

Accounts Coordinator
Procedure Guide

Contents

[INTRODUCTION 4](#_Toc72916925)

[PART 1: EFFECTIVELY TRACKING YOUR COLLECTION-TO-BILLING PERCENTAGE 4](#_Toc72916926)

[KPI Formula: Percentage collected compared to billed 4](#_Toc72916927)

[What the Formula Results Mean 4](#_Toc72916928)

[Formula Results 5](#_Toc72916929)

[PART 2: ACCOUNT COORDINATOR ESSENTIAL POLICIES 6](#_Toc72916930)

[Discussing Pricing Policy 6](#_Toc72916931)

[Patient Financial Policy 6](#_Toc72916932)

[Internal Policy Guidelines for Patient Financial Arrangements 6](#_Toc72916933)

[Option 1: Full Payment at Time of Service 7](#_Toc72916934)

[Option 2: Insurance 7](#_Toc72916935)

[Option 3: Dental Patient Financing 7](#_Toc72916936)

[Option 4: Payment Plan 8](#_Toc72916937)

[Suggested Payment Plan Types 9](#_Toc72916938)

[PART 3: TYPES OF INSURANCE PLANS 10](#_Toc72916939)

[Preferred Provider Organization (PPO) 10](#_Toc72916940)

[Dental Health Maintenance Organization (DHMO) 10](#_Toc72916941)

[Self-Funded Plans 11](#_Toc72916942)

[PART 4: INSURANCE SERVICES CLASSIFICATIONS 12](#_Toc72916943)

[Preventative Dental Services 12](#_Toc72916944)

[Basic Dental Services 12](#_Toc72916945)

[Major Dental Services 13](#_Toc72916946)

[PART 5: GATHERING INSURANCE INFORMATION 14](#_Toc72916947)

[Step 1: Getting Insurance Information from the Patient 14](#_Toc72916948)

[Existing Patients 14](#_Toc72916949)

[New Patients 14](#_Toc72916950)

[Step 2: Getting Insurance Information from the Insurance Company 15](#_Toc72916951)

[PART 6: PRELIMINARY STEPS BEFORE FILING A CLAIM 17](#_Toc72916952)

[Pre-Authorizations for Claims 17](#_Toc72916953)

[PART 7: HOW TO PREPARE AND SUBMIT CLAIMS 18](#_Toc72916954)

[Documentation Attachments 18](#_Toc72916955)

[PART 8: REGULATIONS AND REPORTS FOR COLLECTION EFFICIENCY 20](#_Toc72916956)

[Basic Legal Regulations Covering Claims 20](#_Toc72916957)

[Running and Using Reports to Track Your Claims 21](#_Toc72916958)

[PART 9: HANDLING DENIED CLAIMS 21](#_Toc72916959)

[Denial Categories 22](#_Toc72916960)

[Denials from a Lack of Documentation 22](#_Toc72916961)

[PART 10: FILING APPEALS 24](#_Toc72916962)

[How to Send an Appeal 24](#_Toc72916963)

[Creating an Appeal 24](#_Toc72916964)

[Tips 25](#_Toc72916965)

[PART 11: NON-INSURANCE COLLECTIONS 26](#_Toc72916966)

[General Guidelines 26](#_Toc72916967)

[Billing Guidelines 26](#_Toc72916968)

[Collecting Non-insurance Past-due Accounts 27](#_Toc72916969)

[Collection Call Guidelines 28](#_Toc72916970)

[Prior to the Call 28](#_Toc72916971)

[The Call 28](#_Toc72916972)

[After the Call 30](#_Toc72916973)

[PART 12: NEGOTATING RATES WITH INSURANCE COMPANIES 31](#_Toc72916974)

[PART 13: FEE SCHEDULE – ADDENDUM A 32](#_Toc72916975)

# INTRODUCTION

This guide is a tool to demonstrate the specifics for your position and the procedures for operation. It breaks down each component of the accounts coordinator position and the expectations for performance. For detailed patient scenario scripting examples, please refer to ePractice Manager’s online document library on your company’s portal.

# PART 1: EFFECTIVELY TRACKING YOUR COLLECTION-TO-BILLING PERCENTAGE

One of the key performance indicators (KPIs) you should measure is Percentage Collected Compared to Billed. However, although cash patients should be paying as close to the time of service delivery, insurance payments usually include a 15- to 60-day turnaround from the time of billing. For this reason, data must be collected for more than just one month's services and collections, otherwise the metric would not take into account the turnaround time for insurance payments.

## KPI Formula: Percentage collected compared to billed

 THIS MONTH'S COLLECTIONS + LAST MONTH'S COLLECTIONS

LAST MONTH'S SERVICES + SERVICES FROM THE MONTH BEFORE LAST

The services amount used are the adjusted services. This means that only paid services resulting in monetary collection should be counted. Any services that were not paid for (e.g., barter, charitable work, etc.) should not be counted when generating this metric.

