Revenue Cycle Management

Why Aren't You Being Paid 100% of the Time?

HENRY SCHEIN ONE

According to a Henry Schein One survey, 56% of respondents said getting insurance claims paid is a bigger issue than staff retention – and with good reason.

An average of 8% of dental claims are denied from total procedures billed[1] and each of those denied claims takes 30+ minutes to research. Just consider that: nearly 1 out of every 10 of your claims submitted may be denied -- translating to additional work for your staff, lost revenue, and negative patient experiences.

Verifying a patient's eligibility and benefits affects everything from your bottom line to whether your patient accepts the treatment they need. Your ability to provide complete, accurate, and current data and a clear view of patient benefits is essential to your practice, but it's a lot easier in theory than in reality, with no one source of eligibility and benefits robust enough to accurately create insurance plans, coverage details, and treatment plan estimates.

We're breaking down the eligibility verification challenges you're up against and the steps you can take to help you reverse course, enhance patient and staff satisfaction, and start getting paid 100% of the time.

[1] A Time for Disruption; ADG; survey limited to a large dental insurance company only

What You're Up Against

Currently, the system is not set up for you to succeed. Insurance carriers provide differing levels of response, making it difficult to determine whether particular procedures are covered and at what percentage. In many cases, the payors supply little of the total plan coverage data. If your office doesn't receive the necessary benefit information initially, you may be forced to spend time calling payor call centers or visiting the payer's web portal to get whatever data elements are missing, and all of this can take up to 20 minutes per verification.[2]

And the consequences of the current process can be felt throughout your entire practice.

It's a drain on staff time.

Even worse, when you finally get someone on the phone or find the right portal, there's only limited information, nothing is standardized, and the information available is inaccurate and incomplete, forcing you to spend even more time chasing down the information you need.

It can lead to increased write-offs.

To avoid the confrontation and work associated with collecting – especially after the patient portion estimate was incorrect -- dentists often write off balances less than $25. That seemingly small amount can add up quickly, though. Can your practice really afford frequent, incorrect insurance estimates?

> There's no one on your team who wakes up in the morning and says, "I can't wait to verify insurance today. I love waiting on hold or browsing terminals and portals for the information I need."

[2] Based on internal Henry Schein One survey with 23 customers completed in 2023

It creates a poor patient experience.

There's no quicker way to irritate a patient than to blindside them with a remaining balance that they didn't expect. Patients trust you know the correct amount they owe upfront, but if your team can't obtain the information you need, you may discover post-visit the patient owes more than originally thought. However it ends – whether the patient pays after you send numerous bills, you write it off, or you take it to small-claims court -- you're left with an unhappy patient who no longer trusts your practice.

Patients are missing out on necessary treatment.

The average case acceptance rate for the dental industry is 46%. Dentists, in general, though, aren't going around proposing unnecessary treatment to their patients. So, where's the disconnect between recommendation and acceptance? Often staff avoid having an essential conversation with a patient about their true needs because they're not prepared to talk about cost or there's ambiguity about costs, and patients balk at the idea of further treatment.

It affects how quickly you're paid.

Collections experts estimate the value of every dollar owed past 90 days is worth 10 cents.[3] And that's if you're even able to collect. Research suggests there's less than a 15% chance of collecting on a patient account once it's more than 90 days past due. Your practice's profitability is a direct result of your ability to collect before that timeframe is up.

[3] Cleaning up your receivables | Dental Economics

The Real Cost for Your Practice

Time to Payment

Average duration from claim submission to receipt of payment or claim closure.[5]

20 days

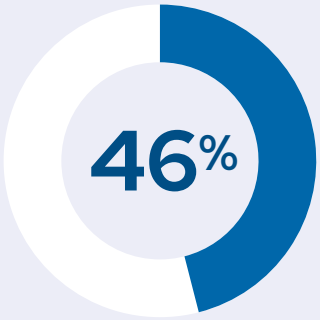
Average Collection Rate

Portion of production that results in payments.[5]

84%

Average Case Acceptance Rate

Rate at which patients agree to the treatment plan presented to them. Accepted Treatment = Completed or Scheduled Treatment Planned Producedures[5]



Time Spent Per Day Accessign Portals, Calling and Manual Entry

Time spent accessing insurer portal, retrieve additional eligibility, and benefit detail:

7+ hours

Average time spent calling a payor to obtain additional eligibility and benefit detail:

12 hours

Time spent manually entering eligibility date into patient record. (Dependent on all tables being populated):

13+ hours

Money Spent Mailing Paper Statements

$16,800

Production Loss

lost to uncollected revenue[7]

9%

Electronic Eligibility Verification

It costs on average

$7,500

per clinician, per year to do manually eligibility checks[6]

Claim Errors

Eight percent of dental claims are denied from total procedures billed due to administrative errors.

