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Achieving best-in-class billing for behavioral health practices

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It's important to set realistic expectations about the billing process, which isn't easy to integrate into regular workflows.

Billing is one of the most critical parts of running a behavioral health practice. This is especially true for large practices, as maximizing efficiency at scale significantly affects their revenue cycle. It's important to set realistic expectations about the mental health billing process, which isn't easy to integrate into regular workflows.

To take on practice billing, clinicians must devote time to learning and accommodating new processes. This includes creating clean claims and monitoring them after submission, correcting and resubmitting rejected claims, negotiating denials, collecting payments from patients, and reconciling bank statements. If any of these steps are skipped, clinicians risk losing some of the reimbursement that is due.

Expecting too much too quickly can lead to disappointment and possibly burnout, neither of which are conducive to competent practice management. Behavioral healthcare billing can be challenging at first, but plenty of clinicians and practices have mastered it with the right tools and guidelines. This includes:

Setting sensible income goals

Clinicians should use billing best practices to their advantage to maximize reimbursement for services. However, they should be patient with the process. It takes time to hone in on service coding skills and become adept at negotiating with payers. These changes will increase a practice's revenue, but it won't happen overnight.

Developing a reporting system

To understand a practice's revenue cycle, clinicians should set up reporting, whether they do that independently or use billing software. A system with advanced reporting features can help clinicians understand exactly what is happening in the revenue cycle. Billing software should provide an overview of aging claims and show how many days each claim has been waiting. This tracking helps with cash flow and allows practices to fix mistakes and denials more quickly.

Payment breakdown reports show which payments have been received from insurance and which from patients so they can be reconciled with bank statements. Productivity reports for providers, while not directly related to billing, nevertheless help make practices more profitable. Also, provider efficiency can be reviewed and reminders can be sent about submitting bills on time.

Setting up a repeatable process

Behavioral health practices should compose a written process for billing procedures that every staff member will follow. This guide should include every step from creating and coding the bill, to submitting it, tracking it, following up on rejections/denials, and receiving payment. This is the best way to stay organized and prevent any oversights.

It is important to document what information to gather from new patients when to perform insurance eligibility checks, and how claims are generated once services are complete.

Practices should keep a schedule for submitting claims, track them, investigate aging claims, and respond to rejections and denials.

Additionally, insurance coverage for existing patients should be periodically checked. Some practices run the insurance information for every patient before each appointment because a patient's insurance status may change at any time, while other practices find this checking frequency too burdensome and instead schedule specific days to update insurance information.

Creating a good billing cadence

The cadence of these tasks will differ depending on the size of the practice and the number of individuals devoted to the billing process. For individual therapists, it's best to check documentation regularly and claims submissions throughout the week, designating time to review any rejected and unpaid claims.

Larger practices with a dedicated biller on staff should visit the revenue cycle every day. Staff should routinely submit each day's claims, work on a portion of claims that require follow-up, check bank statements, and collect patient payments. If a practice is large enough to have one or more billers on staff, the billing workload is heavy enough to require constant and thorough attention. All providers and practices should aim to review their list of aging claims at least every 30 days.

Creating a discipline of regularly managing the revenue cycle is vital for practices today or work will backlog quickly and revenue could be lost. This includes making time to carefully check each claim, running reports on a regular basis, and filing claims promptly after treatment.

Behavioral health practices must be adept at medical billing to survive. Whether they opt to bill in-house or vet and partner with a competent third party to manage the process, it is essential to have a meticulous billing process in place in order to truly flourish.

Ram joined Valant in 2020 as an experienced technology executive to lead the organization through its next stage of growth. His passion for listening to the customer and building strong teams, coupled with his demonstrated ability to drive scalability, provide a solid foundation for Valant to grow as it finds new ways to serve the behavioral healthcare market.

MGMA 2022: Planning for payer contract negotiations

Payer contract negotiations can be a fraughtfor medical practices, but with the right preparation a negotiation can go your way.

Doral Jacobsen, MBA, FACMPE, CEO of Prosper Beyond VBC Inc., gave helpful strategies for how to approach preparation for payer negotiations in her session "Payer contracting 101 – strategies that work" as part of the Medical Group Management Association's Medical Practice Excellence Leaders Conference in Boston.

She says the first the first, important step in preparing for payer negotiations is analyzing the payer mix, which is a breakdown of a practice's charges by payer. Next should come an analysis of gross collections which is the payments received minus the charges by the payer. Then an analysis of administrative burden which allows the practice to quantify the financial impact of the burden. And finally analyzing reimbursement and cost per visit/procedure.

All of these analyses should be folded into the practice's proposal development by reviewing them and identifying the practice's payer targets. The practice should also determine whether their relationship is direct or through another entity.

"Then probably one of the most challenging parts of negotiations or starting negotiations is finding the representative," Jacobsen said.

Once the practice identifies its representative, that individual should supply all executed agreements, production participation list, full fee schedules by CPT code for all products, and the renewal date.

“You’ve got to ask the payer if they have a renewal date that you need to be mindful of,” she explained. “Because if you don't, you might start a negotiation, but it won't be effective for another year because of this renewal date.”

The next step in preparing for negotiations is to model. Jacobsen says her company compares the payment per CPT codes to Medicare.

Next the practice should survey the market.

“This is really important because you’re preparing to talk to them,” she said. “So, you need to know what's going on. Are they rolling out a new product? What are they selling in the marketplace?”

Jacobsen says that she is often asked whether a practice should negotiate with a new payer in the market. She says this is the best time to negotiate.

“They're looking to create a network adequacy,” she says. “That means when they want to sell a product, they have to have a certain amount of OBGYN ,and a certain amount of family practice, a certain amount of orthopedics; and you are part of that equation. So, you're in a position of power whenever when a product is trying to emerge in your market.”

With this information, the practice should be prepared to start crafting their proposal to begin the negotiation.
