Denials:
Overview & Resolution Strategies

ICAHN Healthcare Billing Webinar Series

Session 3 – May 20th, 2020

ICAHN
Illinois Critical Access Hospital Network

efficientC
developed by OS inc.

Introduction

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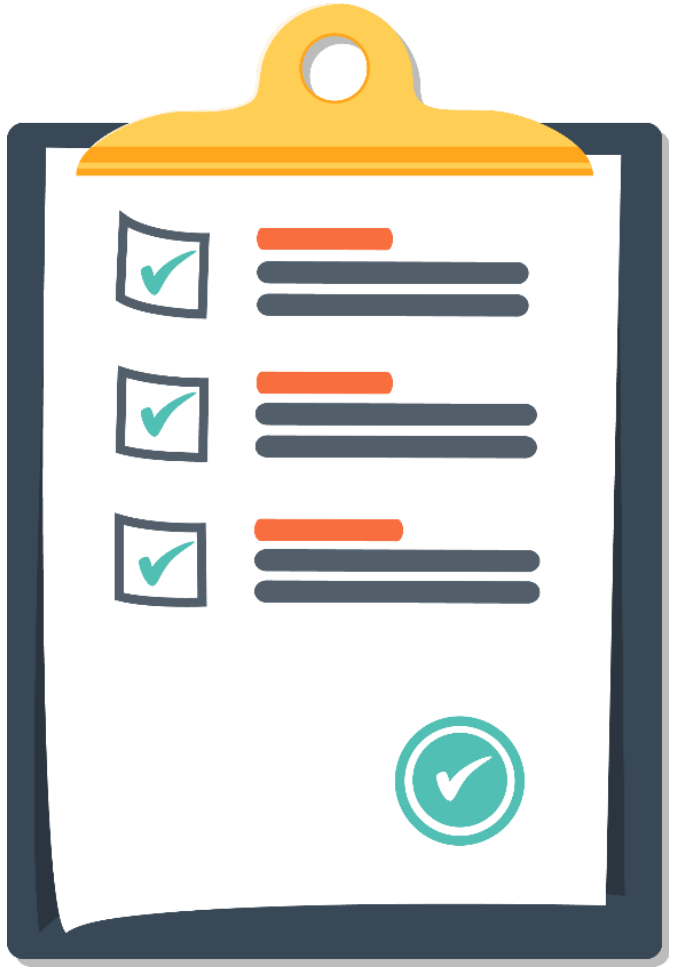
Be Sure to Note & Submit Questions!

