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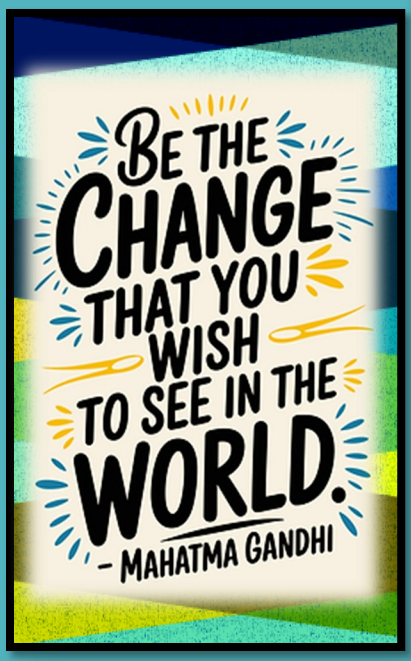

LRPHO NewSource is a Quarterly Publication for our Clinical Providers, Office Management, Staff and Contracted Facility Members

NewSource

2026—3rd Quarter Edition

6 Ways to Cut Denials at Your Practice

[by Keith A. Reynolds - from PhysiciansPractice.com]

Verify Eligibility Before Every Encounter:
Patient eligibility issues account for nearly one in five denials, making this the No. 1 cause of claim rejections. Even longtime patients change jobs and insurance plans, creating coverage gaps that practices often discover only after services are rendered. The solution requires vigilance at the front desk. Staff should verify coverage before every appointment, not just new patient visits. Practices experiencing reduced denials credit enhanced training for front office workers who learned to check demographic information, confirm insurance details and verify that plans cover scheduled services. The time invested in verification pays dividends by preventing denials from occurring.

Master Prior Authorization Requirements:
Prior authorization denials have surged as payers impose more requirements and change rules with little notice. Establishing regular check-ins with top payer representatives can reveal changing requirements before they trigger denials. These conversations often uncover issues like outdated credentialing status or new documentation standards that staff need to address. Consider creating a denials task force to track authorization requirements across payers. As one practice management consultant notes, fixing problems up front rather than adding staff to manage accounts receivable yields better results and happier teams.

Improve Clinical Documentation Quality:
Insufficient documentation drives a significant portion of denials. Payers reject claims when documentation doesn't adequately support billed services, required documents are missing or diagnosis codes don't justify medical necessity. The issue often stems from communication gaps between providers and coding staff. A patient may receive a covered service, but an incorrect or incomplete diagnosis code makes the claim appear not medically necessary. Effective practices hold regular in-services to educate physicians about payer changes and documentation requirements. Using artificial intelligence (AI)-powered coding audits helps identify documentation patterns that trigger denials, allowing practices to correct behaviors before claims go out the door. Consider implementing documentation prompts in your EHR that remind providers to include necessary details. Complete documentation should specify the diagnosis, procedure details and patient history that justify the services billed.

Code with Precision and Keep Current:
The best way to reduce coding denials is coding to the highest level of specificity, often to the fifth digit. Common coding mistakes include: Using outdated codes from old codebooks; Duplicate billing when claims are accidentally resubmitted; Unbundling services that should be reported together; Missing modifier requirements, especially Modifier 25. Practices should ensure their chargemaster contains Current Procedural Terminology, Healthcare Common Procedure Coding System and ICD-10 codes. When relying on hospitals or facilities for procedure data, verify they're using the latest code sets. AI-powered automation can handle routine coding tasks such as payment posting and common encounters, freeing coders to focus on complex cases that require human expertise. This approach reduces errors while addressing staffing challenges.

