

Denials: Overview & Resolution Strategies

ICAHN Healthcare Billing Webinar Series

Session 3 – May 20th, 2020



Introduction



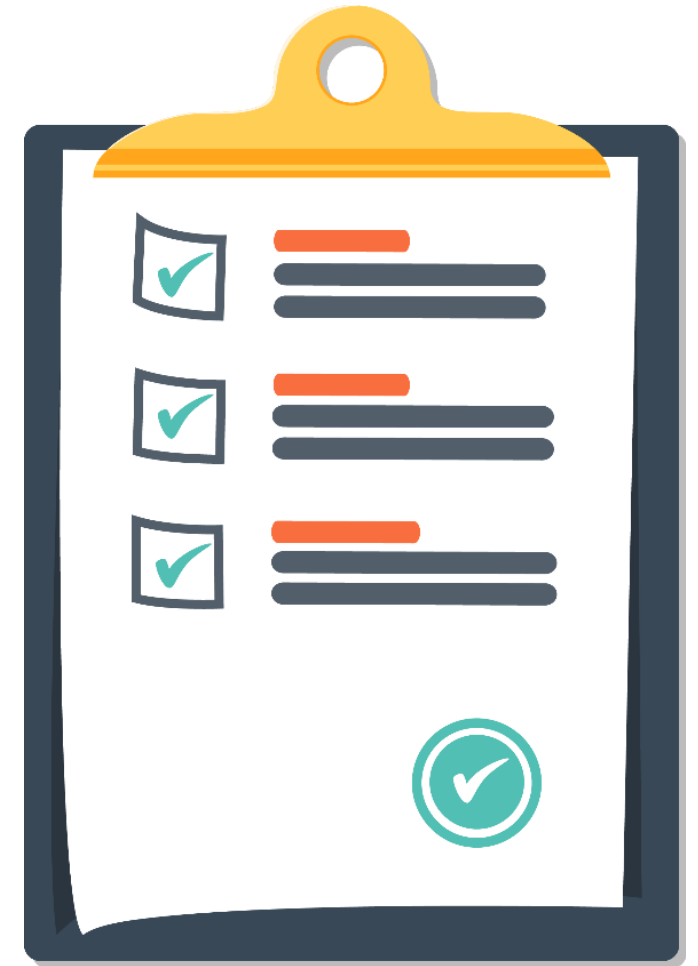
Lori Zindl
efficientC | OS inc.
President

Be Sure to Note & Submit Questions!



Learning Objectives

- Overview of Different Denial Types
- Denial Reporting & Prevention
- Prioritizing & Planning for Denial Work
- Working Common Denials

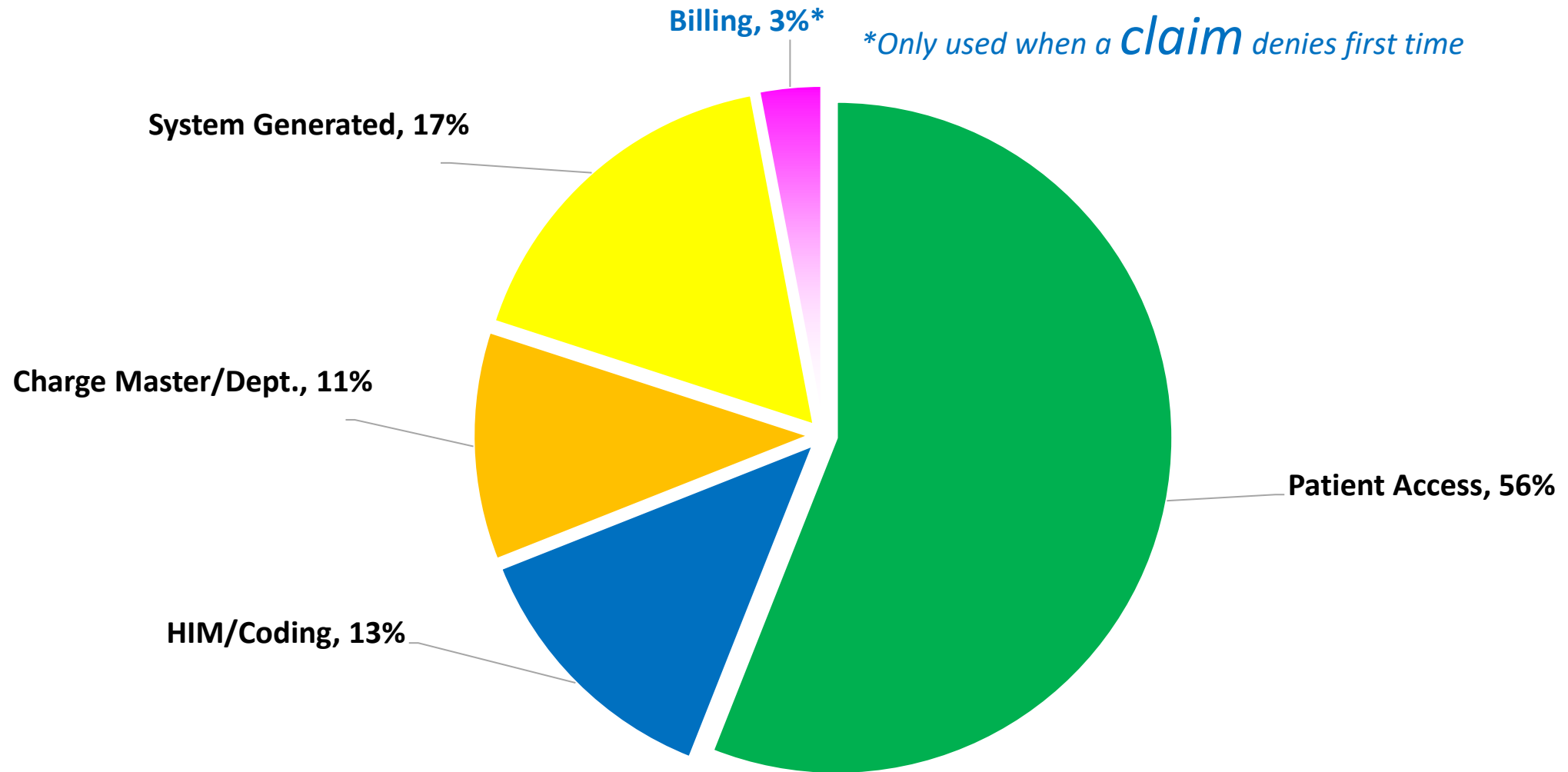


Who Really Bills Claims?