For example, if this month is March, you would take the total of March's collections plus February's collections. You divide this total by the total of February's adjusted services plus January's adjusted services.

MARCH COLLECTIONS + FEBRUARY COLLECTIONS

FEBRUARY ADJUSTED SERVICES + JANUARY ADJUSTED SERVICES

This formula covers the collection and services figures of the same month (February's collections and February's services), a 30-day lag (March's collections and February's service), and a 60-day lag (March's collections and January's services).

## What the Formula Results Mean

The percentage you get from this formula should be graphed monthly. An effective accounts department should be collecting at a rate of at least 90% each month.

### Formula Results

|  |  |
| --- | --- |
| **Percentage** | **Indication** |
| 98% to 100% | **Excellent** Indicates that the accounts manager has the accounts well under control. |
| 95% to 97.9% | **Acceptable**Indicates that the accounts manager is working the accounts and has the area fairly under control, but there may be money slipping through the cracks that should be collected. |
| 90% to 94.9% | **Barely satisfactory**Indicates that the area is collecting money but not really diligently working the accounts. Receivables are likely increasing and going into the 90 to120-day range, and funds are becoming less collectible. |
| 89.9% and below | **Unsatisfactory**Indicates there are problems in the accounts area that need to be found and handled immediately. |

# PART 2: ACCOUNT COORDINATOR ESSENTIAL POLICIES

## Discussing Pricing Policy[[1]](#footnote-1)

Pricing and payment terms should not be discussed over the phone with potential patients. Instead, you must ensure that the proper procedure is followed by the staff member handling patient enquiries.

Although this job duty is usually handled by the patient coordinator when potential patients call, the accounts coordinator should also be fully able to

1. ensure the schedule coordinator is properly performing this job duty
2. handle this duty in the absence of trained front office staff

## Patient Financial Policy[[2]](#footnote-2)

Your office should have firm written financial policies that are clearly understood by both staff and patients, and which every patient or patient guardian should sign. If your office does not have such a written policy, it is important that you develop one and get it approved by your office manager and owner. Never service patients without them reading and signing your office patient financial policy. Without this signed policy, you will have no written agreements with patients and, therefore, collections will be much more difficult.

## Internal Policy Guidelines for Patient Financial Arrangements

Patients have multiple financial arrangement options. The accounts coordinator provides the patient with the following options, in the order listed, until a firm financial arrangement is made:

### Option 1: Full Payment at Time of Service

If it is known that a patient has insurance coverage, proceed to option 2. If a patient does not have insurance, payment in full is expected. Requiring payment in full at the time of service ensures higher practice cash flow and overall simplicity.

If a patient indicates a concern or problem regarding payment in full and your practice owner approves it, you might offer a 5% or 10% discount for payment in full. This provides incentive for the patient and cuts your administrative costs, as you do not have to do any extra financing work and the practice does not have to carry the balance for the account.

Whether payment in full is made by credit card, cash, or check, the accounts coordinator should be able to handle each of these payment methods (e.g., able to obtain credit card authorization, require check guarantee or verification for personal checks, issue receipts for cash transactions, etc.).

Do not offer other options unless there appears to be an obvious need.

### Option 2: Insurance[[3]](#footnote-3)

Make every possible attempt to gather all pertinent insurance information prior to the patient’s arrival so that you can obtain the necessary pre-authorization, co-payment percentages, and deductibles.

Ensure that the patient is covered for the services that will be performed. Submit pre-authorizations as soon as possible, but do not allow this to slow or stop services.

Your patient policy should clearly state that the patient is to pay the copay amount at the time of service as well as any deductible that has not been met.

### Option 3: Dental Patient Financing

If patients cannot pay in full for the amount that is their responsibility, using a finance service is preferable than the practice carrying a balance for a patient. There are several finance companies offer low or no interest credit lines for medical/dental care. Almost all have fast, online or over-the-phone applications, and most provide a response on approval almost immediately (depending on the amount requested and the person’s credit worthiness). These finance companies typically pay the practice, and the patient then pays the finance company monthly. Sometimes the finance company provides a type of medical credit card that the patient can use for approved services.

