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Optometry Coding & Billing Alert

Build a Better Business: Keep Your Payments Coming In By Focusing on Timely Filing

With the Medicare deadline cut from three years to one, using a chart can help.

As the impact of healthcare reform continues to define how medical practices work, one result is a decrease in the amount of time you'll have to file your optometry claims. Section 6404 of the Patient Protection and Affordable Care Act reduces the maximum time for submission of all Medicare FFS claims from three years to one calendar year after the date of service.

So if you're unprepared to process claims quickly, you'll be doing a lot of write-offs. That is, of course, unless you follow these expert-approved tips.

1. Keep a Chart and Stick to It

Timely filing means that your practice submits a Medicare fee-for-service (FFS) claim within the timeframe determined by the carrier.

Under the new law, claims for services furnished on or after Jan. 1, 2010, must be filed within one calendar year after the date of service. The previous timeframe was three years.

The result: Medicare will deny your claim if it arrives after the deadline date, so your practice has to stay on top of claims.

Tracking claims with short filing times is key to staying on top of filing deadlines, stresses **Quinten Buechner, MS, MDiv, CPC, BMSC:ACS-FP/GI/PEDS, ACMCS:PCS, PHIA: CCP, PAHCS:CMSCS,** president of ProActive Consultants, of Cumberland, Wis.

Best practice: Perhaps the easiest way to keep track of multiple payer timely filing rules is to make a chart (such as a spreadsheet) that lists each insurance company's timely filing limit. Look through your claims and pay special attention to ones that were not sent within 30 days, Buechner says. Then, using your chart, you'll be able to quickly identify the payer with the shortest limits and work on those claims first.

2. Make Sure You Keep Proof On Hand

One good rule of thumb is to always keep proof of the electronic filing, says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPC-H, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J., and senior coder and auditor for The Coding Network.

Option 1: You can use a claims clearinghouse that stores your confirmation of receipt by your payers so that you can access them on demand when you need to appeal timely filing denials. If your clearinghouse does not provide this service, consider changing to one that does, Buechner advises.

Option 2: If your practice does not want to or cannot change its process, the alternative is to print these confirmations on paper. You might also save them as PDF files when you receive them from your clearinghouse and store them locally on your computer so that you can use them to prove timely filing.

Keep in mind: Timely filing denials from payers are not always correct. Pull your electronic confirmation reports and see if you have proof that the claim was in fact submitted on time. This will give you ammunition to appeal the denial,

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Cobuzzi explains.

3. You Have Options if the Patient Held Up the Claim

If your practice had the claim ready to send, but the patient did not provide his insurance information in time, you may have a few options. You can

1. Appeal

2. Write off the claim

3. Follow-up with the patient for the money.

The only time you can submit a bill to the patient after the timely filing deadline and successfully seek payment is if the patient did not provide you with the proper information before the filing deadline. The payment then becomes the patient's responsibility, and you should bill the patient rather than write off the claim amount.

Here's how: To appeal when the patient delays insurance information, send a letter to your payer and include a printout from your system that shows the insurance information and when the patient gave it to your office. In the letter, ask the payer to rescind its denial based on timely filing and instead deny the claim as the patient's responsibility because the patient failed to provide insurance information.

If you use an electronic system, you can easily keep track of when patients call in and make changes to their insurance as well as when you get copies of new insurance cards. This documentation will help you prove when the patient gave you her insurance information.

Good news: Some billers say that they've successfully appealed timely filing denials when the patient did not provide the information until after the filing limit. You can try appealing the denial, explaining that if the patient had provided you with the correct insurance information, you would have filed the claim within the proper amount of time.

You may want to include documentation showing when you first billed the patient and a history of all other statements you sent to the patient.

Exceptional circumstances: There may be times when your practice experiences exceptional circumstances, such as the recent flooding in Nashville, Cobuzzi says. If a disaster, whether manmade (such as computer crashes) or naturecreated (such as floods, hurricaines, etc.), you can contact the payer to assist you and extend the timely filing deadline.

Often times the practice will receive one time extensions due to these extenuating conditions.

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