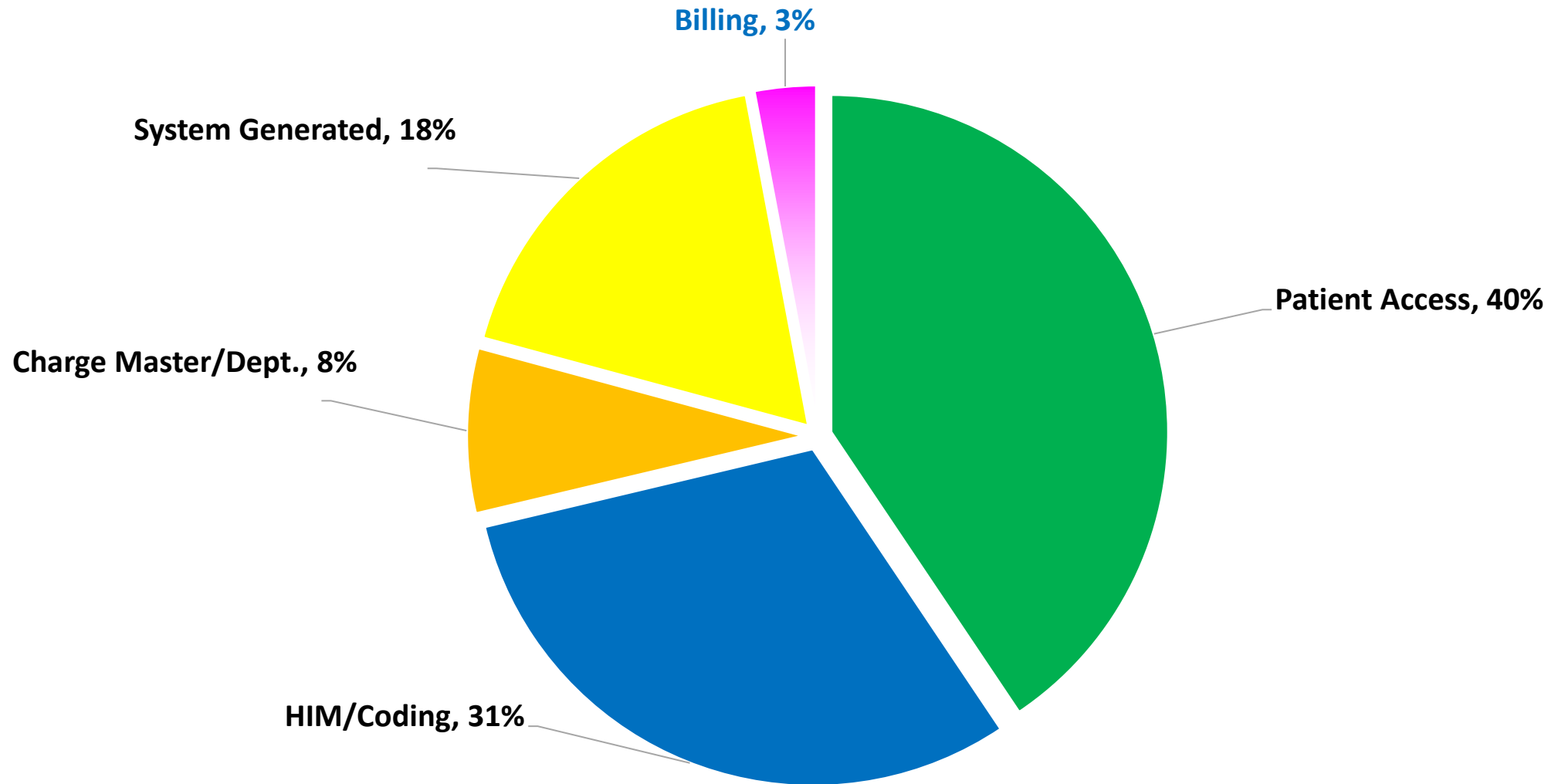
Green	Patient Access
Blue	HIM/Coding
Orange	Charge Master
Yellow	System Generated
Pink	Billing

1		2		3a PAT CNTRL #		4 TYPE OF BILL	
5a MED REC #		5b FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7	
8 PATIENT NAME				9 PATIENT ADDRESS			
10 BIRTHDATE				11 SEX			
12 DATE				13 HR			
14 TYPE				15 SRC			
16 DNR				17 STAT			
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Not the Billing Department

