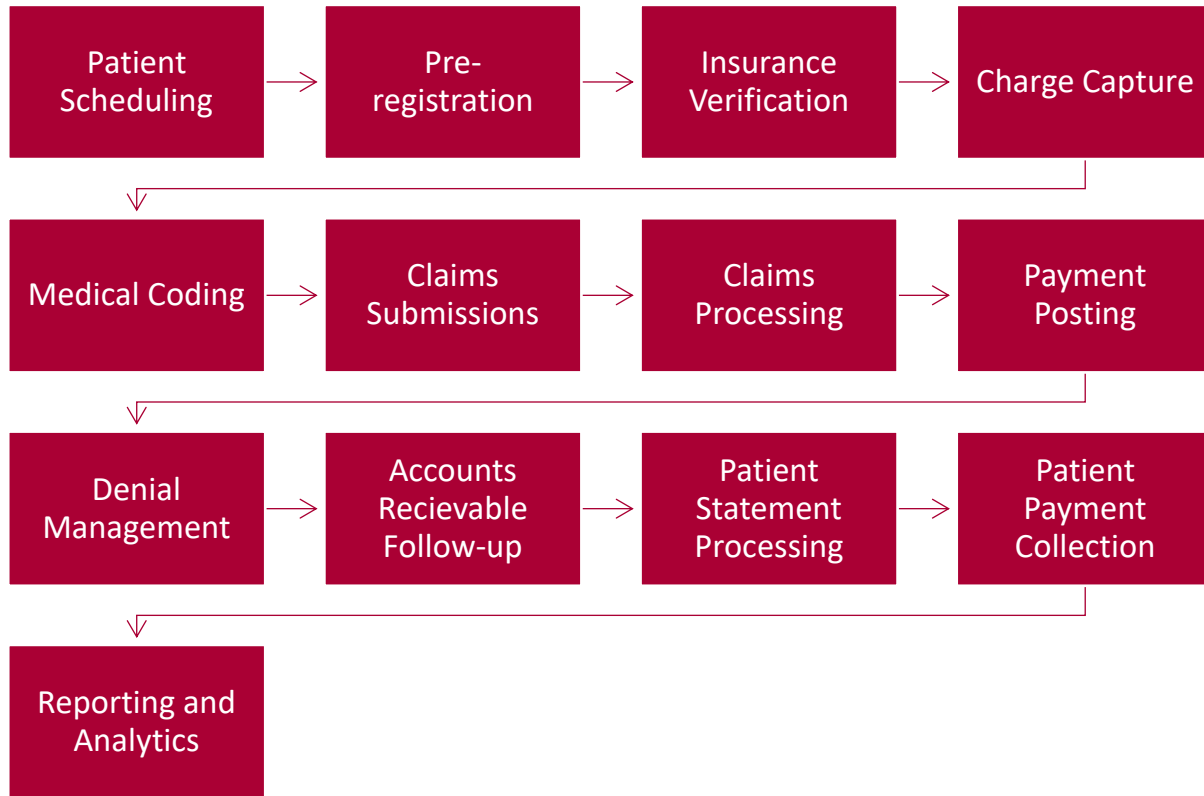
Real-Time Eligibility Checks

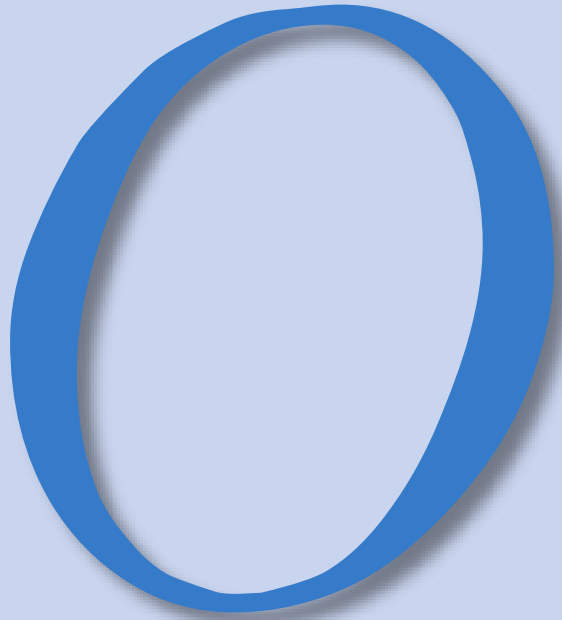
Reimbursement

Referral

Records

Revenue Cycle Management





Operational
Out-of-Pocket
Overpayment
Outline
Obtain Consent
Obtain Prior Authorization

Obtain Prior Authorization

- Remember that prior authorization is not a guarantee of payment by the insurance company. Consider all aspects of claims processing:
 - Member eligibility;
 - Contractual limitations and provisions, e.g., preexisting conditions, limitations in contract riders;
 - Premiums satisfied and paid; and
 - Claims general processing guidelines.
- Create a list of your top procedures and know which require a prior authorization for the major health plans you accept in your office
- Familiarize yourself with the steps required for each health plan as the steps may vary.
- Verify coverage with your patient's specific plan and confirm if a service, procedure, or medication requires prior authorization.
- Ensure medical necessity is well documented and supports the service requested. If a change to the service occurs after you have obtained prior authorization, keep detailed records of what occurred and why the change was made.
- Submit prior authorization requests in a timely manner to allow enough time for the health plan to process it so you avoid disruptions to care.

