maxRTE

Are Eligibility-Related Denials Holding Your Organization Back?

5 Common Pitfalls and How to Avoid Them

Speakers:
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House Rules

While waiting for others to come in, here are some rules and reminders to keep in mind.

01

Our speakers will present for ~40 minutes

02

Please type any questions you have throughout the session in the chat box

03

Questions will be at the Q&A after the presentation.

Agenda

What we'll cover in this session

01 Top 5 Eligibility Verification Mistakes Leading to Denials and Why it Matters

02 Effective Tools and Processes to Address Common Eligibility Verification Mistakes

03 Engaging Your Team to Create a Comprehensive Strategy for Minimizing Eligibility-Related Denials

About the speaker

Carla Larin
CEO of maxRTE

Top 5 Eligibility Verification Mistakes & How to Solve Them

Why it matters

20%

Increase in denial rates over the past 5 years

$118

Cost to re-work a single denial

>50%

Share of denials that are preventable

60%

Share of denials that are never appealed

1%-3%

Net revenue improvement with a strong denials program

The Top 5 Most Common Errors Leading to Denials

1. Not capturing or incorrectly capturing patient information
2. Not checking active insurance coverage early enough
3. Not verifying coordination of benefits
4. Not performing a spend versus maximum check and not understanding specialty maximums
5. Not appealing denials - Leaving revenue on the table

1.

Not capturing or incorrectly capturing patient information

The wrong plan or lack of a Social Security number prompts 61% of initial medical billing denials and account for 42% of denial write-offs

Pre-service

- Verify eligibility in batch for all pre-scheduled patients
- Run insurance discovery for all self pay scheduled appointments

POS

- Leverage tools that flag data mismatches when patient demographics in your EMR are different from what the payer has on file
- Leverage Insurance Discovery via API integration at registration to locate active insurance

2. Not checking active insurance coverage early enough

Over 25% of denials are caused by eligibility-related errors, with inactive insurance policies being one of the most common reasons for this type of rejection

Pre-service

- Run eligibility and then discovery for all patients without eligible coverage

POS

- Provide patients with resources to help them enroll in Medicaid if they qualify

Must be completed prior to the patient's departure.

3.

Not verifying coordination of benefits

65% of patients struggle to understand what their health insurance covers, and patient access teams are overstretched - meaning some coverage is never discovered

POS

- Empower registration with training, documentation and processes to capture secondary and tertiary coverage

Post-service

- Verify the correct Medicaid plan is being billed using batch eligibility checks
- Run Insurance Discovery on all Medicaid primary patients to locate any commercial coverage that may have been missed

4.

Not performing a spend versus maximum check and not understanding specialty maximums

Pre-service

- Set up automated filtering to compare insurance covered benefits with visit type and flag uncovered services

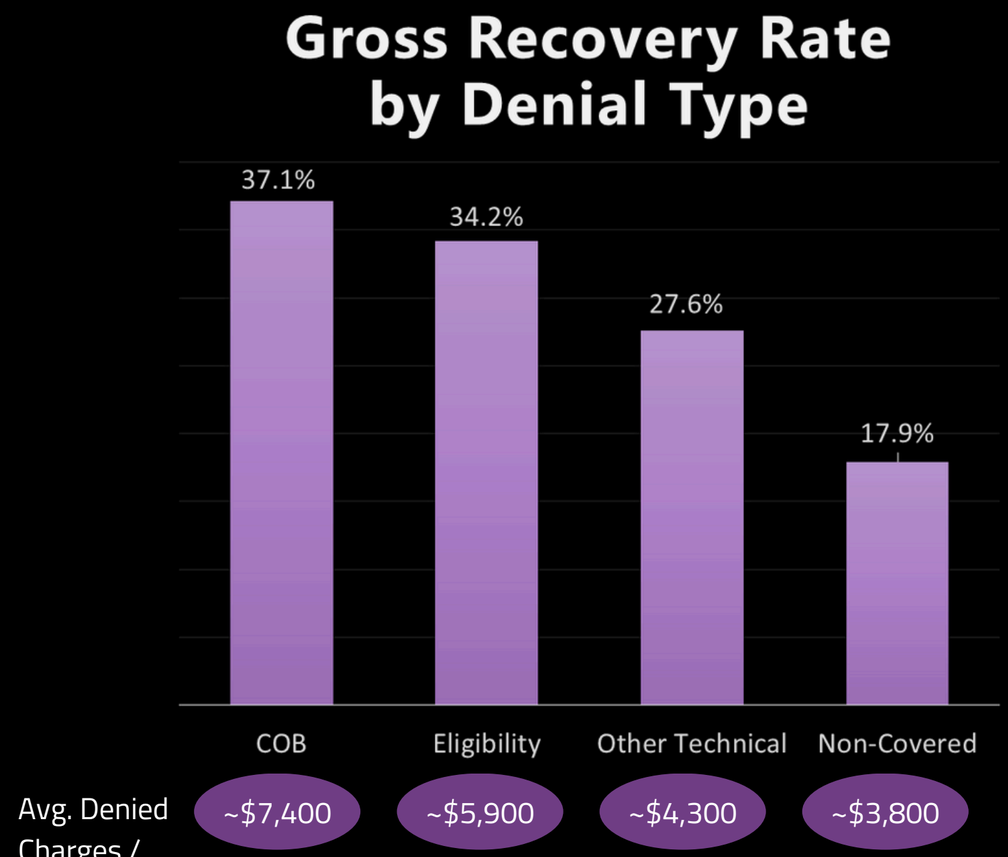
POS

- **Empower staff with tools and training** to verify benefits and collect the appropriate amount due by the patient

5. Not appealing denials - leaving revenue on the table

Post Service

- Automate daily Insurance Discovery for all eligibility-related denials to ensure (1) plan information is corrected or (2) find the correct coverage



Effective Tools and Processes to Address Common Eligibility Verification Mistakes

What you can do

1. Categorize why claims are being denied and inform staff by continually reporting trends

2. Build KPIs to help staff gauge their performance compared to peers and reward through incentive programs

3. Institute ongoing monitoring and governance to pull in the right stakeholders at the right time

Q&A

If you are interested in implementing any of these tactics, we are here to help

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