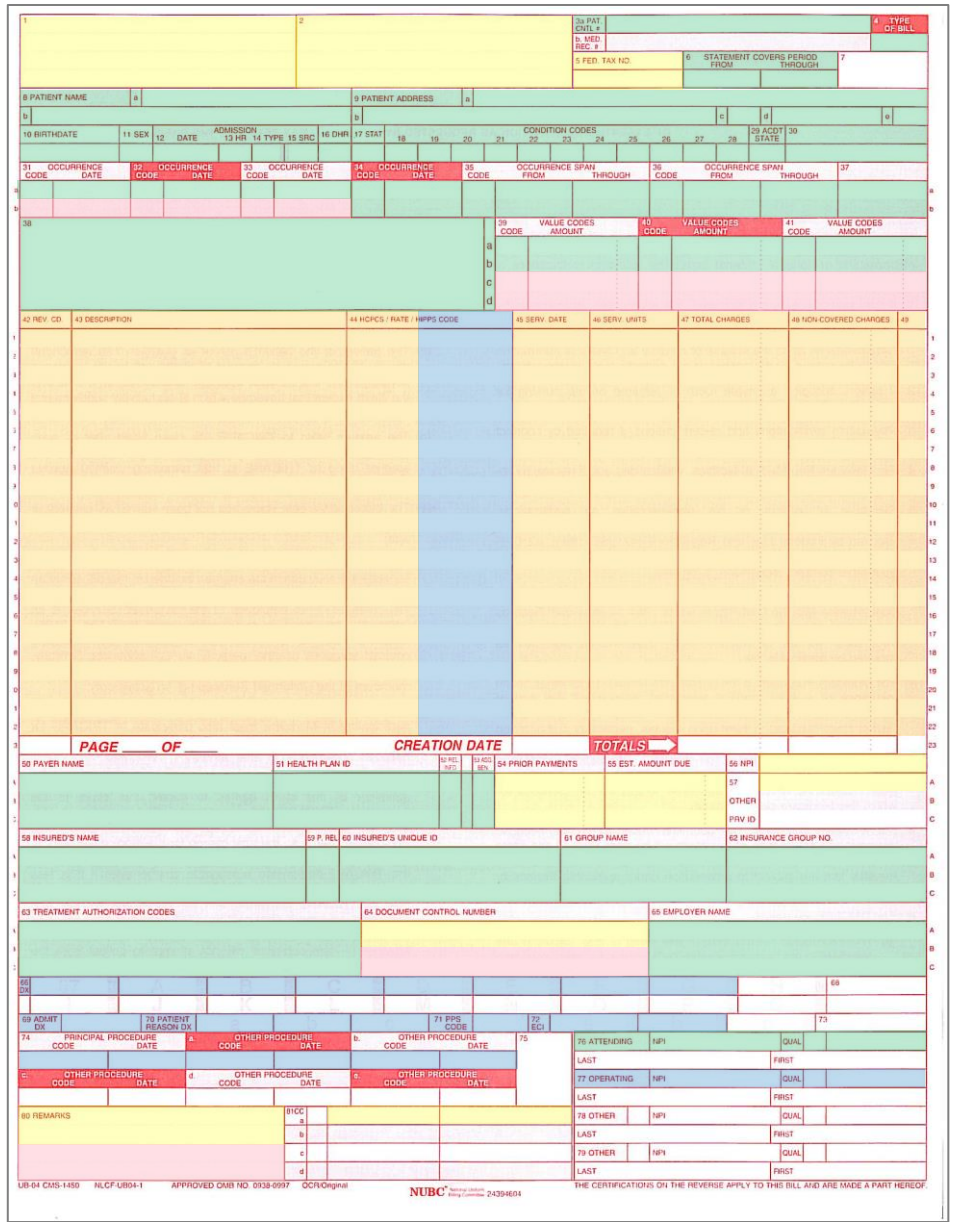
Learning Objectives

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

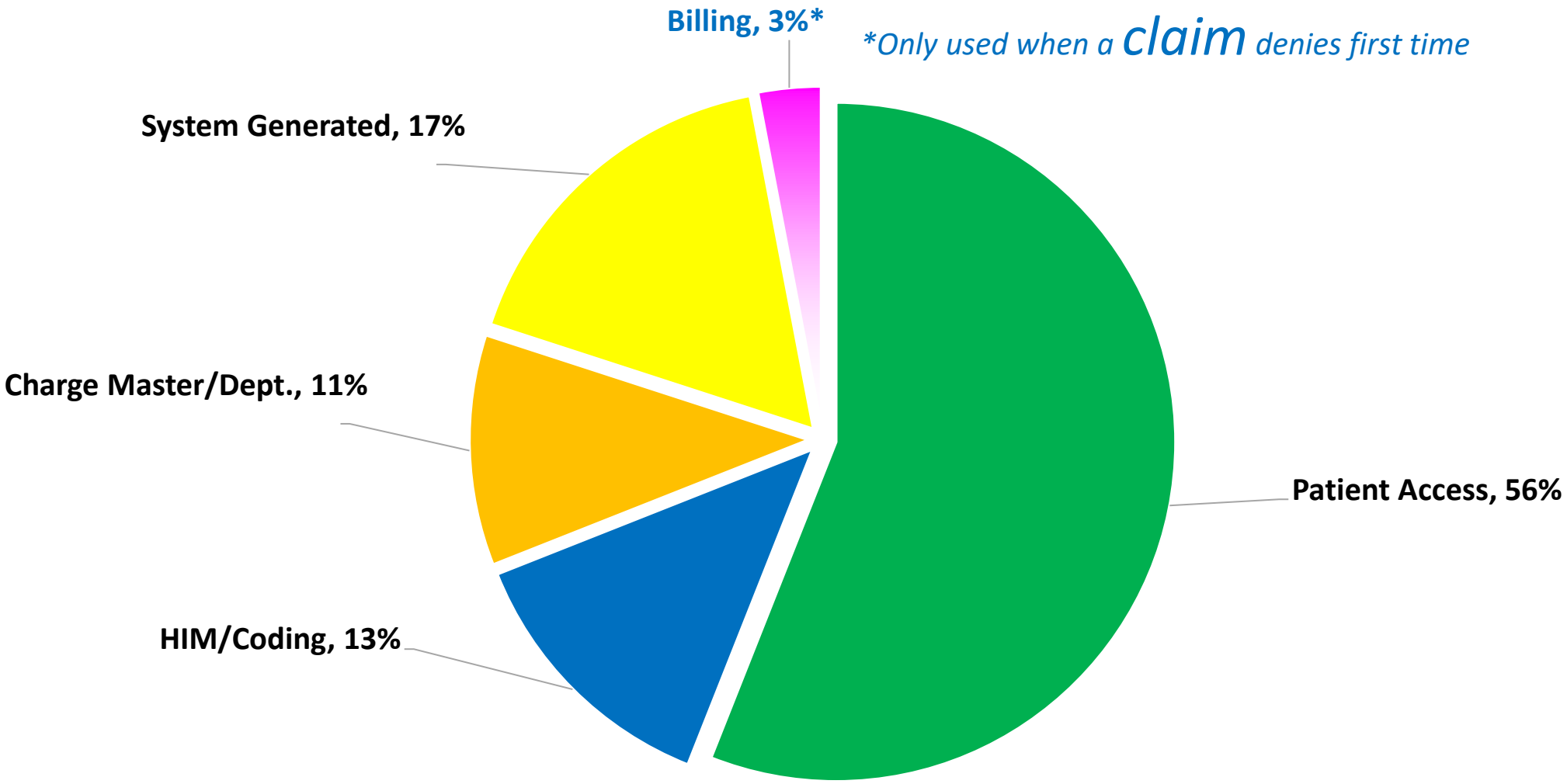


Who Really Bills Claims?