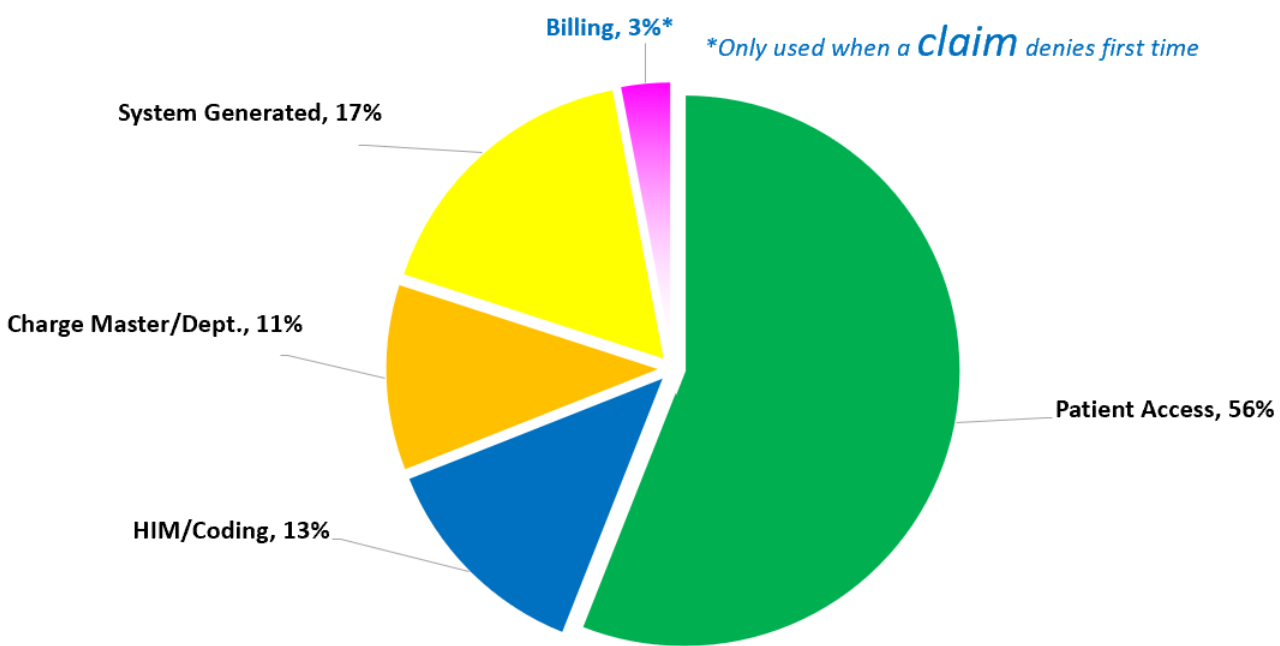


Who's Responsible for Denials?

