

STEP BY STEP GUIDE FOR DENIAL FREE ORTHOPEDIC BILLING

Denials can turn your business upside down! Orthopedic billing has to be dealt with more patience and concentration as it might easily halt your revenue cycle process. Orthopedic billing process is one of the most critical things in healthcare professionals' practice. For no delays and denials in billing, accurate coding and billing practice must be followed which decreases revenue payment issues by also reducing the stress.

When it comes to orthopedic billing, several things are to be kept in mind to minimize errors and claim denials. Claim denials in orthopedic billing can lead insurance companies to easily hold the payments from letting it into healthcare professional's accounts. So, it's very important to understand the possibilities of claim getting delayed or denied or rejected.

3 Major types of denials to be avoided in orthopedic billing:

In general orthopedic billing denials are categorized into three that haunts every orthopedic practice to demonstrate the opportunities to improve practice operations.

By isolating and being aware of these common problems, healthcare professionals practice will have an opportunity to take solid decisions that directly affects revenue cycle management process.

Those categorized denials are mainly clinical, administrative and omission denials.

Clinical denials :

- ❑ Medical necessity
- ❑ Level of care determination
- ❑ Number of follow up visits those not adhered
- ❑ Length of hospital stay



Administrative denials:

- Q Incomplete or missing Information
- Q Uncovered services
- Q Bundling
- Q Clarification in coding which is invalid, inaccurate as well as missing
- Q Ultimate filing
- Q Medical records requested
- Q Itemized bills

Omission denials:

- Q Inaccurate and missing prior authorization reports
- Q Inaccurate demographic details or registration
- Q Not qualified in insurance eligibility verification.

What can be the solutions to prevent the above denials?

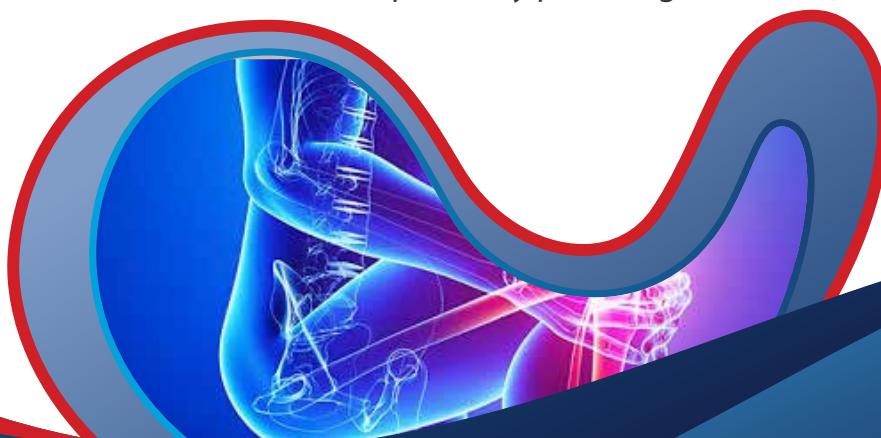
Once denials are identified, solutions must be found too. The main work is to look for the solutions that improve orthopedic billing practice by initializing claim submissions and capturing accurate reimbursement.

It's evident and obvious to look at the process followed to submit claims.

Prior authorization inaccuracies can be one of the most significant reasons for claims getting denied and rejected. The missing and incomplete prior authorization happens because of patients without filling their absolute details while consulting doctor.

It's better to engage in automation solutions rather than preferring the same old paper work which stands as the main cause for errors and mistakes.

Artificial intelligence determines the prior authorization process and submits accurate information to insurance companies by providing 24/7 monitoring and also follow up.



This process fastens the prior authorization reports that require days and hours to complete.

Leveraging AI can complete the process in minutes with tech enabled solutions by also saving hours of time and effort.

Insurance verification and benefits eligibility process can be done manually as well as electronically. It's yet difficult to manage manual process by accessing patient process efficiently.

If the information is electronically verified before each encounter, claim denials will be reduced for these kinds of issues.

Additionally, it also lends itself in collection of patient portion at the time of service or before as healthcare professionals need to work with accurate information.

Orthopedic billing and coding should be done in most effective manner by providing complete documentation of patients to insurance companies and coding with accuracy.