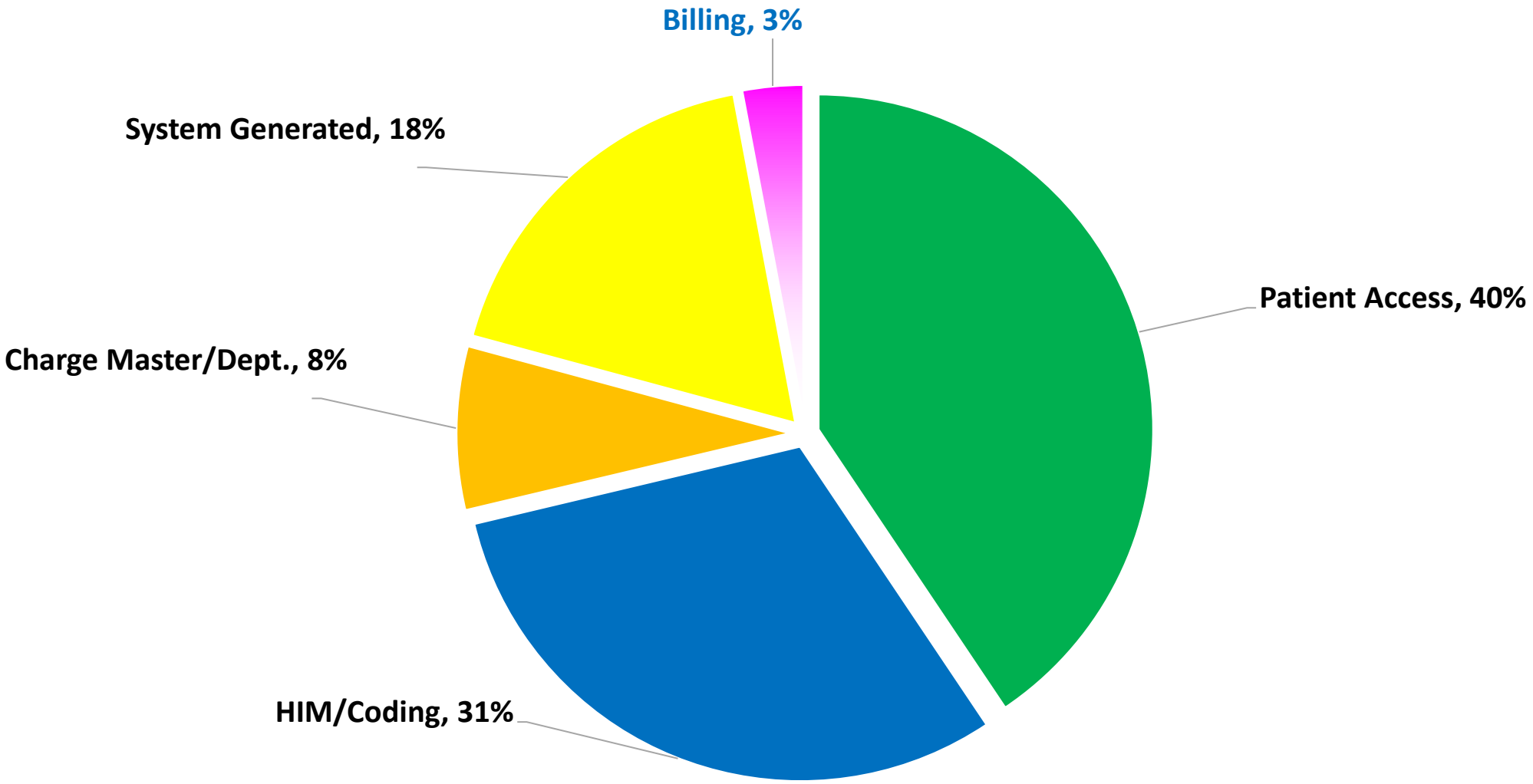
Green	Patient Access
Blue	HIM/Coding
Orange	Charge Master
Yellow	System Generated
Pink	Billing



Not the Billing Department

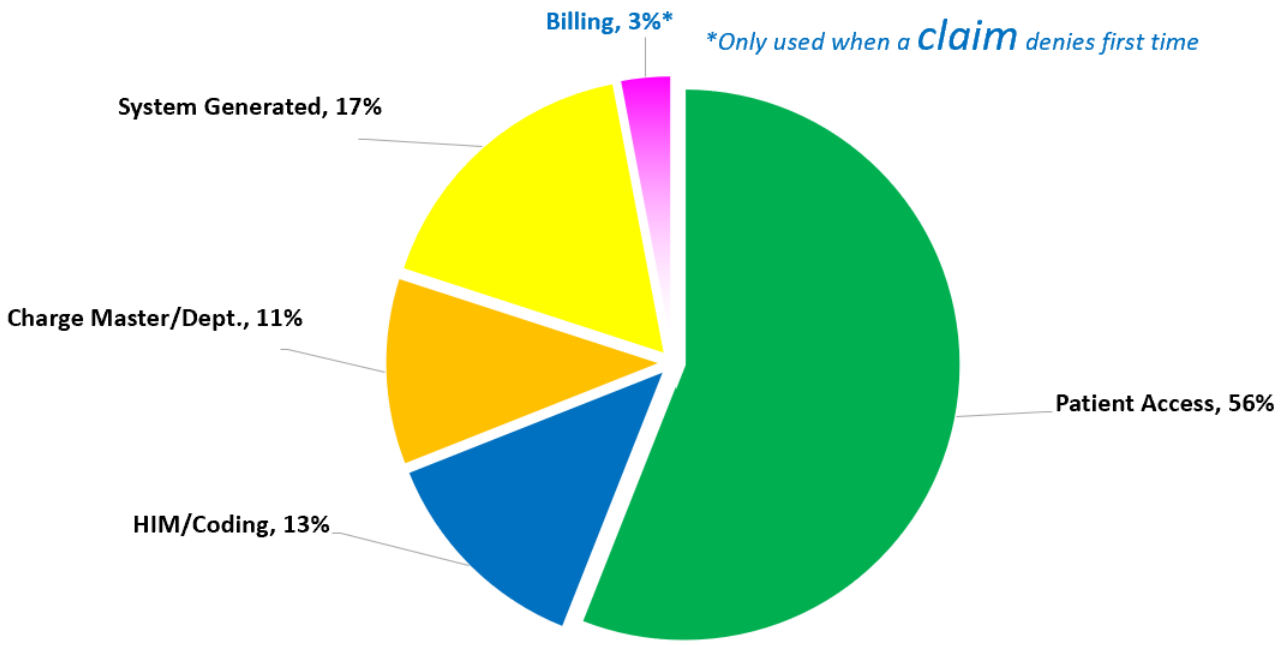


Who's Responsible for Denials?