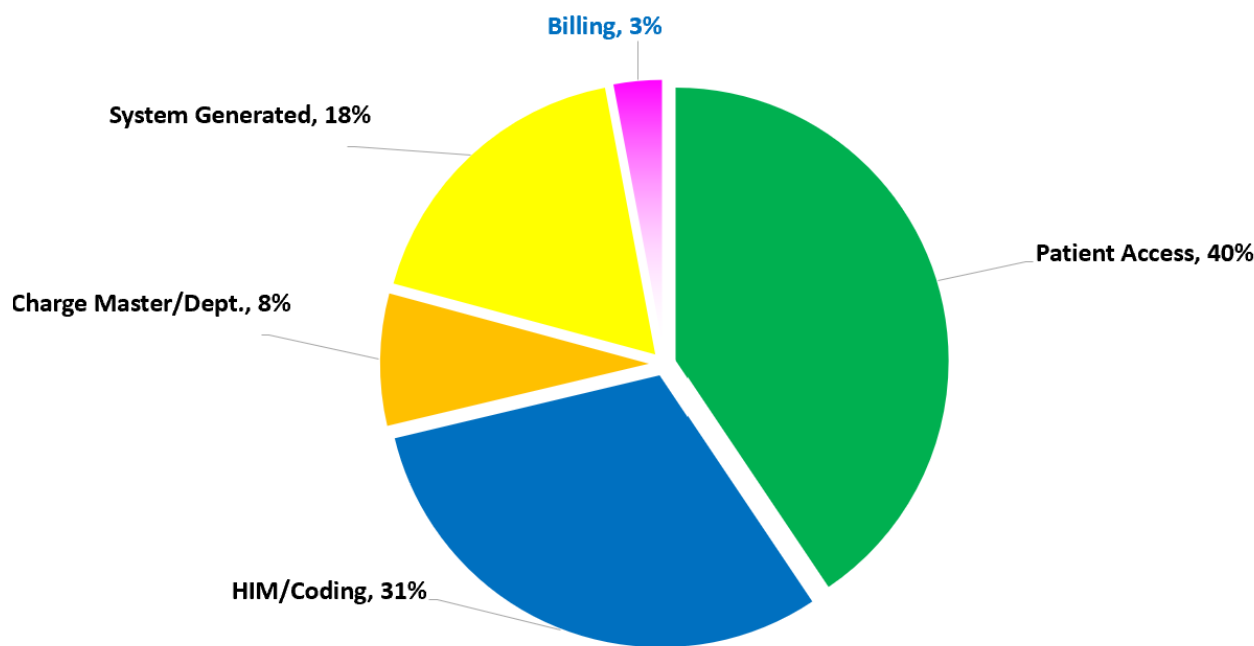


Comparing Billing Requirements to Denials by Department

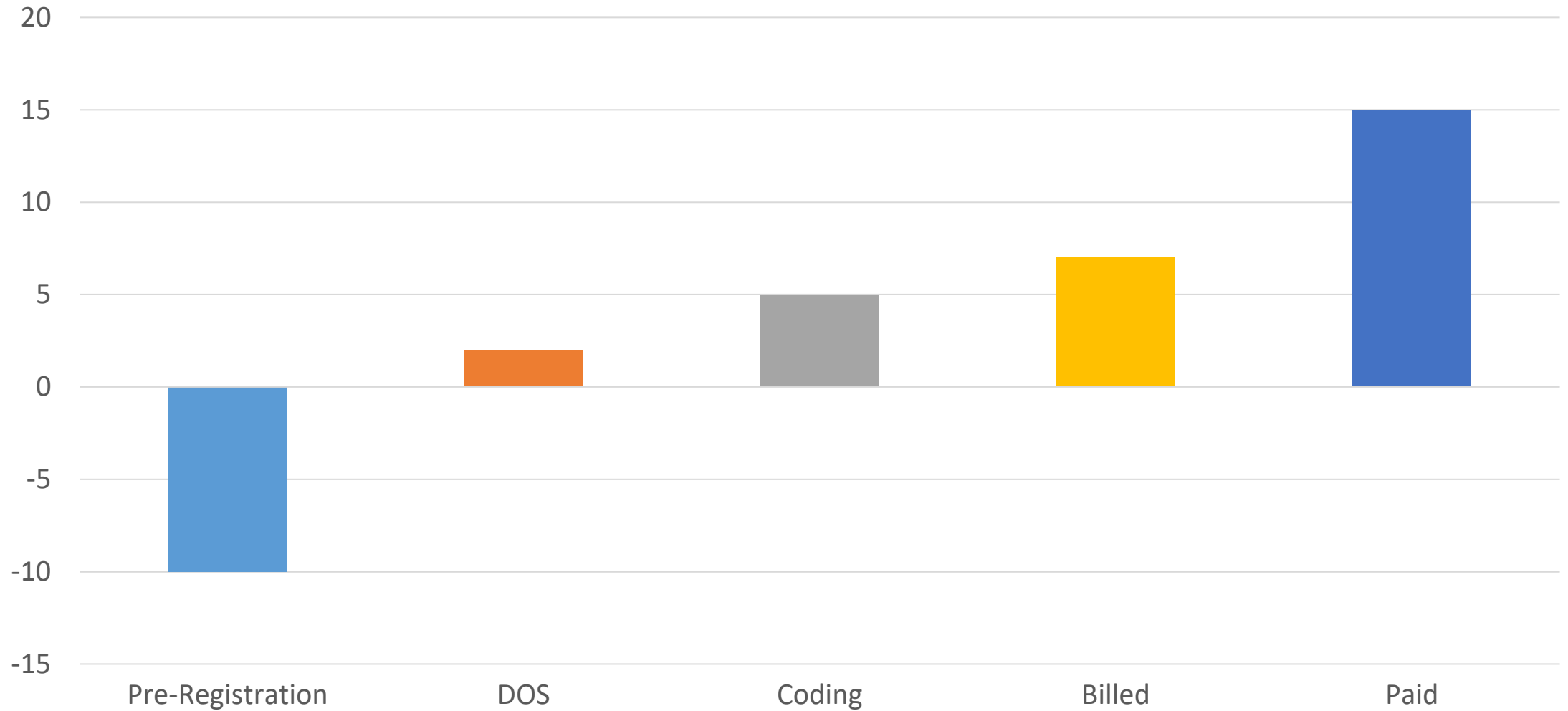
UB Fields by Department



Denials by Department



Timeline of a Paid Claim

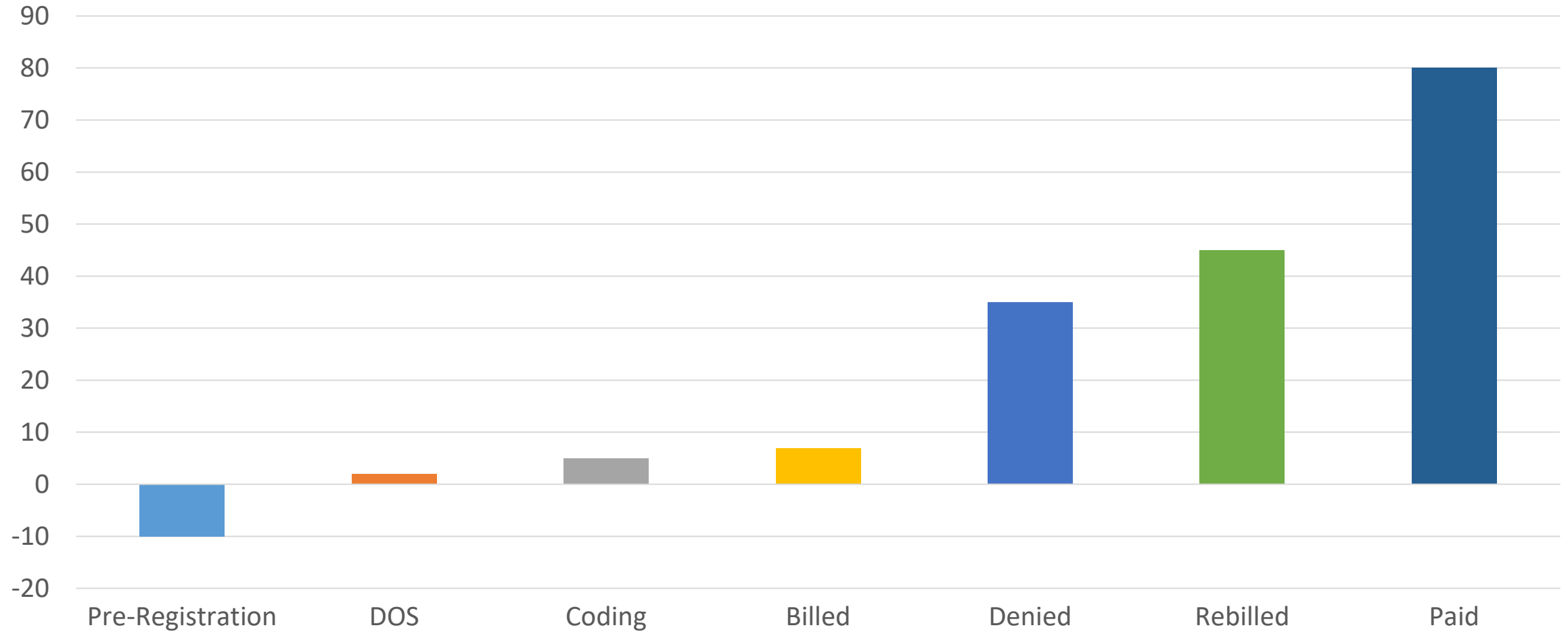


Payment Turnaround Time

Statement Date To Import			
Institutional	Current Month 17.09	Last 6 Months 16.3	Community 18.83
Professional	Current Month 23.1	Last 6 Months 23.2	Community 16.1

Export To Paid			
Institutional	Current Month 14.8	Last 6 Months 19.1	Community 17.2
Professional	Current Month 22.5	Last 6 Months 23.8	Community 17.8

Timeline of a Denied Claim



What is a Denial?

“The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for healthcare services obtained from a healthcare professional.”

