Uncovering and Fixing the Source of Claims Denials

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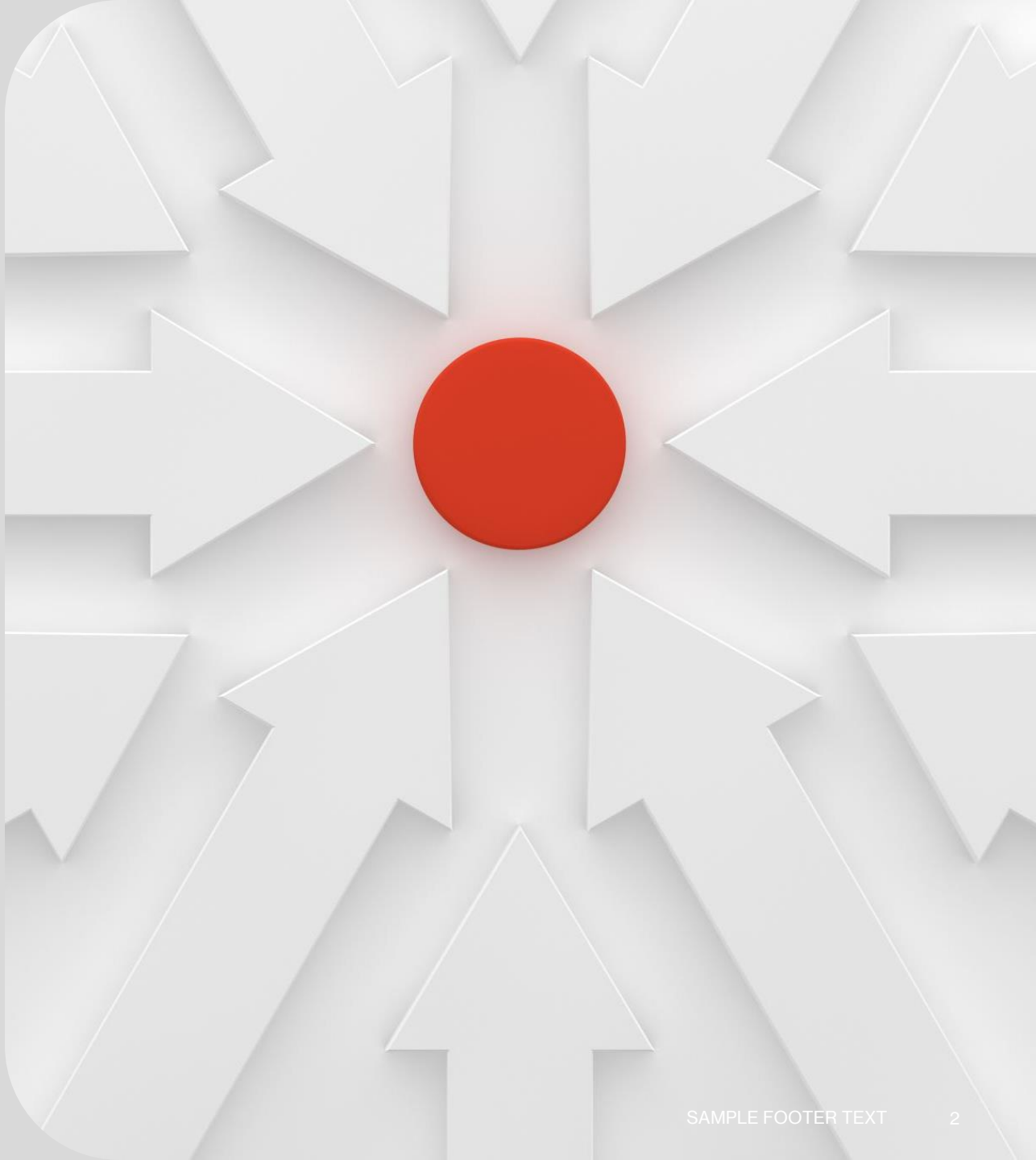
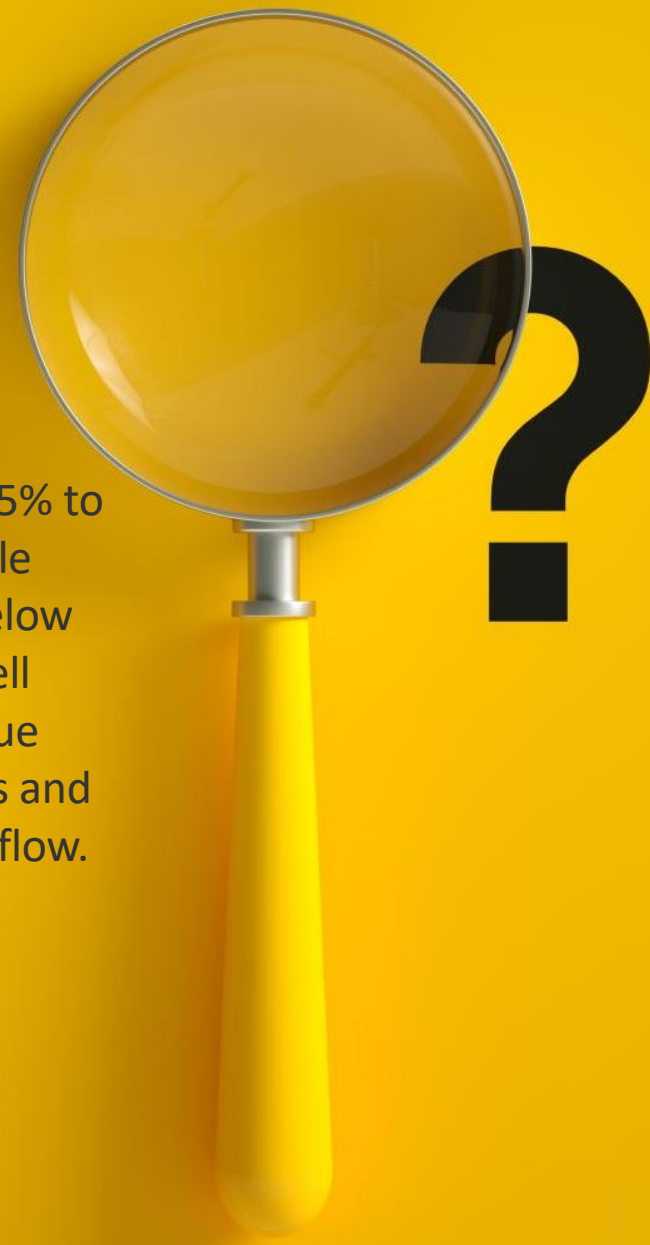
Objectives

