Billing Basics Session 3: All About Denials

Lori Zindl, OS inc. | efficientC

January 16, 2019

REVENUE CYCLE MADE EASY

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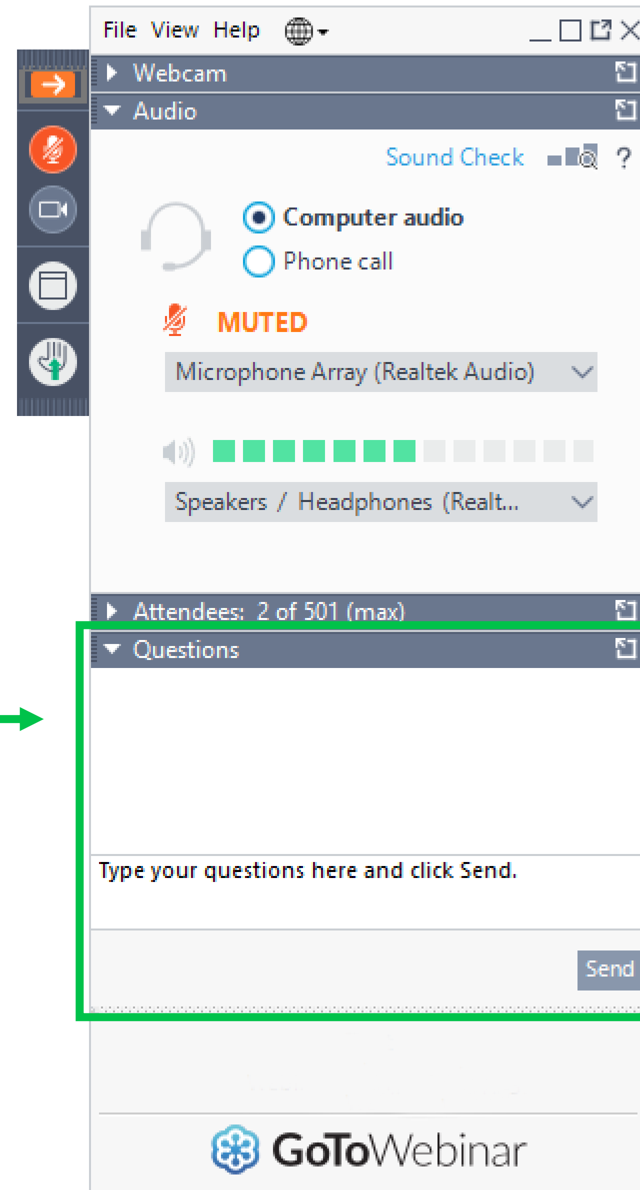

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Introduction

Lori Zindl

President
OS inc. | efficientC

Discussion Topics

1. Review denials by category
2. Understand what the denial means
3. Best practice for working denials
4. Steps to take to prevent future denials

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*

Cost of Unnecessary Denials

Cost to rework a claim due to denial = $118

Denial rates average 10-40% of claims

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

20,000 claims x 10% FPDR = 2,000 denials

2,000 x $118 per denial = $236,000/month

1500 denials worked per FTE per month

Impact of Denials

- 15-20% of all claims come back with an initial denial when first billed
  - Organizations rework or appeal 1 out of every 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

Denials by Category

Denial Category	# of Claims	Total $ Denied	% of Claims	% of Dollars
Additional info requested - Patient	132	$ 131,942.51	3.6%	4.2%
Additional info requested - Provider	204	$ 621,305.48	5.6%	20.0%
Authorization/Pre-Cert	106	$ 101,816.42	2.9%	3.3%
Benefits Exhausted	42	$ 33,012.81	1.2%	1.1%
Billing Related - Edit Review needed	785	$ 308,042.52	21.6%	9.9%
Bundling/CCI Edit	98	$ 14,184.00	2.7%	0.5%
COB Issue	284	$ 109,451.93	7.8%	3.5%
Coding	112	$ 55,211.77	3.1%	1.8%
Duplicate/Overlap	461	$ 854,248.06	12.7%	27.5%
Eligibility/Coverage	756	$ 297,024.26	20.8%	9.6%
Exceeds Frequency	51	$ 45,073.67	1.4%	1.5%
Medical Necessity	72	$ 211,779.28	2.0%	6.8%
Other	191	$ 109,688.08	5.3%	3.5%
Other Facility Overlap	37	$ 5,638.18	1.0%	0.2%
Provider Enrollment	41	$ 11,518.50	1.1%	0.4%
Timely Filing	264	$ 197,471.87	7.3%	6.4%
Grand Total	**3636**	**$ 3,107,409.34**		

Timeline of a Paid Claim

20
15
10
5
0
-5
-10
-15

Pre-Registration DOS Coding Billed Paid

Payment Turnaround

STATEMENT DATE TO IMPORT

ClaimType	Last Week	vs 6 Months	vs Clients
Inst	15.0	13.6 ▼	21.5 ▲
Prof	24.7	18.4 ▼	18.2 ▼