- healthinsurance.org

Denial Types

- Denials vs. Rejections – no real difference
- Anything not paid on first submission is a denial
- Different sources for denied claims:
 - **277 Rejections** – Claim not making into the payer system. Typically eligibility, but could be EDI related
 - **Medicare RTP (Return to Provider)** – Hitting Medicare internal edits allowing the billing staff to make corrections online
 - **835 Denials** – Service line or full claim denials received via the electronic remittance
 - **Correspondence/Paper Denials** – Typically not tracked, but significant volume especially if not getting 90-95% of remits via 835

Denial Types - continued

Hard Denials

- Denial that results in lost or written-off revenue
- Appeal is required
- Examples:
 - No pre-authorization
 - Not a covered service
 - Bundling
 - Untimely filing

Soft Denials

- Temporary or interim denial that has the potential to be paid if the provider takes effective follow-up action
- Examples:
 - Eligibility or COB
 - Pending receipt medical records
 - Denied due to missing or inaccurate information
 - Coding or charge issues
 - Pending itemized bill

Impact of Denials

- 15-25% of all claims come back with an initial denial when first billed
 - Organizations rework or appeal 1 out of every 4-5 claims
 - This rework costs staff, resources and time, and is ultimately inefficient
- Initial denials
 - 61% due to demographic/technical errors
 - 16% due to eligibility
 - 12% due to medical necessity
- Denial write-offs
 - 42% due to demographic/technical errors

Cost of Unnecessary Denials

Cost to rework a claim due to denial = \$25

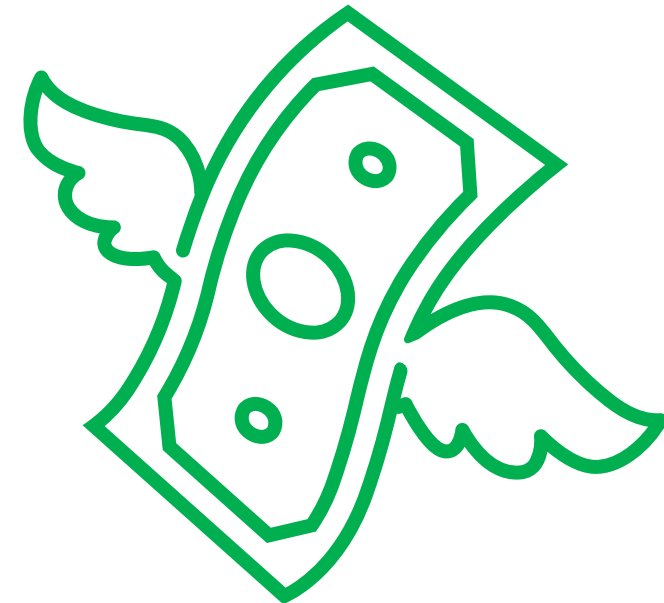
Denial rates average 10-40% of claims

Almost 60% of claims rebilled after a denial **DENY AGAIN!**

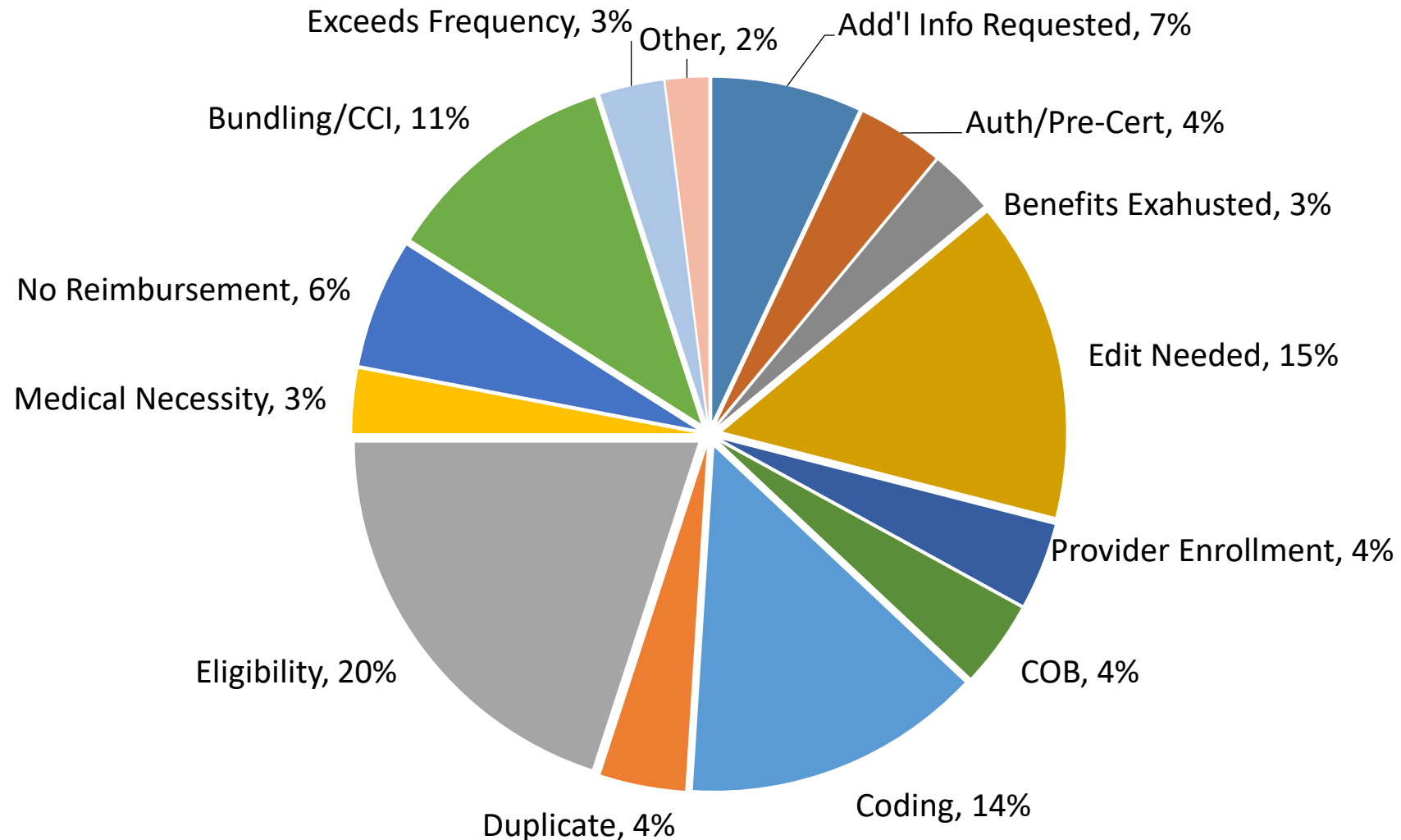
20,000 claims x 20% FPDR = 4,000 denials

