



Premier Newsletter!!

Your Medical Insurance Reimbursement Specialists

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Together We Decide To Succeed

Issue: #1

Mar/2009



Welcome to SilverTree Health's Premier Newsletter Issue! As a dedicated member of the Medical Reimbursement landscape, one of our main goals is to educate medical providers.

Each monthly issue will contain up-to-date educational articles from leading **Practice Management Consultants, Coders, Reimbursement Professionals**, and our **Affiliates** with unique Value Propositions. We welcome your feedback and participation -- Enjoy!

Keys to Success Today and in the Future

Practice Management Consultant Article by Julie Hayes



With all the gloom and doom we continue to hear surrounding the economy and the hundreds of questions that surround healthcare and what that will look like in the future, it's important to remain focused on the "here and now". So much of what you do now to strengthen your current performance will also prepare you for a sound future. There are several key components with which you should pay close attention. These can help shape your success now and put you in the best possible position to weather whatever may come later.

With the rising subscriber base of high-deductible plans and HSA's, one of the most vital initiatives is a well-written and enforced policy for collecting copays, deductibles, and self-pay balances at your front desk. Your cash is your life blood and the most successful practices get this done effectively. Patients are usually aware they have to pay something when they arrive so your staff should be asking "how will you be paying

for services today?" followed by "I'd be happy to take that for you now." This conversation should occur prior to going to the back, not after the visit. Even though you may not know what the balance will be when discharged, collect a minimal office visit fee up front. This insures the patient has the means to pay you and your staff will hear less often "Oh, I forgot my wallet!" as they begin checkout. Collecting money after services are already rendered is far more difficult for a number of reasons, many of which you probably already know.

Next, most patients equate an "excellent" visit with the length of time they were required to wait regardless of the outcome or interaction with the physician. If they have to spend too much time in the lobby, they will be less likely to refer friends and family. Word of mouth advertising can make or break you. So, the second item is stay on schedule when at all possible. You may need to reevaluate your patient flow process; see where you can cut unnecessary steps. Setup a triage area and utilize it to keep the patient moving through the system. Staff and providers must arrive on time and be ready to roll. Keep your patients informed where they are in the system and an approximate time the provider will be with them. Communication and excellent customer service are key here; your patient's experience, or should I say their perception of the experience, is highly important to your future success.

Billing initiatives should be top-notch. Clean claims should be going out the first time and soon after the visit. Develop a system to identify the errors being made and put a process in place to retrain those who are making them. Make sure your practice management system is setup to catch errors on claims before they go to the insurance company. If it doesn't do that effectively, you may need to look for a new system. Waiting for denials to come back is costly and should be fixed on the front end.

Correct coding and capturing all charges is vital as well. This is handled much more efficiently with some form of electronic health record. One thing we are fairly certain of, EHR's will be required at some point in the not too distant future. You should start searching now if you haven't already done so. Implementing the right EHR system for your practice takes considerable time from selection to rollout. You should solicit the help of someone whose experience can benefit you.

Overall, focus on the things you can control now and create a climate of success by doing these things well. That alone will help prepare your practice for the future. Ideally, you should set aside some time every day to 1) review what's working 2) what needs improvement and at the same time 3) prepare for your electronic future.

Julie Hayes is President of Black & White Medical Consulting, LLC (www.bandwmedicalconsulting.com), a Raleigh-based consulting firm that specializes in revenue cycle management for medical practices across the US. They also provide services to healthcare professionals in selection and implementation of electronic medical records systems. Black and White can be contacted at (919) 661-6692 and Julie can be reached at JHayes@bandwmedicalconsulting.com.

What Does It Mean to Scrub an Insurance Claim?

Reimbursement Article

by David Greene, MD

During the rigorous training physicians undergo to learn their craft, very little education is received on how to deal with submitting claims to insurance companies. It's unfortunately a necessary evil, as surgeons who contract with insurance companies rely on that reimbursement as the lifeblood for practice survival.

Receiving payment from insurance payers involves submitting claims after providing treatment. Whether it's in an office setting, emergency room, or an operating room, filing a claim involves supplying the appropriate procedure and diagnosis codes along with any appropriate modifiers pertaining to the treatment performed. However, simply filing a claim does not assure that it will in fact be paid.

The policies of insurance companies for accepting or rejecting claims change often. A claim that got paid last month may be currently denied without notice depending on carrier specific modifications. This results in a large batch of denied claims for surgeons performing many of the same procedures. Not only is it confusing for a practice to attempt following up on these adjustments, it can result in lengthy days in accounts receivables along with rollercoaster collection periods.

Is there a secret weapon orthopedic surgeons can use to assist with streamlining claims to maximize acceptance? That's where claim "scrubbing" enters the picture. The term "scrubbing" refers to an intricate cleaning of a claim prior to submission. Over the past 10 years, automated claims editing has been developed which helps to validate that a claim is appropriate and accurate for submission.

There are two components in scrubbing claims. As the most common error for denied claims is data entry errors, the patient demographic data is reviewed for the most common mistakes. For instance, keying in an incorrect procedure code that is age specific would make the claim invalid, and the scrubber flags those types of errors for correction prior to submission. This is the easy part of the automation.