Some of the most popular finance companies include the following:

* CareCredit: [https://www.carecredit.com/](https://www.carecredit.com/howcarecreditworks/prospective/#howtoapply)
* Healthcare Finance Direct: [http://corp.healthcarefinancedirect.com/](http://corp.healthcarefinancedirect.com/Practices/Orthodontics)
* DentalLoans.com: [https://dentalloans.com/](https://dentalloans.com/landingpage/?PPC=G-MF710&gclid=CjwKEAjwl9DIBRCG_e3DwsKsizsSJADMmJ11CyA0DfBJq9hjyBzWQF08jEpZC0-rb_0PlzRURDUAYRoCi1Dw_wcB)
* SimplePay: <https://www.simplepay.com/>
* Comprehensive Finance: <http://www.comprehensivefinance.com/>
* Lending Club: <https://www.lendingclub.com/patientsolutions/providers>

### Option 4: Payment Plan[[4]](#footnote-4)

The last options, setting up a payment plan, should be used only as a last resort. Before establishing a payment plan,

1. get a credit/background check approval signed so you are authorized to do a credit and/or background check on the patient
2. assess the patient’s credit worthiness through a credit application and thoroughly review their credit history

If the patient meets the credit requirements for a payment plan, establish an appropriate minimum monthly amount that the patient will be billed. Avoid carrying large accounts with small monthly payments, as that is not efficient or cost-effective for the practice. A service charge or interest should be applied to any credit extension.

Keep in mind that in most cases, if the patient doesn’t qualify for financing through a financing company, it is unlikely to be beneficial for the practice to finance them.

### Suggested Payment Plan Types

If you chose to offer a payment plan to a patient, here are some suggested guidelines for installment payments, listed in order by most preferred to least preferred:

1. The patient pays half of the bill at the time of treatment and the remaining amount is paid in the following month.
2. The patient pays half of the bill at the time of treatment and the remaining amount is paid over the next three months through equally billed installments.
3. The patient pays a third of the bill at the time of treatment and the remaining amount is paid in two equally billed installments.
4. The patient pays only the lab fees at the time of treatment and the remaining amount is paid in equally billed installments over the following six months.
5. The patient makes a minimum down payment, such as $300, with the remaining amount paid in equal installments over the following six months.

Have the patient sign a payment agreement[[5]](#footnote-5) that covers the terms agreed upon.

# PART 3: TYPES OF INSURANCE PLANS

Dental insurance plans can either be a Preferred Provider Organization (PPO) or a Dental Health Maintenance Organization (DHMO) plan.

## Preferred Provider Organization (PPO)

You will see PPO plans most often, as they are used by most employers and patients. PPOs offer the patient a choice of dentists within their insurance’s preferred providers network. The preferred providers agree to accept the fees designated in their insurance contract rather than their normally higher customary fees. The patient typically pays a monthly premium for the insurance plan plus a co-pay fee at each visit, which is a percentage of the overall fee.

Other common features of PPO plans include the following:

* Coverage typically includes 100% coverage for preventative services, 80% coverage for basic services, and 50% coverage for restorative services.
* The patient must first pay a yearly deductible before insurance will pay out.
* There are annual dollar limits on benefits.
* Out-of-network providers cost more for the patient.
* The plans are regulated by state insurance departments.

## Dental Health Maintenance Organization (DHMO)

DHMO dental plans provide comprehensive dental care to enrolled patients through one specific dental office only. The dental office receives a flat monthly payment (e.g., a “capitation” or “capitation rate/fee”) for each patient enrolled in the plan regardless of how many or how few services the patient receives; however, the patient must usually receive at least one or two cleanings per year to qualify.

The patient chooses a dentist from a list of approved dentists in their network and pays a monthly fee (e.g., a premium). Co-payments are normally required for each visit.

Other common features of DHMO plans include the following:

* Plans include free preventative care.
* There is an annual dollar limit on benefits.
* The plans are regulated by state insurance departments.

Most dentists try to avoid these plans when possible, as they pay at a much lower rate than their usual fees and/or what PPOs pay. The rates are often so low that they are not profitable for the services rendered.

## Self-Funded Plans

PPO and DHMO plans can also be created as a “self-funded” plan. This is an arrangement where an employer provides dental (or other) benefits to its employees with its own funds. The employer contracts with an insurance company to administer the plan, including processing and paying claims with funds provided by the employer. With self-funded plans, you will still be dealing with an insurance company as you do with any other plan, but the insurance company is not the insurer—they act only as a “3rd party administrator”.

The only other difference between self-funded plans are regular PPO/DHMO plans is that they are governed by federal laws and regulations rather than by the state.

It is an important part of your job to know and understand the specifics of each patient plan that you encounter.

# PART 4: INSURANCE SERVICES CLASSIFICATIONS

There are three categories of classification for services normally used by insurance companies, and each classification is reimbursed differently depending on the specific insurance plan contract. The general percentage guidelines for coverage are discussed below, but you must **always** check the percentages that each insurance provider covers for each service.

## Preventative Dental Services

Preventative services promote good oral health and function by preventing or reducing the onset of oral diseases. PPO providers normally pay a benefit of 80-100%, usually after the deductible is met.

Covered preventative services normally include

* exams
* cleanings (prophys)
* Bitewing, periapical, and panorex x-rays (with different frequency restrictions on each)
* fluoride treatments (age restrictions may apply for some plans)
* space maintainers and tooth sealants (both of which may be a basic dental service for some plans or have age restrictions)

## Basic Dental Services

Generally, basic dental services are straightforward services that don't involve a significant laboratory expense. PPO providers normally pay a benefit of 70-80%, usually after the deductible is met.