4,000 x \$25 per denial = \$100,000/month

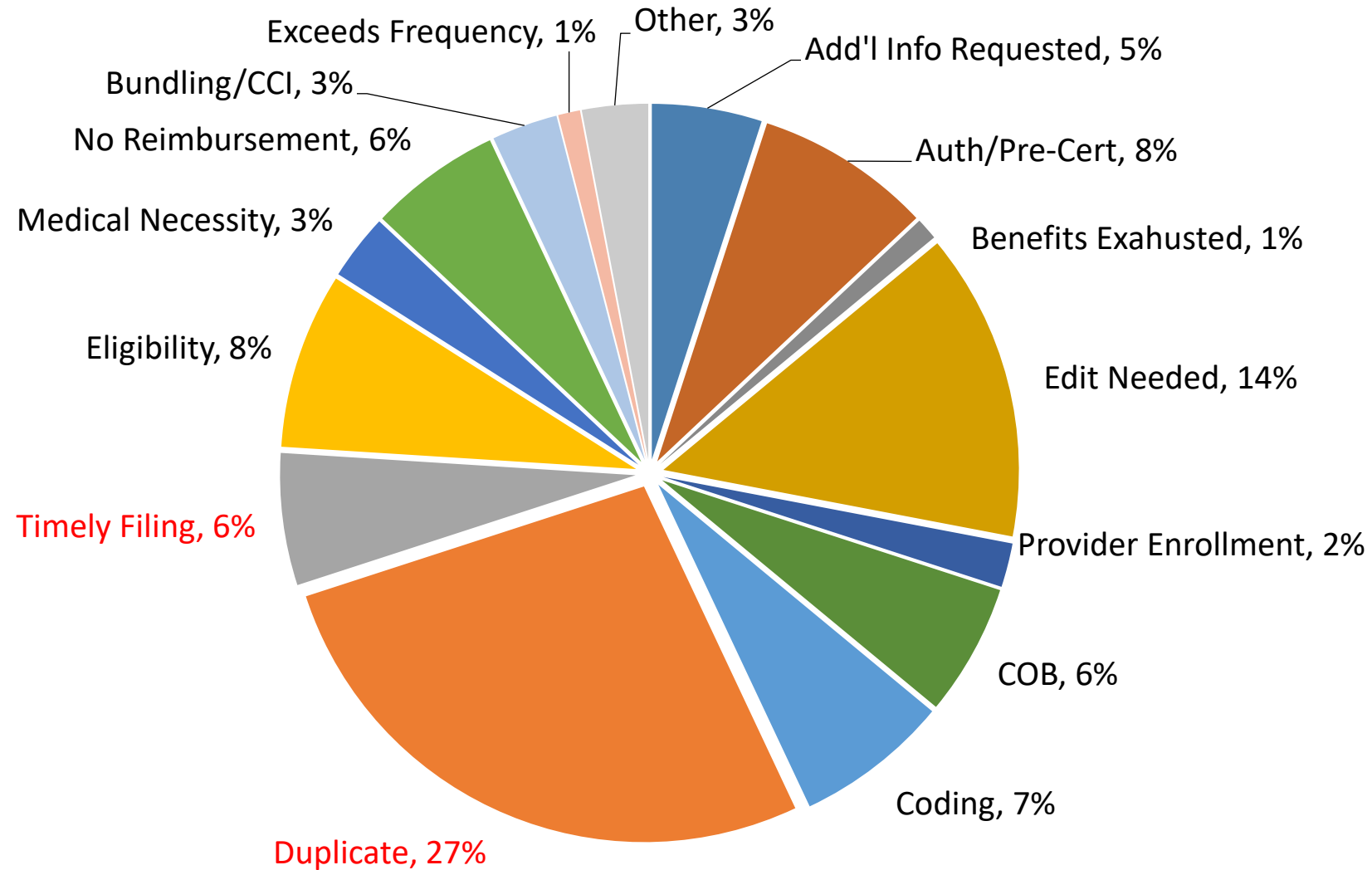
1,500 denials worked per FTE per month



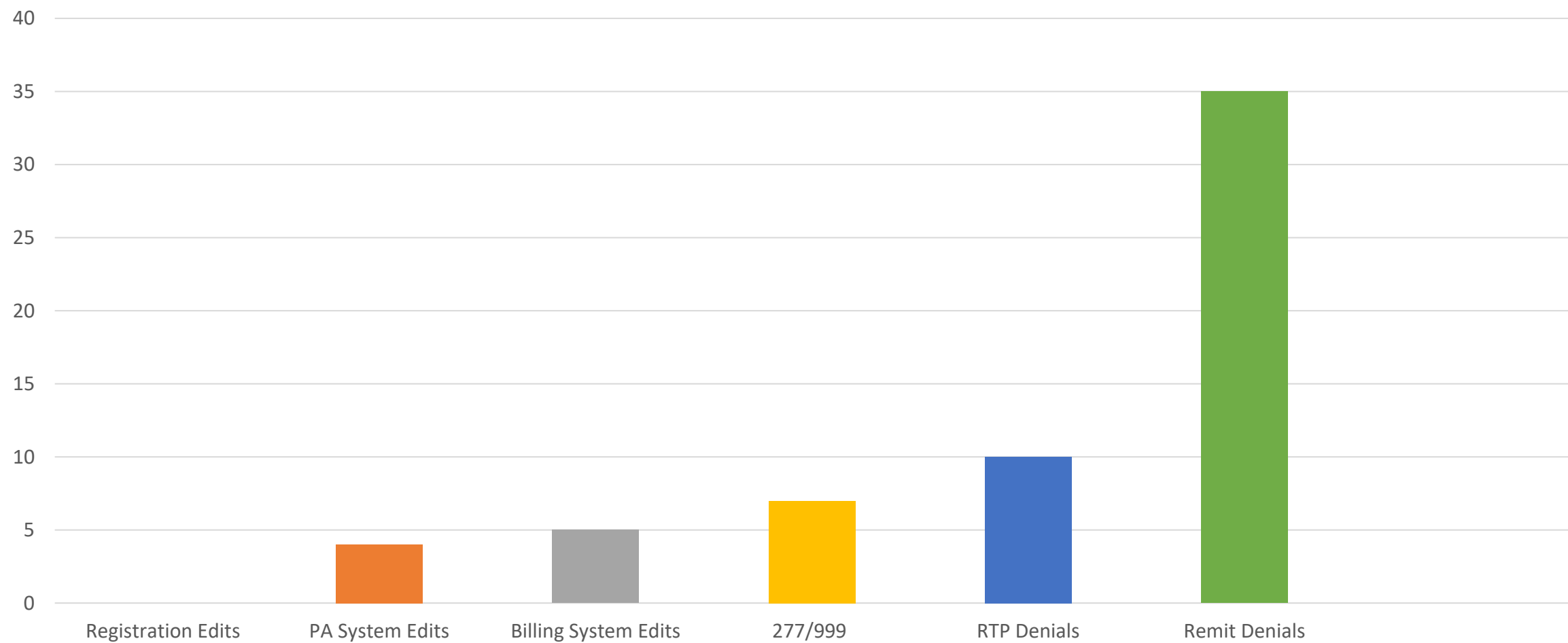
Denials by Category – First Pass Denials