Implement Strong Claims Scrubbing:
Most practice management systems offer claim edit functionality that can catch errors before submission. The key is maximizing these tools rather than letting problems slip through. Configure your system to flag obvious mismatches: If a patient's age or gender doesn't align with the billed CPT code, the claim should be stopped for review. On the back end, use intelligent denial work queues that route claims to staff members with specific expertise for particular payers. Revenue cycle experts recommend establishing clear protocols to reduce risk. Even honest mistakes can create compliance exposure, making prevention essential. Track filing deadlines carefully. Some payers allow as few as 30 days to submit claims, whereas others permit up to two years. With coding backlogs growing due to staffing shortages, practices increasingly risk exceeding these limits and facing automatic denials.

Track, Analyze and Learn from Denials:
You can't fix what you don't measure. Establishing a systematic approach to tracking denials reveals patterns that point to root causes. Track denials by volume, type, payer and reason to identify trigger points. Practices that understand their denial patterns can correct policies, procedures and behaviors at the front office level. Separate denials by insurance class to identify which payers cause the most trouble. What looks like a general denial problem might actually be concentrated with one or two insurers, pointing to specific training needs or payer relationship issues. Some "denials" are actually payment delays: claims transferred to the correct payer for processing. Learning to distinguish these from true denials helps teams focus effort where it matters most.

CARTOON CORNER

OFFICE STAFF EDUCATION SURVEY:

We NEED your input for Future Educational Events and Activities our for Office Staff members.

What TOPICS/EVENTS would YOU like to see us offer that would INTEREST you and that you would attend?

Please EMAIL your IDEAS/SUGGESTIONS to julie.simpson@hcahealthcare.com. Thanks!

BCBS Healthy Blue Exiting Louisiana Medicaid Program

BATON ROUGE, LOUISIANA, SEP 01, 2026 -
The Louisiana Department of Health (LDH) announced today that its Medicaid managed care contract with Healthy Blue will end on December 31, 2026. Current Healthy Blue members' coverage will continue through that date and will then be enrolled with one of the four remaining Healthy Louisiana health plans with new coverage beginning January 1, 2027.

The transition will not affect members' Medicaid eligibility. Members will continue to have Medicaid coverage and will receive information and resources to help them transition to another plan without interruption to the care and services they rely on. Additional resources for affected members will be available to ensure this is a seamless transition, and no one is left without the coverage they need. LDH will provide additional information about existing prior authorizations, prescriptions, scheduled appointments, and other continuity-of-care protections before the transition.

Beginning January 1, 2027, Healthy Louisiana Medicaid managed care services will be provided through:

- Aetna Better Health
- AmeriHealth Caritas Louisiana
- Humana Healthy Horizons in Louisiana
- Louisiana Healthcare Connections

Members currently enrolled in one of these four plans are not affected and do not need to take any action. This change applies only to Medicaid members enrolled with Healthy Blue. It does not affect private insurance coverage provided through Blue Cross and Blue Shield of Louisiana. LDH will continue communicating with Healthy Blue members and providers throughout the transition.

Member notices, frequently asked questions, and other resources will be available at ldh.la.gov/medicaid/medicaid2027.

8 Fixes for your Practice's Digital Front Door

[by Keith A. Reynolds - from PhysiciansPractice.com]

Put real Appointment Slots online; not a Request Form: A request form is not self-scheduling. If a patient fills out a web form and then waits for a callback to learn whether the time is available, the practice has added a step for the patient and a task for the front desk without freeing either one. Patients treat that experience the same way they treat a busy signal. Real self-scheduling means the patient sees open slots and walks away with a confirmed appointment. Start narrow if the schedule is complicated: established patients only, one or two visit types, a limited block of slots per provider per day. Practices that hold every slot back for staff control usually find that the slots go unfilled anyway.

Make the Phone Tree end with a person: The phone is still the busiest door in most practices, and it is often the least measured. Call abandonment rate, average hold time and time to callback are basic operational metrics, and most phone systems already report them. If nobody on the leadership team can say what those numbers were last month, that is the first fix. The second is structure. Cap the menu at three options, put the most common request first and give callers a scheduled callback rather than a hold queue when volume spikes at lunch and at open. A patient who hangs up at four minutes does not call back later. That patient calls the practice down the road.