EXPORT TO PAID

ClaimType	Last Week	vs 6 Months	vs Clients
Inst	17.9	16.6 ▼	15.8 ▼
Prof	13.1	18.3 ▲	16.4 ▼

CLAIM TURNAROUND TREND

Statement->Import
Statement->Import
Import->Export
Import->Export
Export->Paid
Export->Paid
Inst
20
0
Prof
40
20
0
2018 June
2018 September
2018 December

BILL CYCLE TREND

Statement->Import
Export->Paid
Import->Export
Turnaround (In Days)
18
15
12
9
6
3
0
2018 June
2018 September
2018 December

PAYER TURNAROUND (3 MONTHS AVG.)

Payer		Turnaround
AARP	30.5	
HPS	30.2	
DEANCARE CO...	27.2	
CHILDRENS C...	26.8	
MED ADV CAR...	25.7	
MED ADV UHC...	24.1	
UNITED MEDI...	19.9	
UMR 39026	19.3	
WEA INSURAN...	18.7	

PROVIDER TURNAROUND (3 MONTHS AVG.)

Provider		Turnaround
	17.1	
	13.1	

TYPE OF BILL TURNAROUND (3 MONTHS AVG.)

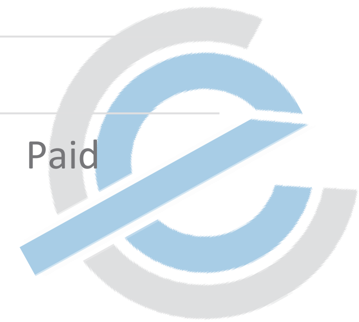
TypeOfBill		Turnaround
121	50.2	
22	30.2	
132	27.0	
11	26.0	
133	23.5	
81	15.9	
111	13.8	
131	10.6	
141	9.3	

Last refreshed: 1/15/2019

Timeline of a Denied Claim

90
80
70
60
50
40
30
20
10
0
-10
-20

Pre-Registration DOS Coding Billed Denied Rebilled Paid



Denials Types

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:
  - Pending receipt medical records
  - Denied due to missing or inaccurate information
  - Coding or charge issues
  - Pending itemized bill

Timeline of Critical “Denial” Points

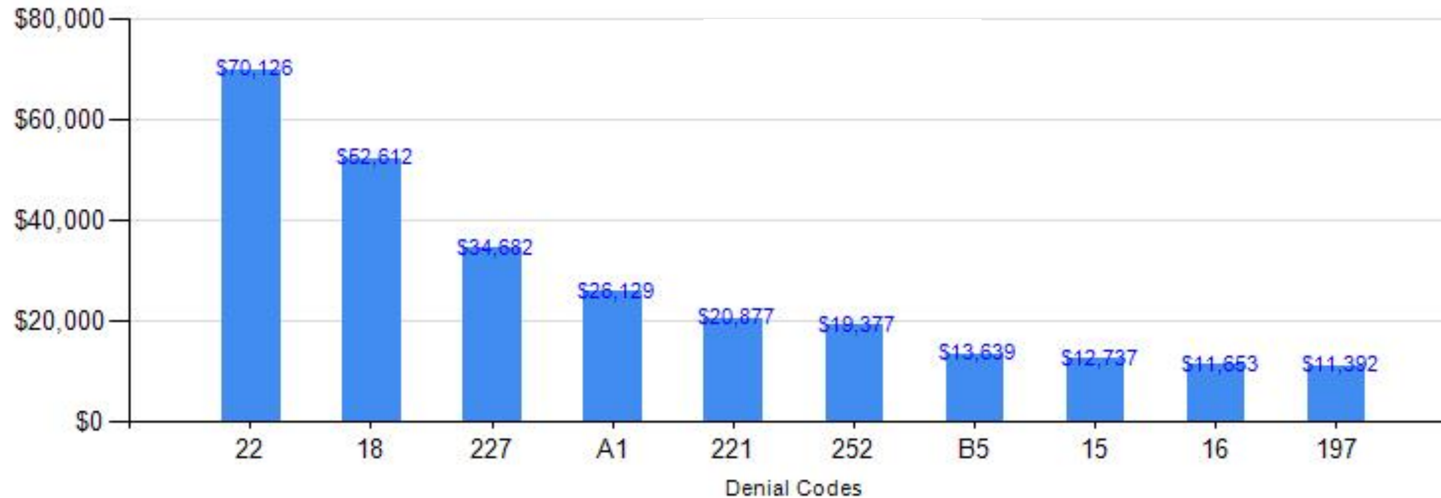
40
35
30
25
20
15
10
5
0

Registration Edits
PA System Edits
Billing System Edits
277/999
RTP Denials
Remit Denials

Denials Management

- Track all denials by payer
- Use system reports – zero pay posting with reason codes
- Select highest volume and highest dollar denial reasons each month to focus on reducing or eliminating
- Add required registration fields, coding, prior authorization and billing edits or system holds to prevent claims from billing with incorrect data.