Denials by Category – All Denials



Timeline of Critical Denial Points



Best Practices for Working Denials



**Sort by ANSI
code/denial
reason category**

Work related
codes all at once



**Refer to other
departments for
review and updates**

Patient access

HIM

Case management



**Work denials daily
to avoid untimely
situations**

No Authorization Denials

Action to Take

- Authorization number IS listed on claim
- Authorization number IS NOT listed on claim
- Rebills **DO NOT** help

Prevention

- Communicate authorization requirements with staff responsible for obtaining it
- Make sure **contracts** are clear on what requires authorization
- Design edits to look for payers/services that require authorization – stop claims with no authorization before billing

Medical Necessity Denials

Action to Take

- Work denials based on modifiers
 - GZ/GA/GY/None
- Denials not reviewed prior to bill should be worked by HIM
- Appeal when additional DX codes are added

Prevention

- Edit against LCD/NCD
- Implement an ABN process
- Know payer requirements
- Coding error or documentation issue?
- Educate physicians with documentation issues

Medical Necessity Denials

GZ Modifier

SERVICES / CHARGES												
Line	42 Rev Coc	44 HCPC	44 Rate	lv	lv	lv	lv	45 Service Date	46 Units	47 Total Charge	48 Non-Covered	
1	0300	36415						4/10/2017	1	\$32.00	\$0.00	Details
2	0301	82306		GZ				4/10/2017	1	\$151.00	\$151.00	Details
3	0301	82607						4/10/2017	1	\$158.75	\$0.00	Details
4	0301	82728		Procedure Modifier 1 NOT REAS OR NECESSARY					1	\$142.25	\$0.00	Details
5	0301	82746							1	\$155.50	\$0.00	Details

SERVICE LINE LEVEL:

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOWED	GC	RSN	AMOUNT
0300	20170410	36415			1	32.00	9.72			9.72
								CO	97	22.08
								CO	253	0.20
0301	20170410	82306		GZ	0	151.00	0.00			0.00
								CO	50	151.00
Remark Codes:										
N372										
0301	20170410	82607			1	158.75	48.23			48.23
								CO	97	109.54
								CO	253	0.98

Medical Necessity Denials

GA Modifier

SERVICES / CHARGES												
Line	42 Rev Coc	44 HCPC	44 Rat	lv	lv	lv	lv	45 Service Date	46 Units	47 Total Charge	48 Non-Cover	
1	0300	36415						5/26/2017	1	\$27.00		Details
2	0301	80053						5/26/2017	1	\$157.00		Details
3	0301	83880		GA				5/26/2017	1	\$202.00		Details
4	0305	85025						5/26/2017	1	\$73.00		Details

Procedure Modifier 1
WAIV OF LIAB STATEMENT

CLAIM TOTALS

										RSN	AMOUNT
0300	20170526	36415				1	27.00	14.02			14.02
									CO	97	12.69
									CO	253	0.29
0301	20170526	80053				1	157.00	81.55			81.55
									CO	97	73.79
									CO	253	1.66
0301	20170526	83880		GA		0	202.00	0.00			0.00
									PR	B22	202.00
Remark Codes: M38 M76 N115											
										B22: This payment is adjuste	

Medical Necessity Denials

GY Modifier

SERVICES / CHARGES												
Line	42 Rev Coc	44 HCPC	44 Rat	lv	lv	lv	lv	45 Service Date	46 Units	47 Total Charge	48 Non-Covered	
1	0470	V5261		PO	GY			6/19/2017	1	\$6,135.92	\$6,135.92	Details
2	0470	V5264		PO	GY			6/19/2017	1	\$120.00	\$120.00	Details

SERVICE LINE LEVEL:

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOWED	GC	RSN	AMOUNT
0470	2017619	V5261		PO GY	0	6135.92	0.00			0.00
								PR	96	6135.92

Remark Codes:

N425

Medical Necessity Denials

No Modifier

SERVICES / CHARGES

Line	42 Rev Coc	44 HCPC	44 Rat	M	M	M	M	45 Service Date	46 Units	47 Total Charge	48 Non-Cover	
1	0510	95885		TC	PO			5/8/2017	1	\$329.50		Details
2	0920	95909		TC	PO			5/8/2017	1	\$1,375.74		Details

SERVICE LINE LEVEL:

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOWED	GC	RSN	AMOUNT
0510	20170508	95885		TC PO	0	329.50	0.00			0.00
								CO	B22	329.50

Remark Codes:

M76

N115

0920	20170508	95909		TC PO	0	1375.74	0.00			0.00
								CO	B22	1375.74

Remark Codes:

M76

N115

Eligibility Denials - COB

Action to Take

- Denials should be worked by Registration staff
- Check insurance card on file
- Verify via website and other sources
- Contact patient
- Medicare COB denials – Medicare is always right 😊

Prevention

- Use auto-verification or electronic methods to confirm coverage prior to billing
- Require ID fields in Registration to match payer requirements
- COB edits

Duplicate Claim Denials

Action to Take

- Review payer website for prior billed claims
- Go back to original claim and see if there is a denial from payer that did not get addressed
- Check if claim should have been billed as an adjustment, corrected claim or appeal