8%

[5] 2024 Henry Schein One Industry Report; Henry Schein One
[6] 2022 CAQH Index; CAQH Explorations
[7] Increase Profitability by Tracking These Dental Metrics; The Dental CFO

How to Stop Leaving Money on the Table

Reduce the legwork for your staff

Automate eligibility checks before patient visits.

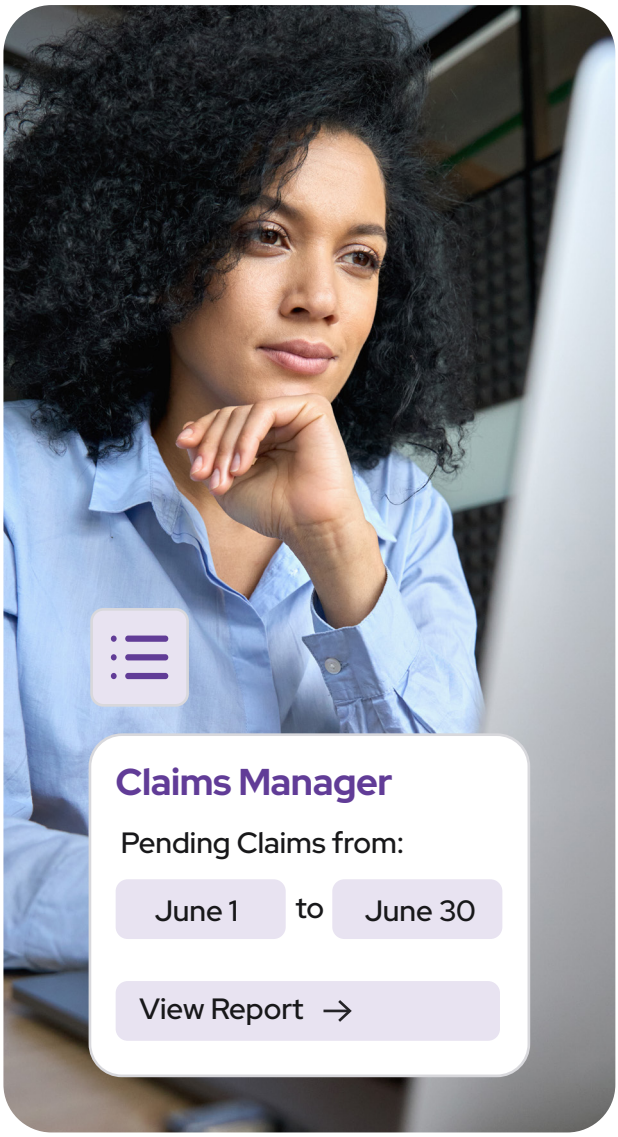
Your RCM solution should automatically pull patients' information from your practice management system (PMS), eliminating the risk of manual errors and supporting a clean eligibility response.

Automate info retrieval:

The traditional process of collecting patient data opens you up to manual errors on two fronts – when your patients provide the information and when you manually enter it into your system. Card Scanning capabilities make it easy for patients to simply scan their driver's license and insurance card via their personal device, and then such information will be stored automatically in the PMS.

Automating eligibility checks pre-visit can save practices approximately $5 per check and $15,000 per year, per provider by eliminating the 10 minutes per patient in staff time calling or visiting insurance portals to collect the information.[8]

[8] https://www.caqh.org/sites/default/files/2023-05/2022-caqh-index-report.pdf



Automatic image attachment.

With the ability to post imaging codes and other attachments to your ledger, you can improve the submission of clean claims, reduce rejections, and speed time to payment without manual intervention and investigation.

Implement electronic statements.

Reduce the speed of collections by up to 14 days.[9] The right RCM software makes it easy for offices to send statements via email or text and track the status of statements in real time.

Automating electronic statements can save your team more than $16,800 a year.[10]

[9] How to Increase Your Dental Practice Collections Percentage; Dental Claim Support
[10] This is calculated by assuming $3 per paper statement x 200 statements mailed a month

Ensure Your Data is Accurate

Know when and why an eligibility check failed.