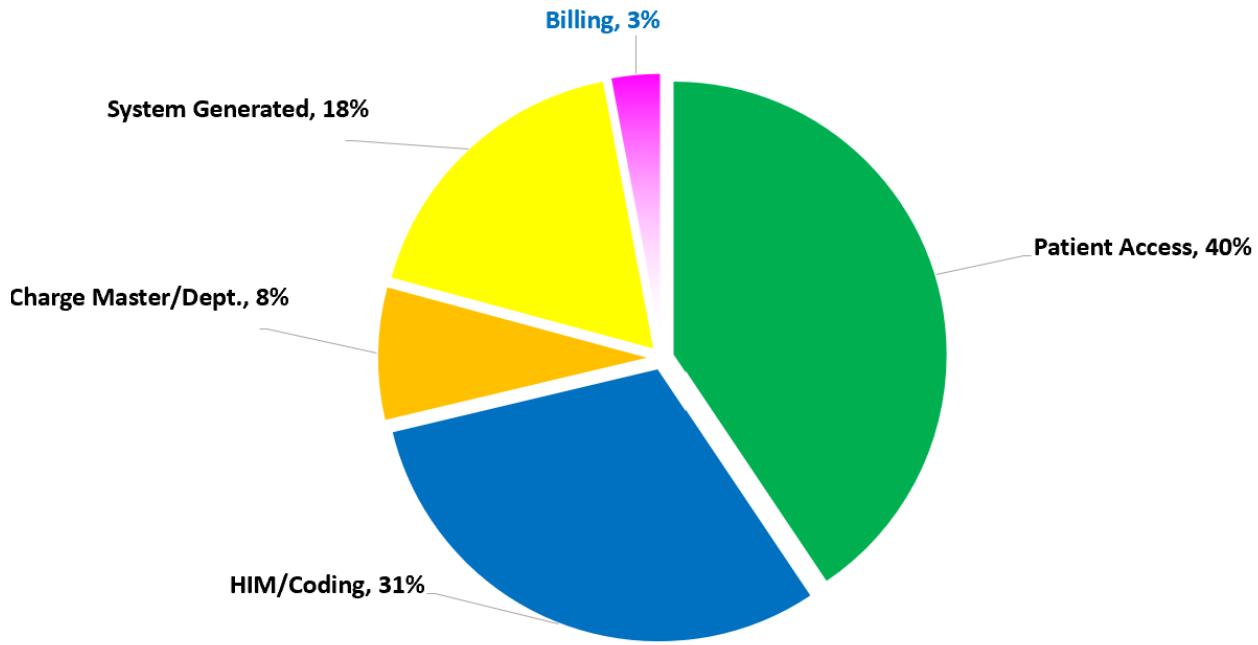


Comparing Billing Requirements to Denials by Department

UB Fields by Department



Denials by Department



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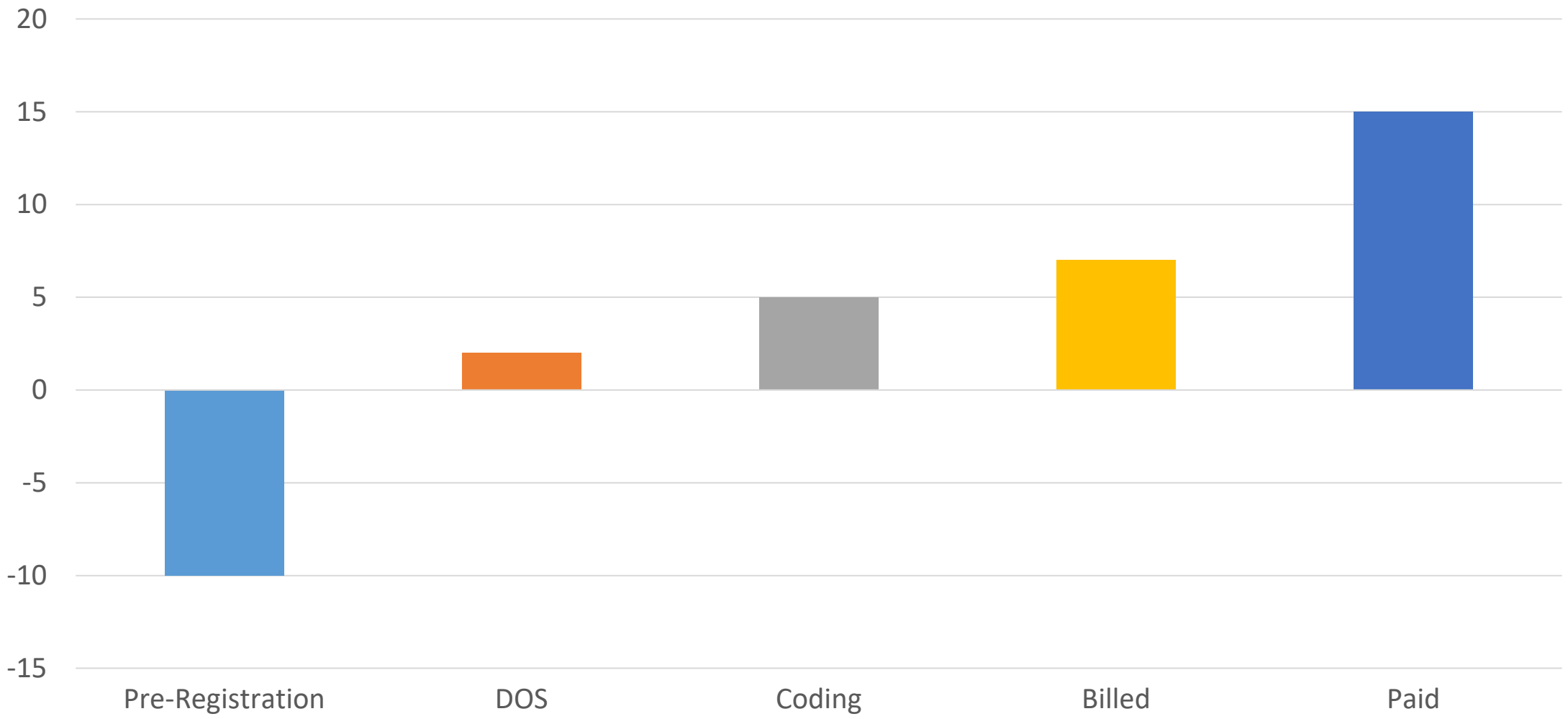
Timeline of a Paid Claim

