Billed Right™
Where we Bill Right

PAIN MANAGEMENT

ARE YOU GETTING **PAID FOR YOUR EXPERTISE?**

Nothing is more frustrating for a medical provider than to receive a rejection or denial notice for services rendered after submitting a claim. While most typical denials for a medical claim include: missing information, duplicate claim or service, service not covered by payer, or limit for filing expired, Pain Management requires a specialized type of billing and meeting specific criteria.

For example, for pain management providers, repeat treatments during a period, or elevating the treatment without attempting other alternative therapies can trigger denials. A similar scenario would be the one where the frequency of services is misused or not properly managed. In these cases, an insurance company may request a peer to peer review and additional documentation that substantiate the need for the services rendered. For example, multiple instances on the same day will require the use of a proper modifier or submitting additional documentation. However, in other cases, there will be limits to the number of times some procedures can be performed in a given time frame, and not being adequately educated in the topic may cause denials and financial losses.

Billed
200+ MILLION in 2020

94 % Collected

DAYS IN AR 24

TAT Hours 48

TAT for Payment 26 DAYS

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Consider another common type of denial involving the validity of medically necessary treatment. Most insurances use Medicare's definition when deciding to cover for certain services. On the other hand, a lack of specificity when providing a diagnosis or one that does not support the service rendered may trigger a denial of a pain management claim.

THE BILLED RIGHT **EXPERIENCE**

With Billed Right, you can use our expertise and knowledge to your advantage. We are in business to help you grow. Our team will start by dedicating an account manager to jumpstart your path to success. We are more than just billers. Billed Right is your strategic partner who will maximize your practice to its full potential. One aspect of this advantage involves coding. Coding errors are one of the most significant sources of denials in pain management billing because it requires many unique codes.

For this reason, before a service is billed to an insurance company, extensive medical records need to be analyzed to translate the complex medical record into a few simple codes. Our certified coders know just how to identify the most appropriate pain management code to submit. Although this coding process does not cover all the variables encountered with every patient, a few denials or rejections may occur. However, we have been very successful with appeals by educating our clients on proper documentation and explaining those variables that do not translate through the coding process. We pay extra attention to details on unusual scenarios to help avoid or minimize insurance rejections.

WHAT WE **SPECIALIZE IN**

- COORDINATION WITH ADJUSTERS FOR ELIGIBILITY ACCURACY
- MONITOR CLAIMS FOR SILENT PPOS THAT UNDERPAY PROVIDERS.
- COMPLETE AND MONITOR SECOND BILL REVIEWS (SBRS) AND INDEPENDENT BILL REVIEWS (IBRS)
- PROVIDE CLIENT EDUCATION ON BILLING & CODING TRENDS FROM CERTIFIED CODERS.
- CONDUCT PERIODIC PRACTICE PERFORMANCE EVALUATION TO DETERMINE UNDERPAYMENTS AND DENIAL TRENDS
- ENSURING ALL PROCEDURES COMPLETED ARE CAPTURED VIA CPT AND ICD CODES