- Understand how to find your practice denial rate and why it is important .
- Discover how most denials are preventable; learn why.
- Discover steps to prevent future denials; bring your questions and examples.



Find your denial rate

- How do you find your denial report?
- How often do you download it?
- Does the report contain the reason for denials ?
- How do you manage denials?



A denial rate of 5% to 10% is acceptable
A denial rate below 5% indicates well managed revenue cycle techniques and good economic flow.

Facts about denials

Physicians lose a significant amount of money every year because of denied healthcare claims.

The average cost to rework a denied claim ranges from $31 to $124 a claim. Only 35% - 50% of all denied claims are ever reworked.

Denied claims also, impacts **dynamics of provider-payer and provider-patient relationships.**

Top Reasons for Denials

- **Missing or incorrect patient information insurance card not on file**
- **Care covered by another payer patient has other insurance**
- **Services not covered by the payer** not part of your contract, like BH services
- **Coding errors:** This is why accurate medical billing and coding is so important in healthcare.
- Codes services that are part of a bundle or global period
- **Missing the payer's deadline:** Untimely filing,
- **Duplicate claims:** Claims for multiple instances of services or procedures can be interpreted as duplicate claims, especially if an appropriate code modifier isn't used to indicate the claim is not a duplicate.
- **Missing authorization:** . If prior authorization was not obtained, the payer is likely to deny the claim for the non-authorized procedure.
- **Dual coverage issues:** When two forms of health insurance coverage apply, as in an injured patient who has both primary insurance and Workers' Compensation, the claims process can be complicated, especially if there is a dispute with one or both insurers.
- **Provider is not credentialed with the payer.**
- **Providers and group are not contracted with the RAE**

Denial Management

Identify
Manage
Monitor
Prevent
Be Proactive, Not Reactive:

Denial Management – Identify

- Run the denial report Is the first step of this denial management process, the manager , biller/coder identifies the reason for the claim denial.
- Claim adjustment reason codes (CARC) are usually given by the payer in the accompanying explanation of payment, but they can be confusing.
- Review Practice management billing reports for denials with reasons for denial.
- The task at hand during this phase of the process is to interpret the payer's feedback and determine the actual reason for the denial. It's time consuming, but this is where the diligence of an experienced *medical billing specialist* or other medical billing and coding professional can pay off.