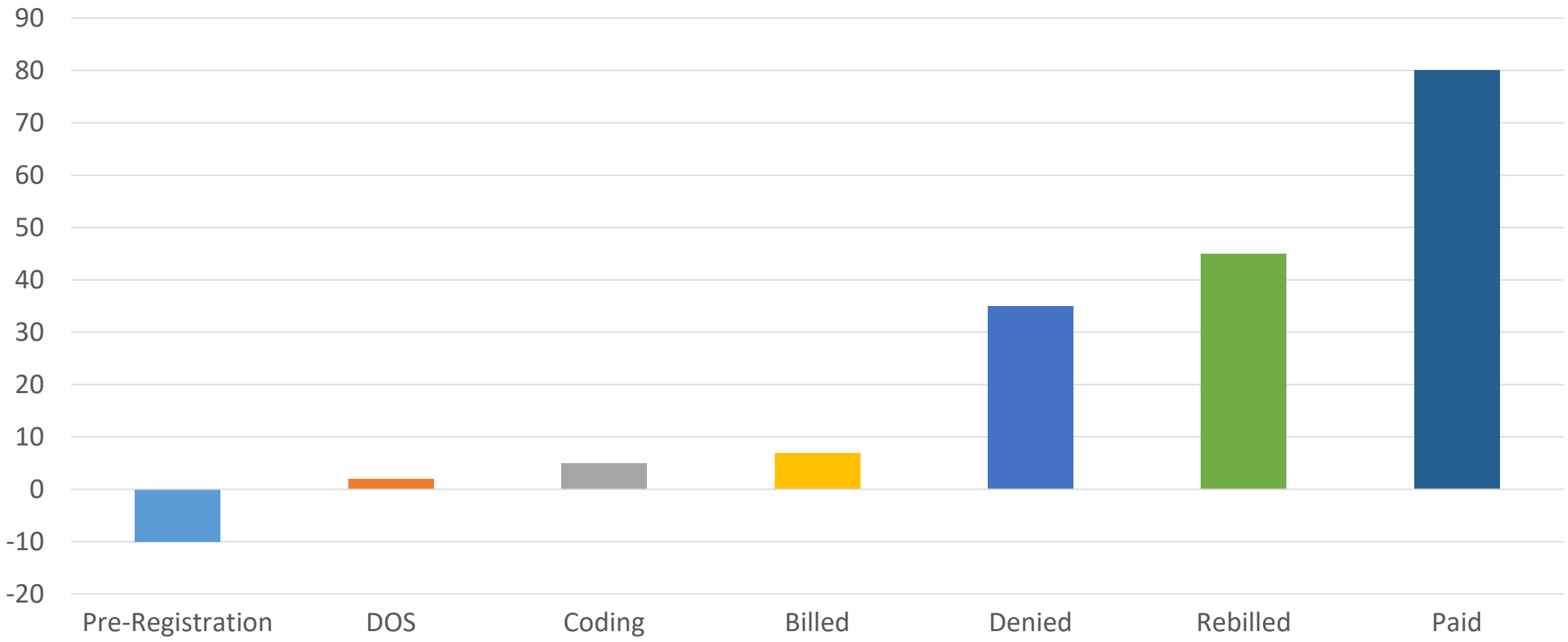


Payment Turnaround Time

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

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

Source: 4 ways healthcare organizations can reduce claim denials - Becker's Hospital Review