Does your RCM system currently tell you why a claim failed? The right solution should be able to designate "eligible" or "not eligible" and several reasons why there is an error -- such as check in progress or eligibility not checked. You should also be able to quickly review your schedule to determine whose eligibility has not been verified.

Stop wasting time on the phone and in the portal:

If your PMS doesn't automate delivery of accurate, reliable, and current eligibility content directly from payors in a uniform format, it's time to upgrade your system. Automating this process prevents the need for the office staff to contact the payor directly for benefit detail eliminating as much as 20 minutes in staff time to call the insurer and 12 minutes to connect to their portal.[11]

Avoid common coding errors.

Choose a software solution that updates codes automatically. With Dentrix Smart Image, diagnostic images are automatically associated with the correct CDT code and saved to the ledger. You'll save valuable time spent correcting errors and looking up codes and improve the submission of clean claims, reduce rejections, and speed time to payment.

Standardize your data.

Insurers don't respond with coverage data in the same format – and it's a pain. Choose a solution that saves data from all providers in a uniform PDF format and automatically saves it to a central location so users can find the data they need quickly and easily.

Henry Schein One's game-changing Eligibility Pro

delivers more robust data, from more payors, including patient history, frequency limitations, and procedure level co-insurance.

[11] Based on internal Henry Schein One survey with 23 customers completed in 2023

Make Payment Collection a Consistent Process

File claims daily.

Practices only have a 15% to 25% chance of collecting accounts one they are past due for more than 90 days.[12] Automatically send patients statements as soon as the claim is returned. If you're only sending bills monthly, you may be looking at 45 to 60 days before you receive payment – up to 90 if there are insurance delays.

Track claims and review reports regularly.

Once claims have been filed, following up on them is the next obvious task—but many practices fail to do so. Daily tracking of your claims is vital to effective insurance management and to supporting the patient journey. Your dental practice management software may be able to generate the necessary reports to track your claims and to show you where follow-up is required.

Find out immediately if something is missing from a claim or when a claim ages over 30 days. Review these insurance-related reports on a regular basis:

Daily

- Clearinghouse claim submission report. This is probably the most overlooked report in the office since it usually comes from the clearinghouse, not your practice management software. It tells you if attachments are required or if claims are sent back for denial. Look for glitches in clearinghouse submissions or employee data entry errors so you can correct and resubmit the claims.
- Unsubmitted claims report. Research missing information, then complete and submit these claims.

Weekly or Biweekly

- Procedures not attached to insurance report. Review to catch any posting errors
- Insurance aging report. Follow up on these claims, starting with the oldest. Almost all insurance plans have timely filing deadlines

[12] What Do Accounts Receivable Cost Dental Practices; Pearly

Simplify the Process for Patients

Make it easier for patients to pay

You should be able to have a detailed, accurate treatment planning conversation with your patients. Talking about money can be uncomfortable, which is why practices need people who excel at it, are the right mix of firm yet friendly, and understand why it's so important to collect payment as soon as possible. Your team members should know the out-of-pocket expenses for every patient on the day's schedule and be able to talk to them about it and collect.

Offer online payment.

Ninety-five percent of patients say they would pay medical bills online if provided the option.[13] Offer flexible payment options including viewing and paying outstanding balance online through e-mail, text, or paper statements. Text and e-mail offer modern, patient-preferred methods for sending statements electronically and making payments directly through the communication.

Implement payment plans.

Ensure your practice offers all the approved methods of patient payment plans or financing. Flexible payment solutions, including membership plans that provide incentives for preventative care, go a long way in getting a patient agree to treatment.

More than half of patients delay or avoid treatment due to cost.[14]

[13] Study: Patients Would Pay Medical Bills Faster with Online Bill Pay; Becker's Review
[14] The Many Costs (Financial and Well-Being) of Poor Oral Health | College of Dentistry | University of Illinois Chicago (uic.edu)

The current insurance verification process provides a significant roadblock to your practice's ability to increase revenue and patient satisfaction. The system's complexity, coupled with inconsistent payer data, makes accurate, upfront estimates an undeniable challenge. It's time to take control of your billing and claims processes.

Ready to save time, minimize errors, and reduce the potential for lost revenue and patient dissatisfaction?
Learn more about Henry Schein One's Eligibility Pro.

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