The complicated portion of scrubbing involves a thorough review of the codes and modifiers to ensure complicity with carrier specific guidelines. This is commonly referred to as the "rules engine." In some fashion, every data element of the claim is analyzed. If a physician submits a claim for a hysterectomy and the scrubber sees a male gender it will obviously be flagged. The scrubber verifies that a procedure performed is associated with a diagnosis code that justifies the medical necessity of that procedure along with variables such as gender, age, date and place of service and any required modifiers. The complexity of scrubbing should not be underestimated. By the time one multiplies the total number of Medicare local and national coverage determinations, along with data from the Correct Coding Initiative (CCI), ICD-9 codes, and modifiers the potential numbers of editable combinations surpasses ten million. Advanced claim scrubbers, though, can review about ten claims per second.

By including national and local coverage determinations from all of the Medicare geographical regions in every state along with data from the Correct Coding Initiative (CCI), approximately 35% of existing CPT codes are represented as a baseline in claims editing programs. There is no Medicare medical necessity guidelines for the remaining 65% of codes, therefore claim scrubber software companies hire clinicians and nurses who work full time evaluating up to the minute medical necessity data posted by insurance carriers around the country on their website as mandated by law. In addition, procedure codes are matched with all feasible diagnosis codes that are believed to be clinically defensible for claim acceptance. As one might expect, this is a costly endeavor so most claim scrubbing software companies license this portion from the few companies performing the research.

So how good are existing claim scrubbers? There's a wide range available, either as a standalone product or integrated with practice management software. Often the billing company utilized will incorporate a scrubber. The best ones will routinely achieve over 95% claim acceptance on the first pass. Practices who were previously performing manual edits typically find that after instituting the technology the scrubber flags over 30% of claims. This means about 30% potential claim denial prior to scrubbing, which drags out the revenue cycle. By having the scrubber flagging problem claims, changes can then be made instantly prior to submission, rather than waiting weeks for a denial. As a result, the practice will see more reimbursement and receive those funds faster. There will also be less back-end work secondary to denied claims.

Can relying on an experienced coder achieve the same acceptance rate? In all likelihood, No. As mentioned, scrubbers check demographic information along with the codes. Also, if a payer changes a filing guideline on its claim form or a medical necessity requirement, a certified coder would probably not be aware of it in a timely fashion. If a surgeon is contracted with a large amount of carriers, the chances of being subjected to rejected claims increases dramatically without a way of continually monitoring these myriad and often complex requirements.

Embracing an advanced claim scrubber, whether directly or indirectly, will allow one's practice to effectively combat the convoluted world of insurance claim rules and regulations. Practices that incorporate claim scrubbing rarely move away from the process. When the bottom line receives a significant boost along with peace of mind from knowing the latest technology is in their back pocket, why would they?

Dr. David Greene is a residency and fellowship trained orthopaedic surgeon. He serves as the Director of Medical Relations for SilverTree Health. He can be reached at dgreene@silvertreehealth.com or (877) 652-8733

WiSpots and STH Announce Joint Venture

Press Release



WiFi media specialists WiSpots Inc., (www.wispots.com) and medical insurance reimbursement specialists SilverTree Health (www.silvertreehealth.com) have announced a new joint venture agreement to provide practice and patient-centric technology solutions for physicians and patients, utilizing the waiting room environment and existing practice infrastructure. The focus of this joint venture is on improving patient satisfaction, education, practice efficiencies and practice revenues.

Combining WiSpots' Web-based and interactive WiFi technology application with SilverTree Health's unparalleled Web-based medical insurance reimbursement technology and client servicing will mean quicker turnaround on accounts receivable and improved service for patients/consumers, health care providers and organizations with a focus on keeping people healthy.

WiSpots Founder and CEO Kevin S. Flannery said, "The broad reach of our solutions will have an enormous, positive impact on the patient, medical practices, the medical community as a whole, media sponsors and health care educators. This joint venture makes perfect sense for WiSpots and will significantly improve our value proposition and position in the marketplace. We are very excited to move forward with SilverTree Health and take the market by storm!"

Together, WiSpots and SilverTree Health will enhance and increase their presence in the health care vertical markets, bringing new growth opportunities to both companies as well as significant support to SilverTree Health's reimbursement technology. They will continue to assist patients, physicians, health care systems, third-party payers and government agencies in their quest for a health care system that's Web-based, easy to use, interoperable, secure and efficient in delivery.

"Our Web-based service offering dramatically increases practice profits ten to thirty percent without increasing fees or volume," said SilverTree Health Director of Medical Relations Dr. David Greene. "By surrounding state-of-the-art technology with unparalleled client servicing, we have shattered the status quo for optimizing practice revenue. In this day and age of decreasing reimbursement, the strategic partnership's value proposition makes perfect sense to increase our client's bottom line substantially."

For more information or to find out how physician practices can participate, contact Kevin Flannery at (919) 272-0204 or Dr. David Greene at (602) 677-8981. Additional information can be found online at www.wispots.com and www.silvertreehealth.com.

SilverTree Health combines state-of-the-art technology with unparalleled client servicing. We are specifically designed to open up profit margins for Medical Practices, ASC's, Urgent Care's, ER's, MCO's and Hospitals nationwide. We only succeed by helping you succeed, it's IN OUR DNA! We'll see you next month.



Sincerely,

David Greene
SilverTree Health