Covered basic dental services normally include

* emergency care for pain relief
* simple fillings (amalgam or composite – not inlays, onlays, or crowns)
* routine extractions
* endodontics (i.e., root canals) (may be a major dental service for some plans)
* periodontal treatment (e.g., root planing and scaling)
* periodontal surgery (may be a major dental service for some plans)
* sealants (may be a preventative dental service for some plans)
* recementing crowns

## Major Dental Services

Major dental services are relatively more complex and often involve dental laboratory expenses. These services tend to be costlier than those found in the basic category. PPO providers normally pay a 50% benefit on these services after the deductible has been met.

Covered major dental services normally include

* crowns
* inlays and onlays
* bridges
* implants
* removal of impacted wisdom teeth (may be a basic dental service for some plans)
* complex oral surgery procedures
* use of sedation or anesthesia
* complete dentures
* denture repair
* orthodontics

# PART 5: GATHERING INSURANCE INFORMATION

The first and most important step to being an effective advocate for your patients and office when dealing with insurance companies is to get all the information you need in order to fully understand all of the terms and conditions of each patient’s policy. Without this, your ability to properly control the claim from submission to payment will be greatly reduced.

Most patients have very little understanding of their insurance coverage terms. Therefore, to properly service your patients, it is important that you know what services their policy covers, what percentage it pays on each service type, what pre-authorizations may be needed, and what benefits exist and/or if any are left.

There are two sources that can be used to gather insurance information: the patient and the insurance provider.

## Step 1: Getting Insurance Information from the Patient

Your first step for gathering insurance information is to get as much data as you can from the patient. In most offices, the patient coordinator gathers the initial policy information from patients when making appointments. As the accounts coordinator, you must ensure that the patient coordinator is fully trained on this process and provide them with the Insurance Verification Form and any other necessary forms.

### Existing Patients

Existing patients often change policies, so it is important that the schedule coordinator always ask if there have been any changes in the patient’s insurance coverage when making appointments. If there have been changes, follow the same steps outlined below for gathering insurance information from a new patient.

### New Patients

When a new patient makes an appointment, the patient coordinator will ask the patient if they have a dental insurance policy and, if so, to answer a few simple questions about it. The patient will know most of this information but should also be prompted to have their insurance card in hand during the call.

The following information should be gathered:

* Name of the policy holder
* Date of birth of the policy holder
* Policy holder address & phone number
* Name and date of birth of the patient (if different than the policy holder)
* Name of the insurance company
* Phone number of the insurance company
* Policy holder’s social security number and/or the policy ID number
* Policy group number
* Name of their employer (if policy is provided by an employer)
* Whether the plan includes single or family coverage (if known or noted on the insurance card)

## Step 2: Getting Insurance Information from the Insurance Company

The second step for gathering insurance information is to speak with a representative from the insurance company. The insurance company’s phone number should have been included in the information received form the patient.

Always attempt to call the insurance company prior to the patient’s appointment. If for some reason you don’t have the necessary information until the patient arrives, call the insurance company while the patient is waiting in reception and/or in their appointment.

When calling the insurance company, you will likely get a recording of options to choose from. Always opt out of any “Fax Back” or “Fast Fax” options for coverage information, as the faxes normally do not include all necessary information. Always speak to a live person and get all necessary information to complete the form.

Being fully prepared to have a conversation with an insurance representative is a very important part of being the patient’s advocate. You can be most prepared by

* ensuring that you understand all the terms and explanations on the form. Not understanding the terms could result in you being confused by what you are asking and/or whether you are getting the answers you need
* having an Insurance Verification Form in front of you that is filled out with all the information you previously received from the patient
* completing the form by hand while on the call, which is much simpler and quicker than trying to enter the data into your system while talking with the representative

Although you will enter the information gathered into various places in your practice management software program, you should also keep a copy of the hand-written form for future reference in case any conflicts arise with the insurance company on coverage. When you are done with the call, type all the data into the same blank form you have in your computer, and scan the original hand-written form into the patient file for easy access.

You do not need to go through the entire Insurance Verification Form when you have two or more patients on the same plan (e.g., family members or co-workers). You can save time by simply verifying with the insurance company that they are on the same plan and get any relevant history information from the patient.

# PART 6: PRELIMINARY STEPS BEFORE FILING A CLAIM

Before filing a claim, complete the following steps:

* Enter the information for each insurance company you encounter into your practice management software, including their phone number, address, and payer ID. If any information is missing, get it from the insurance company and/or clearing house.
* Ensure that the treatment coordinator or assistant has entered the treatment plan into the patient’s chart upon conclusion the of the patient’s exam.
* The accounts coordinator prints out the treatment plan, including the estimates for what the insurance will cover and what the patient will be responsible for.
* The accounts coordinator meets with the patient to go over the treatment plan costs, including the estimate of what their insurance will cover and what the patient will be responsible for. You will then set an agreement for how the patient will pay their portion of the cost, collect payment for that day’s service, and see that they are scheduled for treatment.