Cost of Unnecessary Denials

Cost to rework a claim due to denial = $25

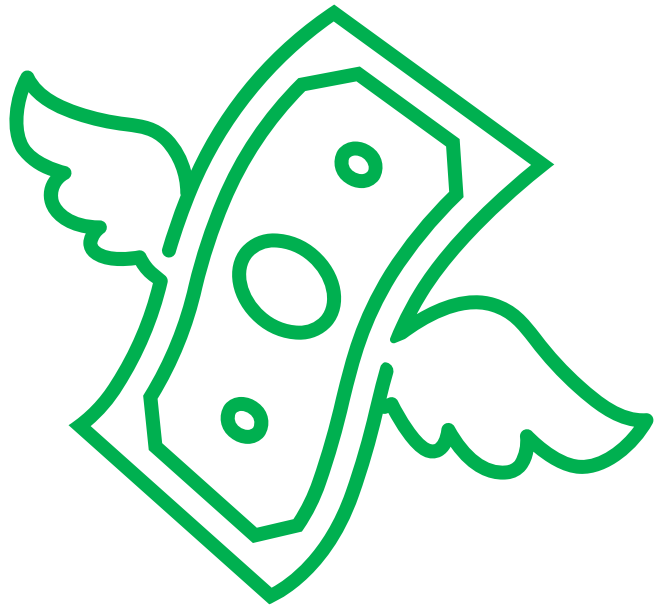
Denial rates average 10-40% of claims

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

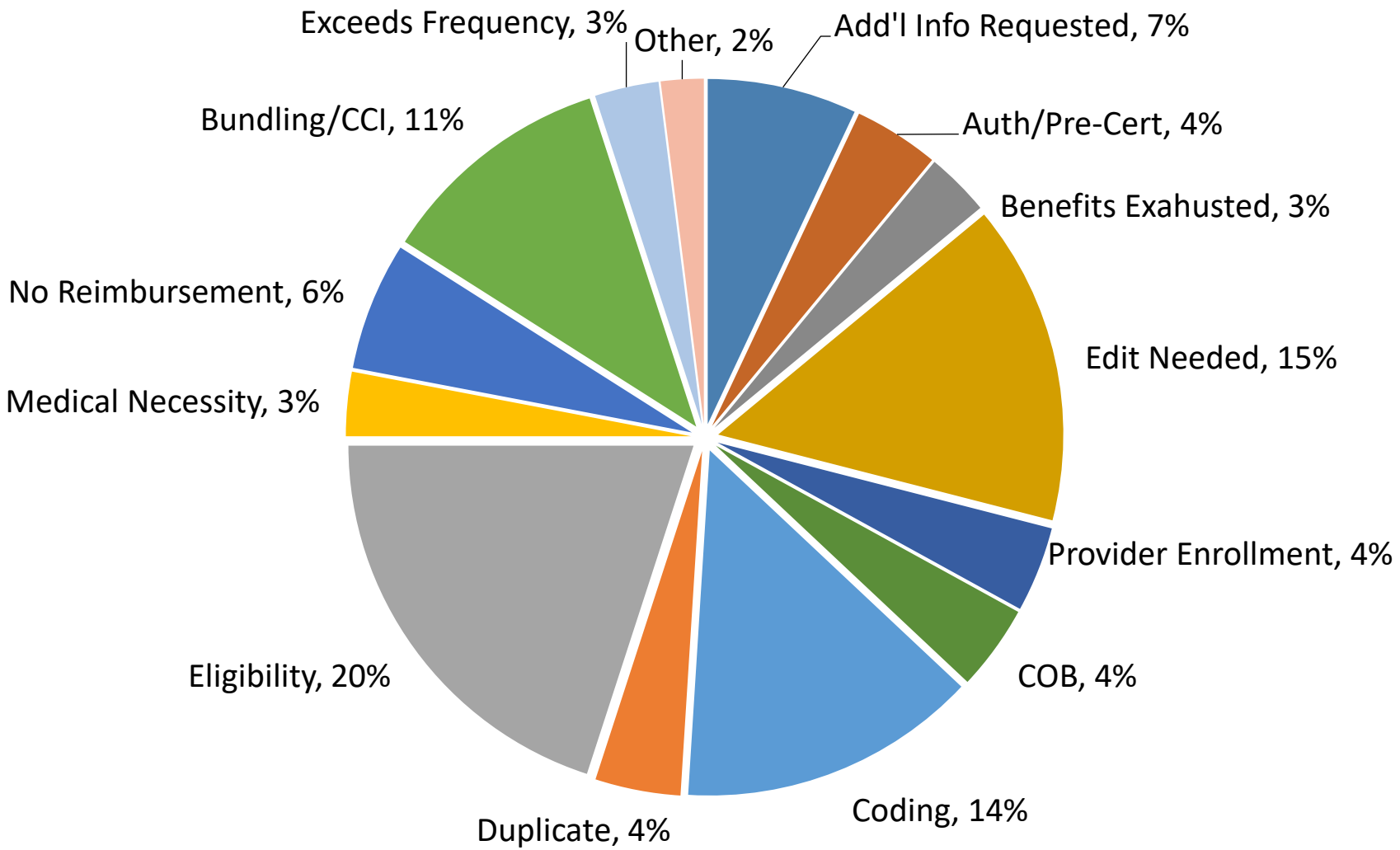
20,000 claims x 20% FPDR = 4,000 denials