Prevention

- Reduce first pass denial for other reasons
- Review multiple visits on same day
- Reduce late charges
- Use a claims scrubber that checks for conflicting claims
- Turn off automated claim generation in PFS system if no payment posted to account

Untimely Claim Denials

Action to Take

- Review account to determine if denial is appropriate
- If claim denied in error, send appeal with supporting documentation showing why claim was billed after time limit
- Mass denials due to technical issues can be appealed

Prevention

- Submit claims as quickly as possible after services rendered
- Retain payer acknowledgement of receipt of claim
- Add edits to billing system to add time limits for different payers
- Reduce first pass denials for other reasons

Timely Filing Appeal - Example

Original Claim

Billed to Medicare on 12/1/16

Date of service: 11/23/16

CLAIM INFO	
Import Date: 11/30/2016 09:30 AM	Claim Status: Closed
Import ID: 93457	Export Date: 12/01/2016 05:10 PM
Import Filename: BUTH_WF_20161130_1929W8EDTHMODIFIED	Export ID: 00270746
	Claim ACK 999 Dat 12/02/2016 06:20 AM
Payer Submission ID: 999CH0000002_001_00000_20161201_270746.WF_00001_20161201192	
Payer Report ID: ASB	

Timely Filing Appeal - Example

12/12/16 Denial received stating patient has Medicare Advantage plan

12/14/16 Registration adds hold in system

04/10/17 Received updated insurance information

The screenshot shows a software interface for managing encounters. At the top, a header bar displays 'Encounter: 11/23/2016 - 11/23/2016'. Below this is a filter dropdown set to 'All' and a status 'Displaying 16 Items'. A table lists several encounters with columns for 'Created', 'Applied To', 'Applied By', and 'Comment'. The table includes entries for dates 04/12/2017, 04/10/2017, and 12/14/2016. Below the table, a detailed view of an encounter is shown with fields for 'Created', 'Applied By', 'Applied To', 'Priority', and 'Comment'. The 'Created' field is highlighted in yellow, showing '04/10/2017 12:11'. The 'Comment' field is also highlighted in yellow, showing 'Changed primary insurance from Medicare Part A and B to MADV UHC Medicare Community Plan'.

Created	Applied To	Applied By	Comment
04/12/2017 17:36	Claim : 11/23/2016 : Institutional	CONTRIBUTOR_SYSTEM, MEDASSETS	OutSource: Claim was exported on 4/11/2017 1:36:20 PM to MED ADV UHC PAYERS; 11/23/2016;
04/10/2017 12:11	Encounter : 11/23/2016	Schneider, Tami	Changed primary insurance from Medicare Part A and B to MADV UHC Medicare Community Plan
04/10/2017 12:11	Encounter : 11/23/2016	Schneider, Tami	Removed tertiary insurance Misc Forward Out of Area Public Aid Payer
04/10/2017 12:11	Encounter : 11/23/2016	Schneider, Tami	Changed secondary insurance from MADV UHC Medicare Community Plan to Misc Forward Out of Area Public Aid Payer
04/10/2017 12:09	Encounter : 11/23/2016	Schneider, Tami	Release Hold CODE: USER:Schneider, Tami
12/14/2016 08:48	Claim : 11/23/2016 : Institutional	Wetherell, Rebecca OS	Pending - Payer Processing CODE:612 USER:Wetherell, Rebecca OS Claim denied due to HMO - placed on registr...
12/14/2016 08:47	Encounter : 11/23/2016	Wetherell, Rebecca OS	Add Hold CODE: USER:Wetherell, Rebecca OS
12/12/2016 13:32	Claim : 11/23/2016 : Institutional	Schneider, Tami	RR Denied


Created: 04/10/2017 12:11	Applied By: Schneider, Tami	Applied To: Encounter : 11/23/2016
Priority: Medium		
Comment: Changed primary insurance from Medicare Part A and B to MADV UHC Medicare Community Plan		

Timely Filing Appeal - Example

04/11/17 Correct insurance billed

04/18/17 Claim denied by correct insurance for untimely filing

05/01/17 Appeal sent with copy of notes from system and original claim billing information

 **PAYER INFO**

EXPORT TYPE

Paper-Appeal ▾

APPEAL INFORMATION

Type of Service: Emergency ▾

Service Lines Denied: ☒ Entire Claim ☐ Specific (Select Service Lines)

Type of Appeal: Waive Untimely Filing ▾

Reason for Appeal: Incorrect insurance information provided at registra ▾ *Include Attachment

Comments: Please see attached documentation. Insurance updated 04/10/17 from Medicare to Medicare Adv UHC - See Claim **PHC0000001077**

MUE – Frequency Denials

Action to Take

- Refer to HIM to review number of units billed for denied CPT
- If HIM updates units, will need to do re-opening in Connex (if Medicare) otherwise send as corrected claim to other payers
- If no changes, post adjustment in PFS system for that charge. Appealing with records to support medical necessity will still deny.

Prevention

- Use a billing system that is editing charges against Medicare's practitioner and facility MUE table
- If able to locate information for other payers, add edits for those also. Update based on denials
- Patient access should be checking benefits for preventative services
- Tracking system for therapy services

Additional Information Denials

Action to Take

- Contact patient immediately and set a specific time for compliance before moving to self pay
- If records are requested, refer to HIM
- Release only the specific records requested, not the entire record
- Blue Cross of IL – does not like modifier 59 or the X modifiers. Submit records along with narrative as to why you should be paid for any charge with those modifiers

Prevention

- Create edit in system to flag Work Comp claims to add records on initial submission
- Keep track of which commercial payers are requesting records before paying claims.
- Include record request restrictions in payer contracts

Questions



Thank you for joining us today!

Don't hesitate to get in touch with any follow up questions.

Lori Zindl
President

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And don't forget to add the final session of our series to you calendar:

Wednesday, June 17th | 12:00 pm - 1:30 pm Central
[Collections & Customer Service](#)

Series Playback & Materials

Registered attendees can access previous session recordings, presentation slides, and follow up materials on our website.

[ICAHN Healthcare Billing Webinar Series – Spring 2020](#)