Denial Management – Manage

- Once the reason for the denial has been identified, the next step is to **appeal the denial and get the claim paid by the insurer**
- **Not every claim needs to be appealed may need to fix and rebill**
- **Sort the work:** The practice management system can use software t*ool*s to sort worklists by amount, time, reason for denial and other qualifiers, making the process more efficient than it might be with manual systems.
- **Create standardized workflows:** A standard action can be created for each type of denial by notating the practices most common reason for denials, identifying the most frequently used code corresponding to that denial and formulating an action plan for the management of similar denials.
- **Use a checklist:** The process can be made systematic and as error-free as possible with the use of a checklist of dos and don’ts to help avoid common mistakes that cause denials.

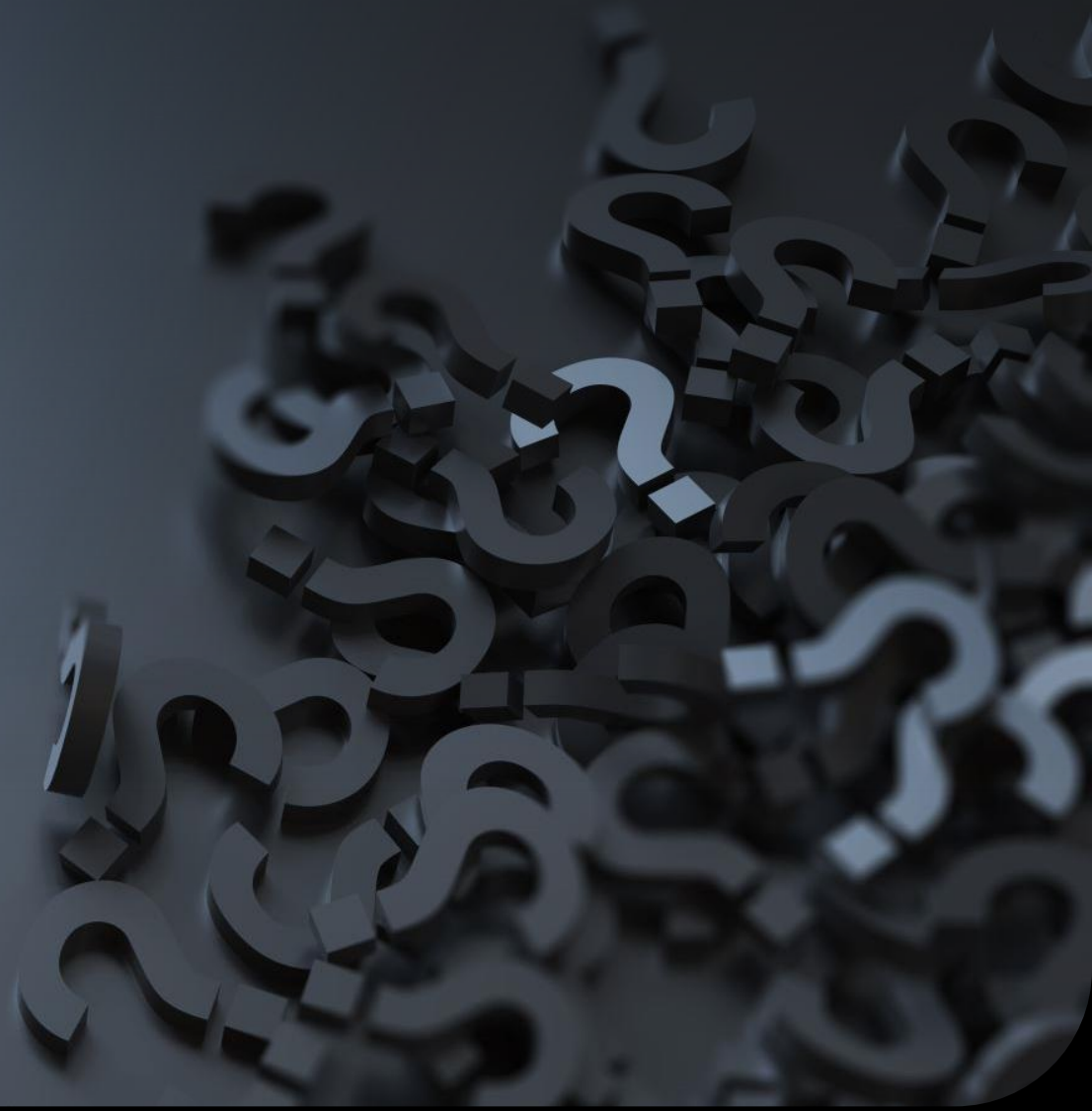
Denial Management – Monitor

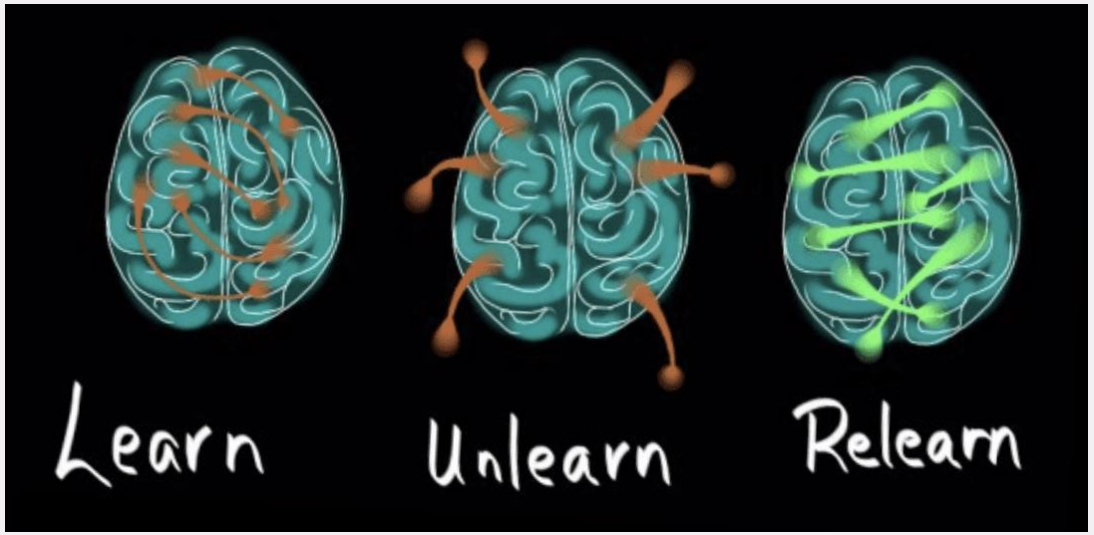
- In the monitoring phase of the process, an accurate record of denials should be kept by type, date received, date appealed and disposition.
- Any time you touch a denied claim put a note in the system as to why denied and what steps you took to correct claim.
- Another important goal in the monitoring phase is to gain a better understanding of each claim denial, determining the time, source, number and type of denial. With this data, the provider organization can identify denial trends and establish a better rapport, provider education and front desk training to mitigate the number of future denials.

Denial Management – Prevent

- After the denial management team has gathered all relevant data regarding claims denial, and conducted root cause analysis
- Taking steps that could include retraining staff, adjusting workflows or revisiting your processes.
- Multiple staff within the practice may have played a role in a claim denial,. Gather the personnel from those teams to familiarize them with claims denial mitigation efforts and reduce the errors that can cause future claims denials in areas like registration, lack of authorization or medical necessity, coding and documentation.
- Staff training and additional education on insurance basics and denial prevention can help employees better understand their role in the process and grasp the devastating impact of claim denials on overall cash flow.

Questions





+What will you take away and do differently ?

Resources

+ Outpatient Behavioral Health Fee-for-Service | Colorado Department of Health Care Policy & Financing
+ Health First Colorado Provider Bulletin B2300502 covers the Autism billing effective Jan 1, 2024
+ Billing Manuals | Colorado Department of Health Care Policy & Financing