## Pre-Authorizations for Claims

Insurance companies may require a pre-authorization for a treatment plan for large cases, such as multiple crowns, bridges, implants, and services that could be considered cosmetic. Pre-authorization should be obtained before the service is completed or the claim is filed. It is also suggested that you send a request for pre-authorization if you are uncertain whether one is necessary.

# PART 7: HOW TO PREPARE AND SUBMIT CLAIMS

Use the following steps to submit a claim:

1. In the ledger, highlight the services you are going to submit.
2. Create a new claim form that includes the highlighted services and the estimated insurance payment. Some software will also show what the patient owes.
3. (Optional) Batch each claim created during the day so they all can be reviewed before being sent to the insurance company. Depending on your software, you can set new claims to auto-batch or manually click to batch each one. Don’t batch the claim if you want to send it right away.
4. At the end of the day, send the batched claims to the clearing house and review them prior to sending to the insurance companies. Check for accuracy of services delivered, correct fees and codes, any necessary documentation attachments, and any errors prior to sending.
5. When done reviewing the claims within the clearing house and correcting any errors, select the ones that don’t need documentation attached, and click send. The clearing house will then submit those claims to the insurance companies.
6. For the remaining claims that require documentation attachments (such as x-rays or a narrative), attach the required documentation to each claim and click send. The clearing house will then submit those claims to the insurance companies.
7. As you soon as the clearing house sends the claims, you will receive a report detailing which claims went through and which didn’t due to missing information (e.g., a missing birthdate, address, etc.). If a claim doesn’t go through, correct it immediately and resend.

## Documentation Attachments

Certain claims require supporting documentation to be attached or included with the claim. Typical attachments include x-rays, intra oral pictures, and narratives (i.e., a short explanation of a diagnosis).

When sending attachments,

* always send the required attachments at the same time you send the initial claim—don’t wait for the insurance company to request them, as that will delay payment by several months
* know which insurance companies accept electronic attachments with electronic claims. You should be able to find this out from your clearing house’s payors list.
* if the insurance company doesn’t accept electronic attachments, call them and find out if they have an email address you can use to send the documentation
* if there is no way to send documentation in any electronic format, send the claim electronically and then print and mail the claim and attachments.
* do not send any attachments (electronic or hard copy) to Blue Cross and Blue Shield or Educators Mutual Insurance (EMI). As of 2017, they do not accept any type of attachments, and submitting attachments will slow down the payment of a claim.

# PART 8: REGULATIONS AND REPORTS FOR COLLECTION EFFICIENCY

Your office loses money when claims or any patient accounts are not paid within 30 days. Therefore, it is important that you do everything possible to ensure the practice is paid on time, and a key part of that is keeping pressure on the insurance company through consistent follow up to ensure they pay on time.

For rapid collections, you must

* understand the basic claim payment regulations in your state for insurance companies
* run regular reports so you know the length of time for each outstanding claim
* properly follow up with the insurance companies on outstanding claims
* appeal denied claims
* file complaints with the insurance commissioner, as needed

## Basic Legal Regulations Covering Claims

The payment of claims by insurance companies are primarily governed by laws and regulations enacted by each state and overseen by the state’s insurance commissioner and/or their insurance department or agency, with self-funded plans being the only exception.

Some key points to know about basic legal regulations for claims include the following:

* Insurance companies are required by law to pay or deny claims within a specific period of time. In most states, it is within 30 days of receipt of the claim.
* If an insurance company denies a claim, they must provide a reason for the denial, which you can then appeal.
* Insurance companies will often take more than 30 days to pay a claim since few offices file complaints, so it is important that you follow up frequently.
* Some insurance companies will not pay claims that are older than a specified time period or that don’t have requested documentation sent within a specified time period, so you must file claims in a timely manner with all necessary documentation.
* If you feel an insurance company is violating state or federal regulations, you can and should file a complaint.

Find out from your state or federal agency which applicable laws and regulations govern dental insurance companies operating within your state, including

* the time period that the insurance company has to pay or deny a claim
* any regulations concerning when a claim can be considered too old to pay

## Running and Using Reports to Track Your Claims

To properly track your claims, the first step is to run reports so that you know the status of every claim submitted by your office. Your software will have a reports section with an option labeled as “insurance aging” or “outstanding claims” from which you create the reports.