Obtain Prior Authorization

- Obtain the prior authorization in writing. Do not count on verbal confirmation and reference numbers.
- Confirm coverage is available in the planned place of service and the date of service is within the approved dates of service.
- Put a protocol in place to follow up on a prior authorization you have submitted. Call the health plan to ensure it was received and in process.
- Do not rely on the hospital to obtain a prior authorization for physician services. Take steps to ensure your services are covered appropriately.

A large, stylized blue letter 'A' with a slight shadow, positioned on the left side of the slide against a light blue background.

Analysis

Audits

Appeals

Automation

Acute vs. Chronic

Advance Beneficiary Notice (ABN)

Avoid

Accounts Receivable Follow-up

Audits & Denial Management

Prospective Audits:

Proactive Error Prevention

Implementation Strategies:

Targeted Reviews: Prioritize auditing claims

Pre-Bill Scrubbing Software: Utilize advanced software solutions

Manual Verification: Conduct sample-based manual reviews of selected claims

Feedback Loop: Establish a robust feedback mechanism

Denial Analysis:

Uncovering Root Causes

Detailed Analysis Process:

Categorization: Group denials

Trend Identification: Use denial management software or robust

Root Cause Investigation: Convene cross-functional teams

Performance Metrics: Monitor key performance indicators (KPIs)

Swift Resubmission:

Maximizing Reimbursement

Best Practices:

Dedicated Denial Team/ Workflow: Assign specific team members or establish clear workflows

Payer-Specific Requirements: Understand and adhere to appeal and resubmission guidelines

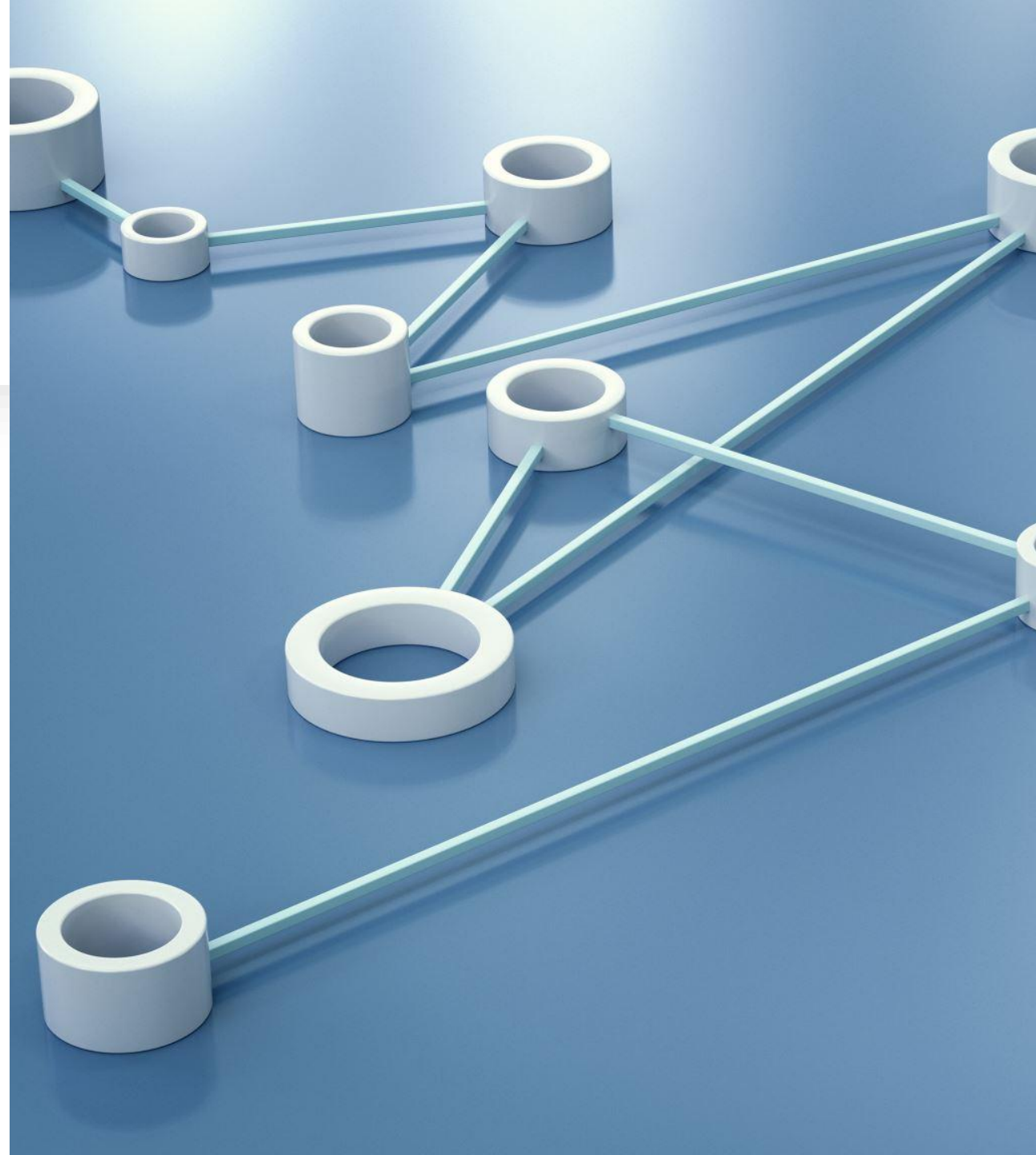
Thorough Correction: Before resubmission, meticulously verify that the denial reason has been addressed