Collect intake once, before the visit: Digital intake fails for a predictable reason: the practice sends a link, the patient fills out 30 fields on a phone screen and then gets handed a clipboard at check-in asking for the same information. Staff stop trusting the digital data, patients stop completing it and the practice pays for a tool nobody uses. Fix the handoff before expanding the form. Confirm the intake data flows into the chart, not into a PDF queue somebody rekeys. Then cut the form to what is actually needed at that visit, pre-fill everything already on file and let returning patients confirm rather than retype. A short form that lands in the record beats a thorough one that dies in an inbox.

Tell patients what they will owe before they arrive: Cost is the question patients most want answered, and the one practices most often defer to the statement that arrives weeks later. That delay is expensive. Balances get harder to collect the further they travel from the visit, and surprise costs generate the phone calls and portal messages that clog the same channels the practice is trying to unclog. Run eligibility a day or two ahead, push an estimate to the patient with the reminder and give them a way to pay or store a card before check-in. The practices that do this well treat the estimate as part of the appointment confirmation, not as a separate collections step.

Triage Portal Messages and bill the ones that qualify: Portal message volume keeps climbing, and a share of it is clinical work: medication changes, new symptoms, results interpretation. Left unmanaged, it lands in physicians' inboxes after hours and shows up later as burnout rather than as revenue. Two moves help. First, route by message type so scheduling, refill and billing questions never reach a clinician. Second, set a clear internal standard for when a message meets the requirements for an e-visit or a virtual check-in code, then train clinicians to flag those encounters. CMS has paid for asynchronous digital evaluation for several years, and MGMA's guidance on coding portal messages as e-visits lays out the time thresholds and documentation. Most practices are not billing them because nobody built the workflow, not because the patients are not there.

Get your Texting Consent in order before January 31, 2027:
Texting is the highest-response channel most practices have, and it carries the most legal exposure. Under the Federal Communications Commission's revocation rules, patients can opt out through any reasonable method, and the practice has to honor it promptly across every system that sends messages. The piece worth watching is the so-called revoke-all requirement, which would treat a single opt-out as an opt-out from all automated calls and texts from that sender. The FCC extended a waiver of that provision until Jan. 31, 2027. Use the runway. Inventory every system that texts patients, including the reminder tool, the recall campaign and the balance notices, and confirm that an opt-out in one propagates to all of them. Keep the consent records; they are the defense.

Fix the 5 things patients check on your Website:
Practice websites tend to get redesigned for aesthetics and neglected on facts. Patients arrive looking for five things: which insurance you take, whether you are accepting new patients, where you are and where to park, who the providers are and how to book. If any of those are missing, outdated, or buried three clicks deep, the patient assumes the answer is no. Put all five above the fold on the homepage and on every provider page, in plain text rather than inside an image or a PDF. Check it on a phone, since that is where most of this traffic lands. Then set a calendar reminder to reverify the insurance list and the new-patient status every quarter, because the version on the site is the version patients believe.

Measure the Funnel, not just the Schedule:
Most practices measure the end of the process, visits completed and no-show rate, and almost nothing before it. That hides where patients are actually dropping out. Pick four numbers and review them monthly: call abandonment rate, share of appointments booked online, digital intake completion rate and time to third-next-available appointment. Track them by location and by provider, since averages hide the one site where the phones are broken. When a number moves, tie it to something that changed.


PAYER DAY + 2026
It's Time for your
Payer Day Check-up!
OCTOBER 22ND
10:00 A.M. TO 1:00 P.M.
RWCH CASCADE ROOM
Come join us for this fun and informative event. Take advantage of the opportunity to meet the Payer Representatives and chance to win one of our awesome Door Prizes!
Let this be your
Prescription for Success!
For more Information call
318-769-7480
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