Sample Denial Report



Denial Code	Description
22	This care may be covered by another payer per coordination of benefits.
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
221	Claim is under investigation. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). (Note: To be used by Property & Casualty only)

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 Charg	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

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

Action to Take

- Denials should be worked by Registration staff
- Check insurance card on file
- Verify via website and other sources
- Contact patient

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

<u>Original Claim</u>

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:	[illegible]	Export Date:	12/01/2016 05:10 PM
Import Filename:	[illegible]	Export ID:	[illegible]
		Claim ACK 999 Dat	12/02/2016 06:20 AM
Payer Submission ID:	[illegible]		
Payer Report ID:	[illegible]		

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

Encounter: 11/23/2016 - 11/23/2016

Filters: All

Displaying 16 Items

Created	Applied To	Applied By	Comment
04/12/2017 17:36	Claim : : Institutional	CONTRIBUTOR_SYSTEM, MEDASSETS	OutSource: Claim was exported on 4/11/2017 1:36:20 PM to MED ADV UHC PAYERS; ;
04/10/2017 12:11	Encounter :		Changed primary insurance from Medicare Part A and B to MADV UHC Medicare Community Plan
04/10/2017 12:11	Encounter :		Removed tertiary insurance Misc Forward Out of Area Public Aid Payer
04/10/2017 12:11	Encounter :		Changed secondary insurance from MADV UHC Medicare Community Plan to Misc Forward Out of Area Public Aid Payer
04/10/2017 12:09	Encounter :		Release Hold CODE: USER:
12/14/2016 08:48	Claim : : 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 :	Wetherell, Rebecca OS	Add Hold CODE: USER:Wetherell, Rebecca OS

Created: 04/10/2017 12:11 Applied By: Applied To: Encounter :

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

READ ONLY

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

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

We will now take questions from the audience.

Submit your questions using the Questions window

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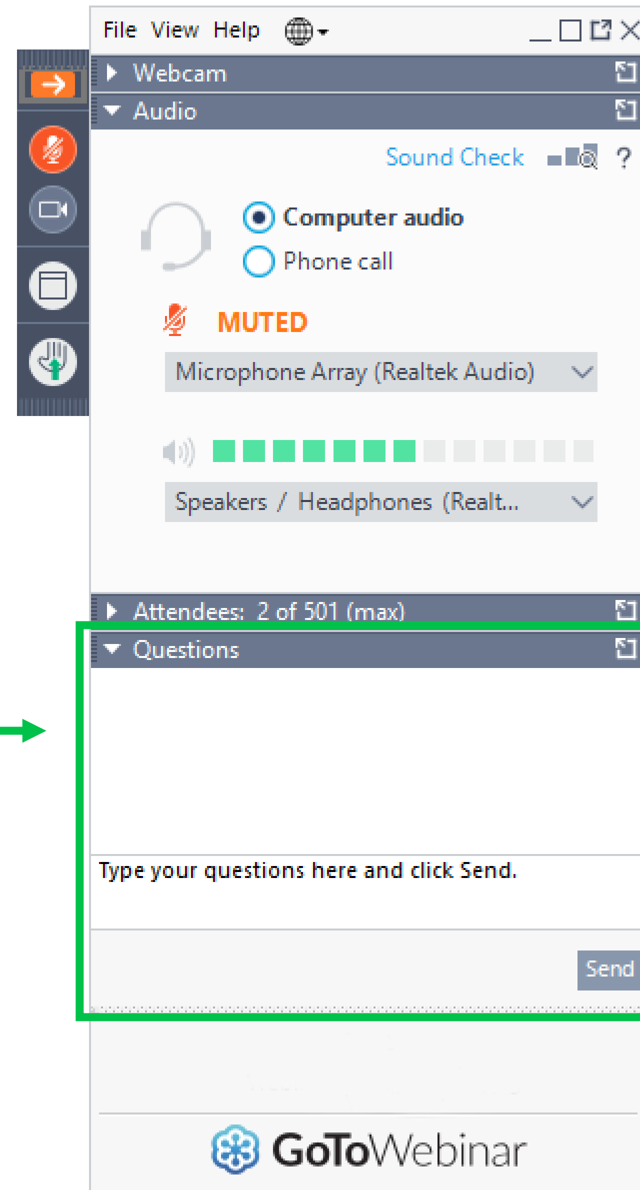

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Thank you for attending!

Add the next webinar in the series Rolling Up Your Sleeves to your calendar for Wednesday, February 20th at 1:00 PM CST.