0 (0s):
Hi, it's Dr. Weitz. Thanks so much for joining me for this episode of the private medical practice academy.

1 (7s):
Do you know what your practices clean claims submission rate is? Or maybe I should ask you if you even know what a clean claim is submitting clean claims is the key to maximizing your ability to collect every penny that is actually due to you. In this episode, I'm going to tell you what a clean claim is, what clean claim rate you should aspire to and how to actually get there. Let's start with the definition of a clean claim. The claim for payment has to be submitted via an acceptable claim form or in an electronic format with all of the required fields completed with accurate and complete information in accordance with the insurers requirements.

1 (48s):
I know that's a mouthful, but very important because basically if the is not filled out, right, you're going nowhere. In addition, the claim has to identify the health professional or whoever provides the service with enough detail so that they know what the affiliation status is. If there is any and includes any identifying numbers, the claim also needs to sufficiently identify the patient and who the health plan subscriber is. It needs to list the date of service and the place of service. The claim needs to be for a covered service for an eligible individual. It must be medically necessary.

1 (1m 30s):
And the appropriateness of the service provided must be documented. And of course, things that are specifically excluded from coverage immediately make your claim not clean. If prior authorization is required for certain patient services, this information needs to be contained to establish the prior authorization was actually obtained in advance of the service. A clean claim is coded correctly and includes additional documentation based upon the services that have been rendered that are reasonably required by the health plan. Now understand that most of these points should be pretty obvious to you, but that doesn't mean that most practices are actually doing this.

1 (2m 12s):
As a matter of fact, most practices have a clean claim submission rate of 75 to 85%, which means that 15 to 25% of submitted claims are not clean. One of the reasons submitting a clean claim is so important is that CMS and commercial insurers are required to pay clean claims within a certain timeframe if they fail to do so, they're actually subject to paying a prompt pay penalty. For example, CMS has to pay an electronically submitted clean claim within 24 days of being received. But if you don't submit a clean claim, all bets are off. Now, you may be thinking to yourself, what has this got to do with me?

1 (2m 54s):
This is an issue for my billing people. I have to tell you that this is a totally myopic view. Clean claims have everything to do with you and your office before you even see the patient, your office needs to make sure

that you've checked eligibility ahead of time and you've obtained prior authorization. If it's required, you have to have your documentation. In order, you need to know what documentation is needed to substantiate medical necessity, your billing folks. Can't complete your note to provide appropriate documentation. That's totally on you. Now. Let's recap your billing folks need to make sure that the demographic data is right and that the form is filled out completely.

1 (3m 35s):
But if your office doesn't collect the right info from the patient, doesn't check eligibility, doesn't obtain the prior authorization. You set the billing process up to fail. If you, as the provider, don't have adequate inappropriate documentation, the claim won't be clean and want to be crystal clear claim. Rejections actually cost you money. When a claim is rejected, it means that those claims have to be reworked and resubmitted. You want your clean claim rate to be 95%, anything lower than this. It means that you're losing money. For example, if your practice has a typical 75 to 85% clean claim rate, that means that 15 to 25% of your claims that are submitted each month have to be worked on twice.

1 (4m 23s):
At least it's like taking four steps forward and always having to take one step back. That doesn't work. Yeah. Yeah. I know. While it delays your payment, you're not the one who has to do this additional work. Maybe you're thinking, oh, I have a billing company and they charge a percent of collections. You may be thinking that's what I pay for. But this thinking is flawed. As I went over, there are multiple places where you and your office affect the clean claim rate. So needless to say, if the person in your office who got the demographic info from the patient and they got it wrong, the billing company would have to go back to your office to get the info corrected.

1 (5m 3s):
If there's an issue with eligibility or prior authorization, someone in your office has to deal with. That said another way, you are going to pay someone in your office to fix those mistakes. This takes them away from doing some other tasks or worse. You need additional manpower and to call out the elephant in the room. If you don't get your documentation ducks in a row, then you will have to fix it. Your clean claims rate directly affects your practices. Overall revenue, problematic billing and coding practices result in delayed or denied claims. And this can have a devastating result in terms of your profitability.

1 (5m 45s):
Let's put some things in perspective, every claim that's not paid on the first submittal, wastes your practices, valuable time and money. The MGMA estimates that the average cost to rework a claim that's been rejected or denied is about $25 per claim. If the average cost of rework is $25 a claim, and your practice has about a hundred claims each month that need rework. Then it's costing your practice. $2,500 a month, and basically $30,000 a year. That's a lot of money to basically lose because you didn't get the thing right from the beginning. Many rejected claims are resubmitted multiple times often without their errors even being

addressed or corrected.