At the start of each week, you should run several reports for outstanding claims

* 0-29 days aged
* 30 - 59 days aged
* 60 - 89 days aged
* 90 days or more aged

Many software programs also allow you to create each of these reports per insurance company. If possible, you should sort the reports in this manner, as it will simplify the process when you are speaking with each insurance company.

Using these reports, call each insurance company for each claim that has been submitted and find out what is going on with the claim and why it hasn’t been paid if over 30 days.

If you are new to the job and/or your office hasn’t been as on top of tracking claims as they should be, you may find many claims older than 30 days. Always follow up on the oldest claims first because, as previously mentioned, insurance companies often will not pay claims older than a specified date—sometimes as little as over 90 days.

Once the older claims are worked, focus on the 30-day+ claims to prevent them from going into the 60 and 90-day categories.

When the 30, 60, and 90+ day outstanding claims have been worked, you can start working on the claims under 30 days by calling 2 weeks after submission.

If you diligently follow this procedure, you will keep the majority of your claims under 30 days, which will enhance the income and viability of your office.

# PART 9: HANDLING DENIED CLAIMS

If an insurance company denies a claim, they are required to notify you and explain why within (usually) 30 days. You will typically be informed of the denial with an explanation and how to rectify the denial (if possible) through a mailed Explanation of Benefits/Payment (EOB), which the patient also receives.

The reason for denial should be found in a “remarks” section at the bottom or on the back of the EOB with corresponding patient and procedure numbers. Additionally, you may find out about a denial when going over claims with the insurance company during your weekly calls.

Usually, the denial is reason is due to a lack of needed documentation, but it can also be for less obvious reasons.

## Denial Categories

Denials can be divided into two categories:

* Claims that require additional information to be reprocessed
* Claims that are denied with no additional requests for information

Each denial will be handled differently depending on the type. Therefore, when you find out about a denial, do the following to ensure you fully understand it and can determine which of the two categories it fits into:

* If the denial is from an EOB, read through it and ensure you fully understand what is being said and what, if anything, is required to rectify the claim.
* If you have any uncertainty on why the claim was denied or what is needed to reprocess it, call the insurance company to fully clarify the information.
* If you first find out about a denial while on the phone with an insurance rep, make sure you fully clarify the reason for the denial and what can be done to fix it.

## Denials from a Lack of Documentation

When claims are denied for a lack of proper documentation, send the needed documents right away and verify that the insurance company received it. The best way to do this is by using a third party document provider like NEA.

If you don’t have a third party document provider,

1. Prepare an email containing the needed reference numbers and additional documents.
2. Call the insurance company.
3. Tell a representative that you want to email the documents and ask for a direct email address.
4. Send the email and stay on the phone until you’ve verified that the email and documentation has been received and that the claim will be reprocessed.

If for some reason you can’t accomplish one of the above re-submission methods, you will have to mail a copy of the denied EOB with the requested documents or send the previously submitted claim again with the needed documents through your clearing house. In the remarks section of the new claim, add that this a response to “claim #\_\_\_ found on EOB #\_\_\_”, so they know which claim the re-submission applies to.

# PART 10: FILING APPEALS

Some claims will be denied without a request for more information. At this point, your only option is to file an appeal with the insurance company *if you feel it is a valid claim for covered service.*

## How to Send an Appeal

The EOB may show where to send the appeal, which may be a different address than their normal claims address. Then call the insurance company to find out

* where to send the appeal (if not provided on the EOB)
* what reference numbers (e.g., claim number, EOB number, etc.) or documents to send with the claim to ensure it goes to the right department
* if it can be faxed or emailed to speed up the process (if possible, get the email address or fax number and document it for future use)
* if you use a third party document processor, find out if the insurance company will accept the appeal through this service. If so, find out any details about what is needed of this process. ***Note****: If you use NEA or a similar company, they will have a list of cooperating insurance companies. If the insurance company you are talking to isn’t on this list, skip this step.*

## Creating an Appeal

Your written appeal should be concisely written in two to three paragraphs and be easy to understand. Only discuss why the claim is valid and why the denial was improper. Show how you’ve given sufficient evidence for the claim to be processed, and request that they promptly reprocess the claim.

If you see any violations of the law or regulations, such as excessive time or a blatantly wrong denial, you can mention that they may be in violation of the law and your next step, if they continue to deny it, is to file a complaint with the insurance commissioner.

Always close the appeal by thanking them for their time and effort in resolving the matter.