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

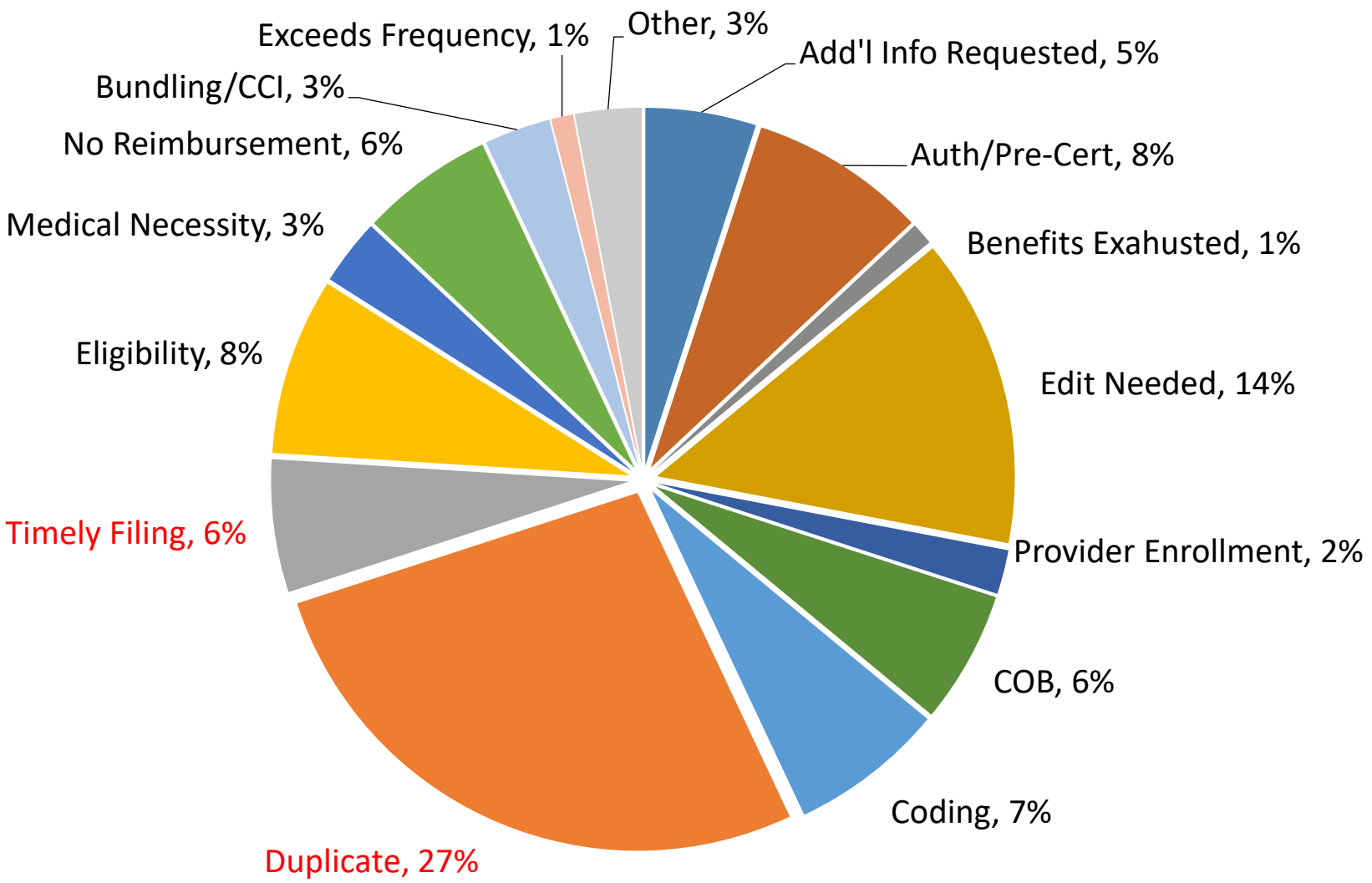
1,500 denials worked per FTE per month



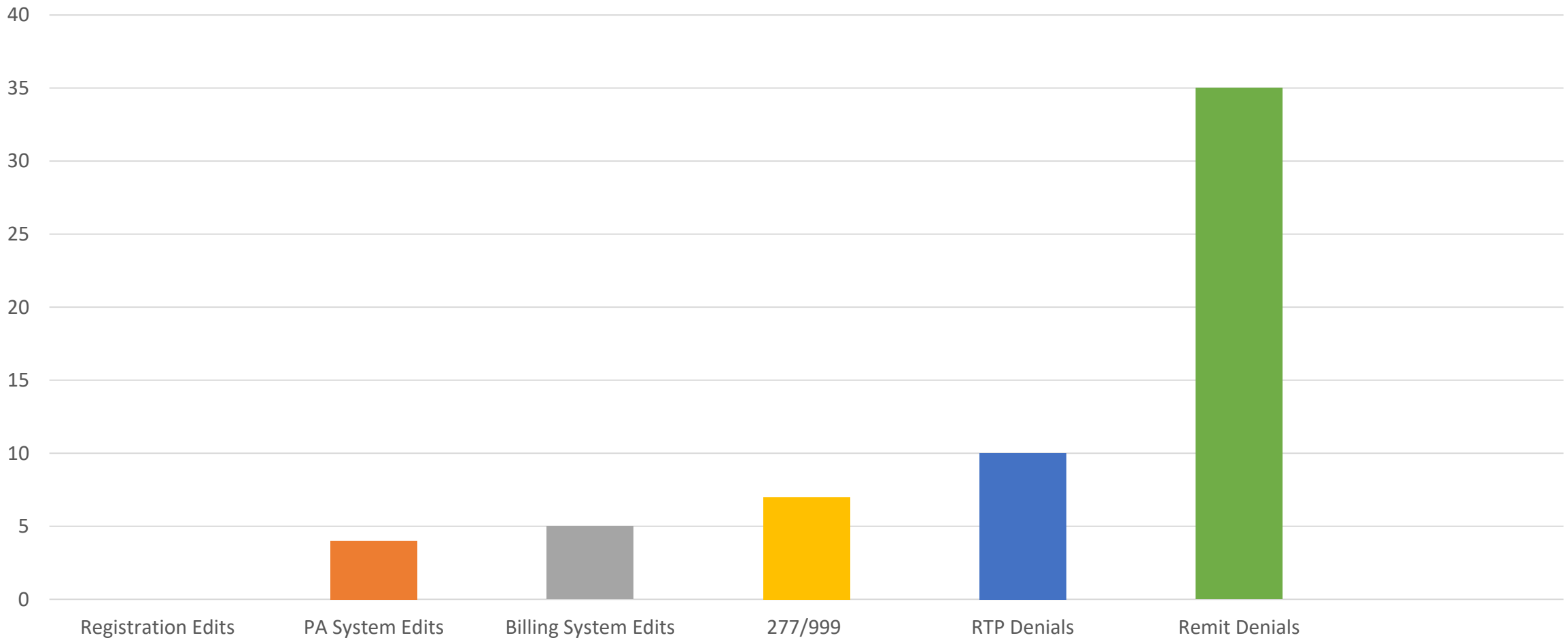
Denials by Category – First Pass Denials



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 Rat	M	M	M	M	45 Service Date	46 Units	47 Total Charge	48 Non-Covere	
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							1	$142.25	$0.00	Details
5	0301	82746							1	$155.50	$0.00	Details

Procedure Modifier 1
NOT REAS OR NECESSARY

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

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Medical Necessity Denials

GA 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-Covere	
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