1 (6m 32s):
Now, why would this happen? Because if you don't have a process in place to check, double-check the original submission. And then again, for the rejected claims things continue to fall through the cracks. I want to point out to you then when a rejected claim needs to be reworked beyond the timely filing deadline, you also end up not getting paid because you missed the deadline. Additionally, inaccurately submitted claims can get you into legal trouble. If your practice admits too many, improperly filled out claims, you can get flagged for potential fraud and abuse. The U S department of justice enforces laws such as the false claims act and anti-kickback statutes to crack down on coding abuse, like improperly use modifiers, overcharged services, and more obviously fraudulent claims can cost your medical practice.

1 (7m 26s):
Thousands of dollars in fines. But even when you aren't doing anything wrong, it's going to cost you time and money to defend yourself. It really is so much easier to do things right from the beginning. And of course, aside from increasing your expenses, rejected claims result in a delay in payment. If you ever get paid at all in the ideal world, you want to have a hundred percent clean claim rate, but let's be real errors happen. There's no way to make it a hundred percent that said, you really shouldn't be satisfied with the clean claims rate. That's under 95% and especially anything under 90%, anything less than 95% is costing your business money in time.

1 (8m 10s):
Your overall profitability depends on having your clean claims rate under control. So how do you achieve that 95% clean claims rate? Well, the first thing is to keep your patient information updated from contact information to insurance carriers and more there's a lot of patient information that can change and it changes quickly inaccurate patient data is the obvious and leading cause of denied claims. Your office needs to have the patient confirm or update their current information before they received the service. You can use an automated appointment reminder to ask patients to update their information. If your EMR has a portal, particularly within each check-in ability, you can prompt the patient to verify info there at minimum, they should be addressed at the front desk every time at the time of service, you want to verify eligibility prior to the date of service, your staff may assume that your established patient has had no recent changes in their insurance.

1 (9m 13s):
However, outdated established patient information is often a source of denied claims. One step towards 95% clean claim rate is to collect and confirm every patient's primary, secondary, and even tertiary insurances, at least five days before their scheduled service. Sometimes patients switched jobs and have a different insurance, one visit to the next, or maybe they are on their spouse's policy. And the spouse switched jobs. Most people aren't looking to put one over on you. They just don't think about the fact that their insurance

changed the issue here is that it, your office doesn't catch it. You're not going to get paid.

1 (9m 53s):
The claim will be submitted, and then it's going to get rejected. And by the time this is recognized and fixed. The claim may actually be outside the timely filing deadline and you don't get paid at all. And while checking eligibility, it's important to also obviously confirm whether there are any in or out of network benefits, what the copays are and what the deductible is next. You want to provide detailed documentation of medical information. Another way to boost your clean claim rate is to ensure that you have the most detailed medical information possible. I would strongly encourage you to understand the documentation requirements for the most common codes you built.

1 (10m 33s):
This is especially important for codes that have very specific definitions for medical necessity. Each insurance company, including CMS can give you information about what's defined as medically necessary for each code as a corollary to this. You also have to know what other tests, treatments, interventions must have been tried and failed before billing a code. If you put all of this info into your note preemptively, your clean claim rate is going to increase dramatically. It will help prevent some of the back and forth for requests for additional documentation. Another way to increase your clean claim rate is to be mindful of insurance claim.

1 (11m 13s):
Filing deadlines, filing claims requires submitting within a tight window. Anytime a claim is submitted outside the window. It means that it's very likely going to be denied. If your goal is to have a near perfect clean claim ratio for your practice. One of the best ways to do that is to pay attention to your claim deadlines. This is one of the things that your billing folks do control that said, this is a metric that you want to track. You want to know on a monthly basis. What percent of the claims are being submitted after the timely submission deadline. And then of course, the followup question to this is why, because there really is not a legit reason that it should ever be submitted late and be prepared to resolve the underlying reasons.

1 (12m 0s):
And if you're not getting the hint, it probably comes back to what's happening in your office. And then my last tip for improving your clean claim rate is to double-check your modifiers. Are you doing your own coding? If so, then you'll want to make sure that you're applying modifiers correctly and to the right procedure. One way to do this is to create your own guideline of the customized national correct coding initiative edits so that you can refer back to this. If you're using a certified coder or your billing folks coat for you, then you're going to want to know what percent of claims are being rejected due to modify our issues. So this can be addressed. Look you want and deserve to be paid for the work you do.

1 (12m 43s):

Having a 95% clean claim rate will increase your profitability by increasing your collections and decreasing the expenses incurred while collecting your money. And of course, it's going to shorten your revenue cycle. So said another way, you're going to get your money faster. If you want to learn to implement the processes, to increase your clean claim rate and maximize your practices, revenue, join me in the private medical practice academy membership. The link is in the show notes.

0 (13m 13s):
Thanks for joining me. Please be sure to sign up for my newsletter below. I'll be sending you tips on how to start a practice, grow a practice, and then add multiple services so that you can maximize your revenue.