This process is so important that if it's not maintained precisely, denials are sure to shoot. Healthcare professionals can decide to engage with outsourcing orthopedic billing and coding practices which has certified billers and coders with experience for years.

Clean claims can always keep healthcare professionals away from denials.

Few tips to minimize risk of denials in orthopedic billing:

Stay up to date on new coding guidelines and policies introduced by American Medical Association every year with changes in CPT coding sets and thus important to ensure if healthcare professionals stay current on coding updates.

In house billing practices must ensure their coding and billing professionals to understand and stay updated regarding the coding changes.

Coders must be aware of the investment involved in coding updates or changes so that it reduces denial risk.



ICD-10-CM has been introduced recently which has 279 additions and 143 revised codes with 51 deletions. So, it's critical and critical for orthopedic billing professionals to speed up their practice on these codes as soon as possible.

It's also important to beware of most common denials as mentioned in the above. Duplicate claims can be one of the most important reasons for denials and rejections. Another reason is charge exceeding the fee schedule.

Healthcare professionals must ensure to be ready to track the root cause for denials those can prevent them in future.

Ensure accurate collection of patient information. Be diligent in obtaining accurate information on insurance and never neglect insurance verification. Start working with automated billing service.

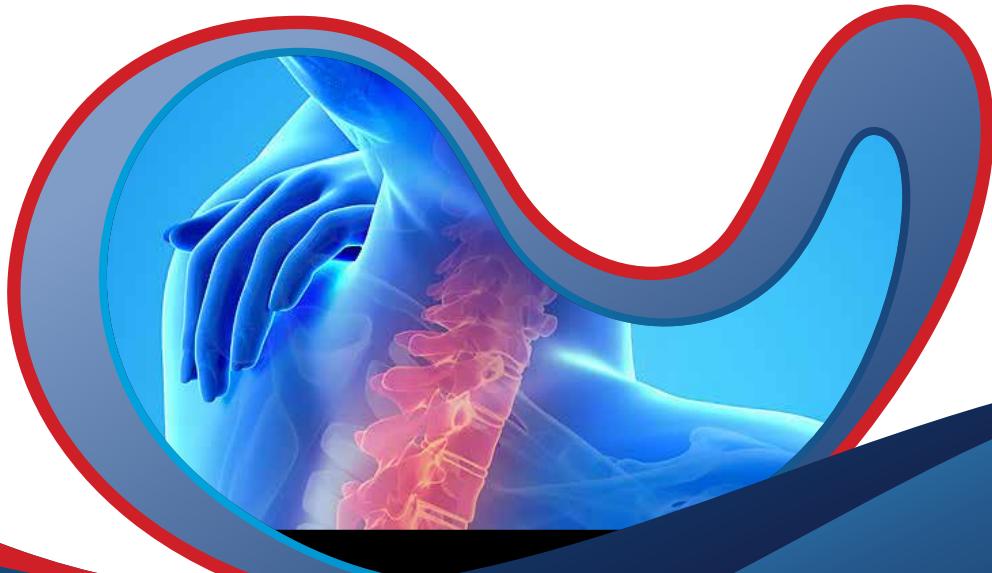
Understand the ways ICD-10 changes affect orthopedic billing and coding practices, so that healthcare professionals can actually stay alert.

ICD-10 changes and coding updates usually will affect every specialty but it affects orthopedic billing and coding service a lot. The ways it actually affects orthopedic billing and coding:

Laterality: ICD-9 codes never dealt with laterality earlier. But ICD-10 requires healthcare professionals documents right, left, bilateral for many conditions those also require individual fractures and joint disorders.

Site specificity: There are many diagnoses for orthopedic practice which ensures the necessity of documents in specific area of the body. If healthcare professionals diagnose for particular area of the disease, it requires specific region for claim submission.

Place of occurrence is also a crucial in ICD-10 coding changes that demand more specificity from orthopedic coding practices. Insurance companies will demand documents for injuries.



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QWay Health LLC,
5 Independence Way,
Suite 300, Princeton,
New Jersey 08540.

✉ shehan@qway.us
☎ +1-844-640-1488