### Tips

* Never back off from appealing what you feel is a valid claim.
* Always check where your appeals are during a weekly call with the insurance company. Hearing back on an appeal should take 1-2 weeks maximum.
* You will sometimes run into denials that really have no validity for being denied. If it seems like a blatantly wrong denial, you can call the insurance company and demand that they pay, as it is obviously a wrong denial and very possibly a violation of their regulations. You can also say that you may have to file a complaint with the insurance commissioner, which may cause them to immediately reconsider it and get it processed.
* Insurance companies often flag offices that always fight denials. It’s been found that, after a while dealing with a “fighting office,” they will pay that office more often than offices that never put up a fight.
* When dealing with patients who have a poor plan and/or a continually difficult insurance company, if the plan is through their employer, you can advise the patient to contact their companies HR department and inform them of the problems with the plan. The employer may not be aware that many of their employees are disgruntled with the plan if they don’t hear from them. If HR receives numerous employee complaints about the plan, they may look into changing insurance companies.
* Each insurance company has varying time limits on how much time you have to file an appeal after a denial. If you have a backlog of appeals to file, find out from each insurance company what their time limit is and prioritize your appeals based on which have the least time left to file.

# PART 11: NON-INSURANCE COLLECTIONS

## General Guidelines[[6]](#footnote-6)

The following guidelines will help your collections on non-insurance amounts owed and keep your aging of accounts as low as possible.

1. Follow the proper credit check procedure before extending credit to any patient**[[7]](#footnote-7)**.
2. Monitor all accounts monthly so you know which have become delinquent. Take immediate action on any account over 30 days past due.
3. Flag past-due accounts with a notation on the patient’s chart. This will make it easier for any staff member to see that the patient has a past due account, making it more likely to get addressed.
4. Each day, review the schedule for the next day so you will be prepared to meet with any patients whose accounts may need to be addressed. Coordinate with the receptionist regarding any patients you want to meet with personally and any patients that need to provide payment at the time of service.
5. If a patient you planned to collect from has forgotten their checkbook or does not have the agreed-upon amount, the receptionist should contact the accounts coordinator or the office manager to address the matter.
6. Patients with delinquent accounts who are not making any attempt to handle the matter should be sent to a collection agency as soon as possible before the account gets too old to realistically expect payment.
7. Ensure statements are accurate and mailed on time every month.

## Billing Guidelines

Use these guidelines when preparing billing statements to ensure accuracy:

* Ensure that bills are neat and professional in appearance.
* Ensure that the spelling of the name and address are correct.
* Itemize the services performed.
* Avoid repeating a charge that has already been paid on the bill.
* Indicate a due date.
* Any amounts that were previously billed but not paid should be listed separately, and the balance should be carried forward.
* Use appropriate notes on the statements such as “Thank you for your payment.”
* Determine exactly when you are going to send your bills out, get them prepared a few days in advance, and promptly send them all out. ***Note****: Most people tend to pay bills that come closest to the beginning of the month and postpone those received later in the month.*

## Collecting Non-insurance Past-due Accounts

All contact with a patient should be handled in a friendly, professional, and dignified manner that promotes respect for the office and its business practices.

Keep in mind the following points regarding patients with overdue accounts:

* Most people have good intentions and want to keep the agreements they have made.
* Even with an overdue account, most people still have good intentions and want to take care of the matter.
* Most people prioritize their bills and will pay those they feel are most pressing first.
* Most people with past-due accounts will pay those bills for which active requests for payment are made.

Keeping these points in mind, your role is to become one of the creditors your patients will not put off further. Ensuring that the following actions are implemented will increase your effectiveness:

* Bill promptly every month.
* Ensure that your bills are accurate.
* Ensure that you have the original signed financial agreement from the patient.
* Contact the patient as soon as you realize the account is delinquent.
* When you make contact, let the patient know you believe they are able to make the payment.
* Let the patient know that you expect to be paid. Refresh their memory regarding the signed agreement.
* Allow the patient their self-respect. Never insult or badger them.
* Explain to the patient that you want to help work out a way to maintain the agreement they made with your office.
* Be prepared to offer some options the patient may not have considered.
* Be willing to communicate with the patient so that a true understanding and agreement can be reached.
* If necessary, and as a last resort, utilize the credit reporting associations and collection agencies. Let the patient know that you are planning to do so and that this will affect the patient’s credit rating.

## Collection Call Guidelines

The following guidelines will help you effectively deal with patients over the phone when calling on overdue accounts.

### Prior to the Call

1. Study the patient's account record and all other documentation to ensure that you have all the information necessary to make a complete and accurate call.
2. Know the correct and complete name of the person you will speak with. You want to talk to the person responsible for the account, so be sure to have that information available.
3. Be in the right frame of mind when you place the call. Think positive and believe that you are going to resolve the account. Do not call with any attitude of anger or anxiety. Be cheerful, yet professional.

### The Call

1. Introduce yourself and state the purpose of the call. Be very deliberate in your statement about the account and do not rush or mumble through it. Once you’ve stated your purpose, give the patient an opportunity to respond.