Audits & Denial Management

By catching errors early, practices can significantly reduce denial rates, accelerate reimbursement, and avoid costly appeals processes.

Understanding the root causes allows for targeted interventions, turning denial data into actionable insights for process optimization.

Timely and accurate resubmission not only secures earned revenue but also reduces the average days in accounts receivable (A/R) and improves overall cash flow.





Claim Scrubbers

Credentialing

Clean Claims

Consent

Compliance Program

Cross-train

Coding

Clearinghouse

Consistency

Communication

Clinical Documentation Improvement

Coordination of Benefits (COB)

Covered Benefits

Continuity of Care

Coding

- Ultimate responsibility – Physician
- Acute vs. Chronic
- Status
- Modifiers
 - 25
 - 59
- Diagnosis Coding
 - Most important listed first
 - Unspecified codes
 - Code symptoms
 - Use the highest specificity
 - Keep updated
- Time
- CPT Updates annually-January
- Know payer rules
- Document thoroughly
- Under-coding and Over-coding

A large, bold, blue letter 'T' is centered on a light blue background. The letter has a slight shadow effect, giving it a three-dimensional appearance.

Trust but Verify

Trends

Timely Filing

Templates

Technology

Transparency Tools

Telemedicine

Third-Party Payer

Top Claim Denials

Transparency Tools



Fee Schedule Downloads

Most practice management systems can download insurance-allowed amounts to compare contracted and actual payments.



Third-Party Estimators

Calculate patient responsibility based on procedure codes and payer fee schedules, including copays, coinsurance, and unmet deductibles.



Reference Sheets

Maintain lists showing common patient responsibilities and typical self-pay amounts for non-covered services by plan.

A large, bold, blue letter 'I' is centered on a light blue background. The letter has a slight shadow effect, giving it a three-dimensional appearance.

Intervention

Implementation

Insurance Network

Inform

Identify

Investigate

Input

Initiative

Implementation

Develop

Assemble a Team

- Billing staff
- Compliance officer
- Physician

Address Key Areas

- Coding accuracy
- Documentation standards
- HIPAA

Implement and Train

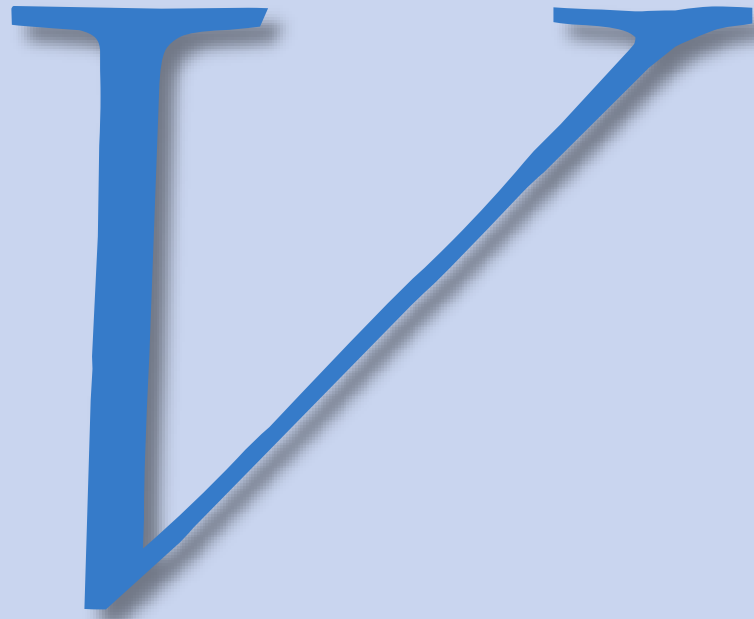
Provide comprehensive training:

Conduct regular training sessions to ensure all staff members understand the policies, including updates on new regulations or coding systems

Monitor and Enforce

Keep policies current:

Regularly update the policy and procedure manual to reflect changes in coding, regulations, and billing practices



Verification

Validation

Value-Based
Reimbursement
(VBR)

Visibility

Viability

Validation

Data and Eligibility Validation

- **Action:** Verifying all insurance coverage, patient demographics, and authorization details before service is delivered.
- **Proactive Benefit:** It prevents claim denials caused by incorrect patient information or non-covered services

Pre-Claim/Charge Validation

- **Action:** Use tools like intelligent claims scrubbing to automatically validate CPT and diagnosis codes against payer-specific rules and medical necessity criteria before the claim is submitted.
- **Proactive Benefit:** It ensures a high first-pass payment rate by catching and correcting errors

Financial Validation

- **Action:** The proactive step of validating the patient's estimated out-of-pocket cost and payment options with them before the service.
- **Proactive Benefit:** It improves collections and minimizes future billing-related complaints or collection problems

E

Estimation

Education

Eligibility

Exclusions

Enrollment

Electronic Remittance Advice
(ERA)

Electronic Funds Transfer
(EFT)

Evaluation and Management
(E/M)

Electronic Health Record
(EHR)

- Gather all required documentation
 - Keep current
- Assign the task to a team
- Utilize credentialing tools, especially Council for Affordable Quality Health Care (CAQH)
- Start early
 - Medicare-backdate claims 30 days
 - Medicaid-backdate claims up to 365 days
 - Commercial- no backdating claims
- Follow-up frequently
- Know your revalidation deadlines
- Expedited

Enrollment

Keys to Success

Continuous Process Improvement:

- Regularly review billing workflows
- Identify bottlenecks
- Implement optimizations

Ongoing Education & Training:

- Payer policy changes
- Coding updates
- Compliance regulations

Strategic Technology Adoption:

Leverage advanced practice management systems for seamless integration of clinical and financial data and speed

Data Analytics:

- Days in accounts receivable (A/R)
- Clean claim rates
- Collection rates

Key Performance Indicators to Revenue Cycle

95%

Clean Claim Rate

Percentage of claims
accepted on first
submission

98%

Net Collection Rate

Percentage of allowed
charges collected

30%

Days in AR

Average time to collect
payment

3%

Denial Rate

Percentage of claims
denied by payers



StoryTime

Empower Your Practice



ROBUST PRACTICE MANAGEMENT SOFTWARE: PROVIDE INTUITIVE AND COMPREHENSIVE SOFTWARE THAT SIMPLIFIES:

- SCHEDULING
- REGISTRATION
- BILLING
- REPORTING

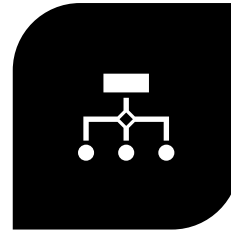
REDUCING MANUAL EFFORT AND POTENTIAL ERRORS



COMPREHENSIVE KNOWLEDGE BASE: CREATE ACCESSIBLE RESOURCES INCLUDING:

- POLICY MANUALS
- CODING GUIDELINES
- FAQS

TO ENSURE STAFF HAVE IMMEDIATE ANSWERS TO COMMON BILLING QUESTIONS.



CLEAR WORKFLOW PROTOCOLS: DEVELOP WELL-DEFINED, STANDARDIZED PROCESSES FOR EVERY STEP OF THE REVENUE CYCLE, FROM PATIENT INTAKE TO PAYMENT POSTING, ENSURING CONSISTENCY AND ACCOUNTABILITY.



DELEGATION & AUTONOMY: FOSTER AN ENVIRONMENT WHERE STAFF FEEL TRUSTED AND HAVE THE AUTONOMY TO MAKE DECISIONS WITHIN THEIR ROLES, BOOSTING MORALE AND RESPONSIVENESS.



PERFORMANCE FEEDBACK: IMPLEMENT A SYSTEM FOR CONSTRUCTIVE FEEDBACK AND PERFORMANCE REVIEWS, RECOGNIZING ACHIEVEMENTS AND IDENTIFYING AREAS FOR FURTHER DEVELOPMENT