B22: This payment is adjuste

Remark Codes:
M38
M76
N115

Medical Necessity Denials

GY 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-Covere	
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-Covere	
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

REV	DATE	HCPCS	APC/HIPPS	MODS	QTY	CHARGES	ALLOWED	GC	RSN	AMOUNT
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

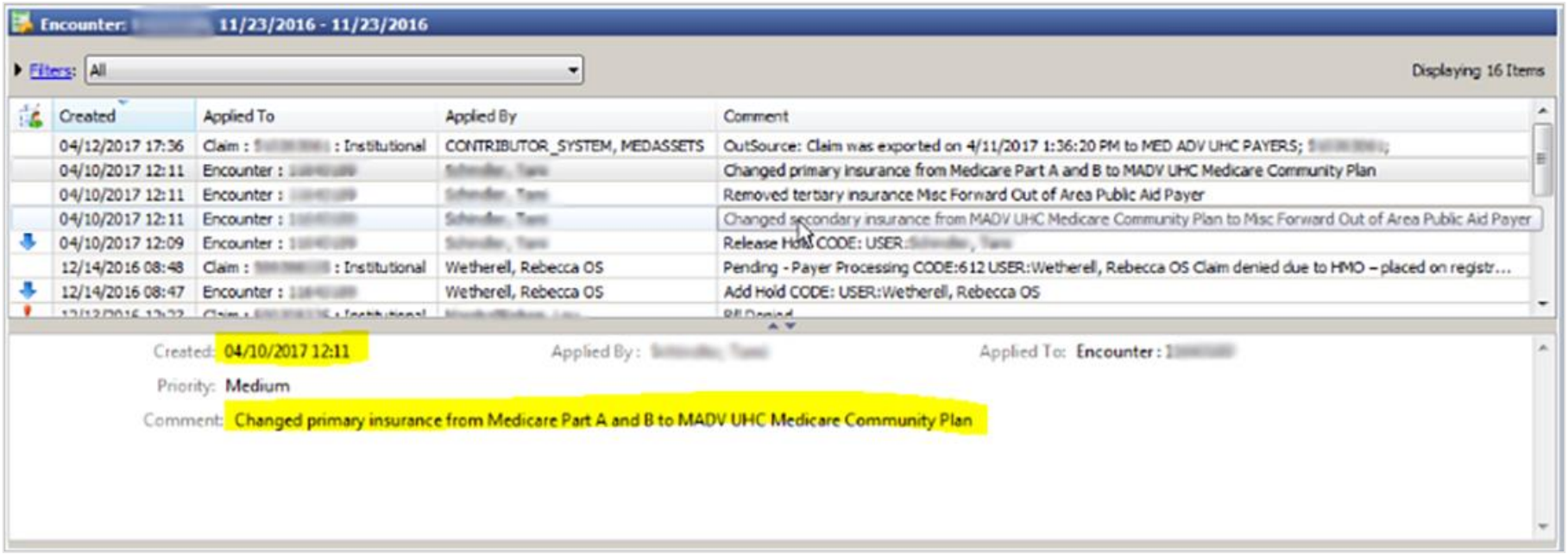
Original Claim
Billed to Medicare on 12/1/16
Date of service: 11/23/16

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

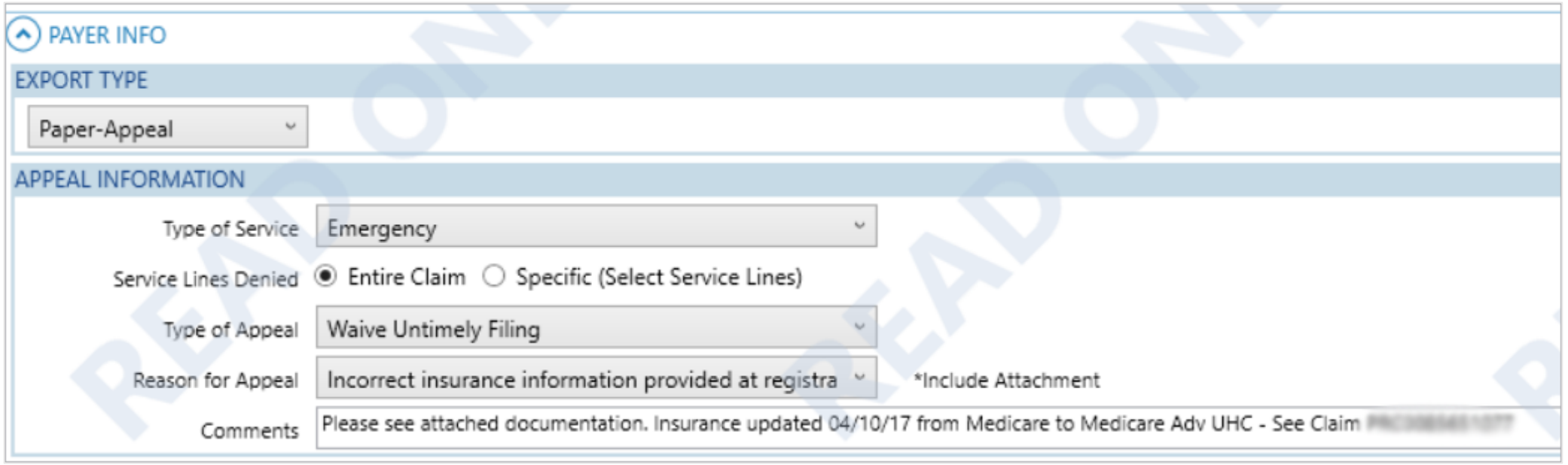


Timely Filing Appeal - Example

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



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

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Series Playback & Materials

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

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