***Example****: “Hello, Mrs. Smith? This is Mary Jones from Dr. Nelson's office. How are you this evening? I am calling you about your account. Our records indicate that you have an outstanding balance of $350, and I am inquiring as to when we might expect that payment.”*

1. Do not make the patient feel embarrassed or as though they have done something wrong. Do not verbally attack them, and avoid statements such as, “I'm calling about the $350 that you haven't paid us for four months!”
2. Your tone of voice is very important. Do not be hostile or angry, and never be abrupt or accusatory with the patient. Understand that this is a tough position to be in, and think of yourself as helping the patient solve a problem.
3. Don't harass or attack the patient’s character, and don't make threats (such as sending to collections and/or an attorney) except as a last resort only if you fully intend to follow through.
4. Once you have identified yourself and stated the purpose of your call, do not say anything more. There may be a long silence, but if you must wait for the patient’s response.
5. Give the patient the chance to speak and truly listen to what they say.
6. If the patient resists, throws out objections, or is just generally uncooperative, let them say everything they have to say, let them know that you understand, and then handle the objection, confusion, or other statement by giving honest and realistic answers. This will leave them with no arguments to fall back on.
7. Tell the patient that it is an advantage and benefit to make a payment. Let them know the advantages include not getting turned over to a collection agency, feeling better because an agreement has been reached, and not harming one’s credit rating.
8. Ask leading questions that will bring you to a resolution. You must determine the actual cause of non-payment, and to do this you need information from the patient. Work with them to find out how the bill can be fully paid.
9. Keep in mind that the patient really does have the ability to pay. It is most likely just “inconvenient” to pay you in full today. So be persistent and realistic, and keep going until you get the results.
10. Only suggest partial or monthly payments if you have determined that it is the only way the patient will be able to make the payment. If the patient is already on monthly payments that have fallen behind, then the amount to collect at that time would be the amount needed to bring the account current.
11. At the end of the call, in a deliberate and clear manner, reconfirm what the patient has agreed to do, and ensure that the exact amount and due date are clear.

### After the Call

1. Follow up with a letter confirming the arrangement and thanking the patient for taking the time and effort to handle the account.
2. Keep a very accurate and careful record of the phone call in the patient file, including the exact agreement reached during the call. In some states, it is legal to record the conversation. Recording calls is advised when permitted.
3. Set up a system with a calendar or logbook so you know exactly when to expect the payment and when any follow-up calls should be made.
4. If you have taken each of these steps and payment has not been made, place the account with a professional collection agency or write it off. Then notify the patient.

# PART 12: NEGOTATING RATES WITH INSURANCE COMPANIES

Insurance carriers will never reveal that you can negotiate reimbursement rates, but many dentists who know how have successfully negotiated rate increases of nearly 20% from enforced lower rates. That means you can get up to 20% more income for the same amount of work.

To do this, you should treat insurance negotiations no differently than negotiations with any vendor. Just as you shouldn’t hesitate to negotiate better prices for supplies to keep your overhead down, you shouldn’t hesitate to negotiate better reimbursement rates to increase your income.

The best person to negotiate reimbursement rates for the office is normally the dentist. They carry more weight with the insurance representatives, and they are much less likely to try to intimidate a doctor than an accounts coordinator or office manager. The best time to negotiate is when you take on a new PPO plan.

# PART 13: FEE SCHEDULE – ADDENDUM A

A fee schedule is an outline of codes and charges according to insurance contracts. Addendum A contains the standard allowable fee schedule that is submitted by the practice for all patients and all procedures in order to charge everyone the same fees. Those without insurance will pay these fees, while insurance contracts have their own fee schedules and adjustments that must be adhered to in order to participate with a carrier. Any adjustments to a patient’s account are done once the EOB is received and we are informed what the adjustments should be.

1. For a thorough write-up on how to properly handle price inquiries from potential patients, refer to **Handling** **Price Shoppers and New Patient Inquiries** in the ePM Document Library under the Receptionist & Scheduling Coordinator Course. [↑](#footnote-ref-1)
2. Example patient financial policies and associated forms can be found in the ePM Document Library under the **Accounts Coordinator Course**. [↑](#footnote-ref-2)
3. For information on insurance-related tasks, refer to the **Insurance** **Coordinator** **Job Description** in the ePM Documents Library, and to the **Accounts Coordinator Courses**. [↑](#footnote-ref-3)
4. For example, payment plan forms, refer to the **Credit Application Form** and **Credit/Background Check Authorization Form** in the ePM Document Library under the Accounts Coordinator Course. [↑](#footnote-ref-4)
5. For an example of a signed payment agreement, refer to example **Installment Payment Template** in the ePM Document Library under the Accounts Coordinator Course. [↑](#footnote-ref-5)
6. For additional guidelines on collecting insurance amounts owed, refer to the **Insurance Coordinator Job Description** in the ePM Documents Library, and to the **Accounts Coordinator Course** and the **Insurance Coordinator Course**. [↑](#footnote-ref-6)
7. For credit check procedure, refer to the **Accounts Coordinator Courses.** [↑](#footnote-ref-7)