A FREE GUIDE FOR OPTOMETRY PRACTICES & THEIR TEAMS

The Revenue You're Not Seeing

Seven overlooked billing truths quietly costing optometry practices money.

A practical guide to finding what's slipping through the cracks

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Collective Revenue

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A note before we begin

Let's talk about the hard things.

I started in optometry in 2006 at a private practice. Since then I've managed billing groups, built a billing company, and sat across the table from more practice owners than I can count. Here's what I've learned: the problems that cost practices the most money are almost never dramatic.

They're quiet. They're a little awkward. And they're the things nobody wants to bring up in the morning huddle — the conversation at checkout, the stack of denials, the write-off report no one opens.

This guide names seven of them, plainly, with exactly what to do about each one. None of it requires new software or a bigger team. It just requires a willingness to look.

Hannah Boyd

CEO & Founder, Collective Revenue

HOW TO USE THIS GUIDE WITH YOUR TEAM

1

Read one a week

Bring one of the seven to your team huddle. Five minutes, no more.

2

Ask one question

"Does this happen here?" Then listen. Your team already knows.

3

Give it an owner

One person, one fix, one date. Then check back next month.

01 Two insurances, one patient — and nobody asked.

WHAT IT LOOKS LIKE

A patient hands over a vision card. In the chair, it becomes a medical visit — dry eye, flashes, diabetes. The claim goes to the wrong payer, or the patient gets a bill they never saw coming.

WHY IT HURTS

Denials, rebills, unhappy patients — and a front desk that gets blamed for a process problem.

WHAT TO DO MONDAY

- [ ] Collect medical **and** vision insurance on every scheduling call.
- [ ] Verify both before the visit — not at check-in.
- [ ] Teach the team: the reason for the visit decides which plan is billed, not the card in hand.

SAY THIS *"We bill your vision plan for routine exams and your medical insurance when we're treating an eye health concern. Can I grab both cards so you're covered either way?"*

02 The refraction conversation.

WHAT IT LOOKS LIKE

A Medicare patient is surprised by a refraction fee at checkout. To avoid an awkward moment, someone quietly waives it.

WHY IT HURTS

Refraction (92015) isn't covered by Medicare or many medical plans. Waivers that depend on who's at the desk add up fast — and raise compliance questions.

WHAT TO DO MONDAY

- [ ] Post your refraction fee at the front desk and on your website.
- [ ] Tell patients **before** the exam, not after.
- [ ] Collect at time of service. Make waivers a written policy, not a judgment call.

SAY THIS *"Medicare doesn't cover the part of today's exam that determines your glasses prescription. That fee is $_____, and we collect it at check-in."*

03 The chart doesn't tell the story.

WHAT IT LOOKS LIKE

Excellent care in the exam room, but the note is missing the chief complaint, the diagnosis link or the plan. Visits get coded by habit — the same level, every time.

WHY IT HURTS

A claim is only as strong as the note behind it. Overcoding invites paybacks; undercoding leaves earned money on the table.

WHAT TO DO MONDAY

- [ ] Every note: chief complaint, findings, assessment and plan.
- [ ] Make sure a diagnosis supports medical necessity for every service billed.
- [ ] Each quarter, pull 10 charts and code them fresh. Compare to what was billed.

SAY THIS *"Can we look at five charts together this month? Not to criticize — to make sure your notes get you paid for the work you're already doing."*

04 Denials sitting in a pile.

WHAT IT LOOKS LIKE

Denials come back and get set aside "for later." Later turns into past the payer's timely filing deadline.

WHY IT HURTS

A denial nobody works is a write-off nobody approved. Many are fixable in minutes — eligibility, a modifier, a missing detail.

WHAT TO DO MONDAY

- [ ] Work denials every week — same day, same person.
- [ ] Track them by reason. Your top three reasons are your training plan.
- [ ] Post every major payer's timely filing limit where billing can see it.

ASK THIS *"What were our top three denial reasons last month?" If no one knows, that's your answer.*

05 Write-offs nobody reviews.

WHAT IT LOOKS LIKE

Balances get adjusted off to "clean up" AR. Small amounts disappear with no reason code, and no one ever opens the adjustment report.

WHY IT HURTS

Write-offs are where revenue leaves quietly — and where honest mistakes (and occasionally dishonest ones) hide.

WHAT TO DO MONDAY

- [ ] Every adjustment gets a reason code and the initials of who made it.
- [ ] Set a dollar amount above which the owner must approve.
- [ ] Review the adjustment report monthly. Every month.

SAY THIS *"I'm not questioning anyone. I just want to see where our money goes, the same way I read the bank statement."*

06 Aging you haven't looked at in months.

WHAT IT LOOKS LIKE

Total AR looks "fine," but the 90- and 120-day buckets keep growing. The oldest claims start to feel impossible, so nobody touches them.

WHY IT HURTS

The older a claim gets, the less likely it is to be paid. Old AR is usually a symptom of a process problem upstream.

WHAT TO DO MONDAY

- [ ] Run aging **by payer** every month — not just the total.
- [ ] Measure against a goal. Ours: 61–120 days at or under **4%** of total AR; 121+ at or under **2.5%**.
- [ ] Work the oldest, highest-dollar claims first.

ASK THIS *"What percentage of our AR is over 120 days?" You want a number, not "not too bad."*

07 Credentialing that slips through the cracks.

WHAT IT LOOKS LIKE

A new associate starts seeing patients before they're credentialed. A revalidation letter lands in a drawer. An address change never gets reported.

WHY IT HURTS

Visits by a provider who isn't enrolled often can't be billed at all. A lapse can stop a payer's checks entirely.

WHAT TO DO MONDAY

- [ ] Start credentialing 90–120 days before a new doctor's first day.
- [ ] Keep one tracker: every provider, every payer, effective and revalidation dates.
- [ ] Set a reminder 90 days before each revalidation.

Bonus

The 15-Minute Monthly Billing Checkup

Same day every month. Owner and billing lead, together. Write the number down. Watch the trend.

- [ ] What % of AR is over 120 days? (by payer) _____
- [ ] Top three denial reasons this month _____
- [ ] Adjustment report reviewed and initialed _____
- [ ] Any visits not yet billed after 3 days? _____
- [ ] Patient balances collected at checkout — up or down? _____
- [ ] Credentialing: anything due in the next 90 days? _____
- [ ] Quarterly: 10-chart coding spot check done? _____

You don't have to carry these alone.

Want a second set of eyes on your billing?

Collective Revenue is an optometry-only billing company. We're a small business, not a corporation, and we never outsource — so you work with people who know eye care billing and care about your practice like it's their own.

Insurance Billing
Clean claims. Faster payments.

Credentialing
Get in network, and stay there.

VerifEYE
Know their coverage before they're in the chair.

A/R Clean Up
A fresh start for old balances.

YOUR NEXT STEP

Book a free 20-minute billing conversation

Book your call → **or call 833-327-2726**

Collective Revenue

OPTOMETRY'S PREMIER BILLING SERVICE

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