# Are You In Denial?

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# What is a Denial?

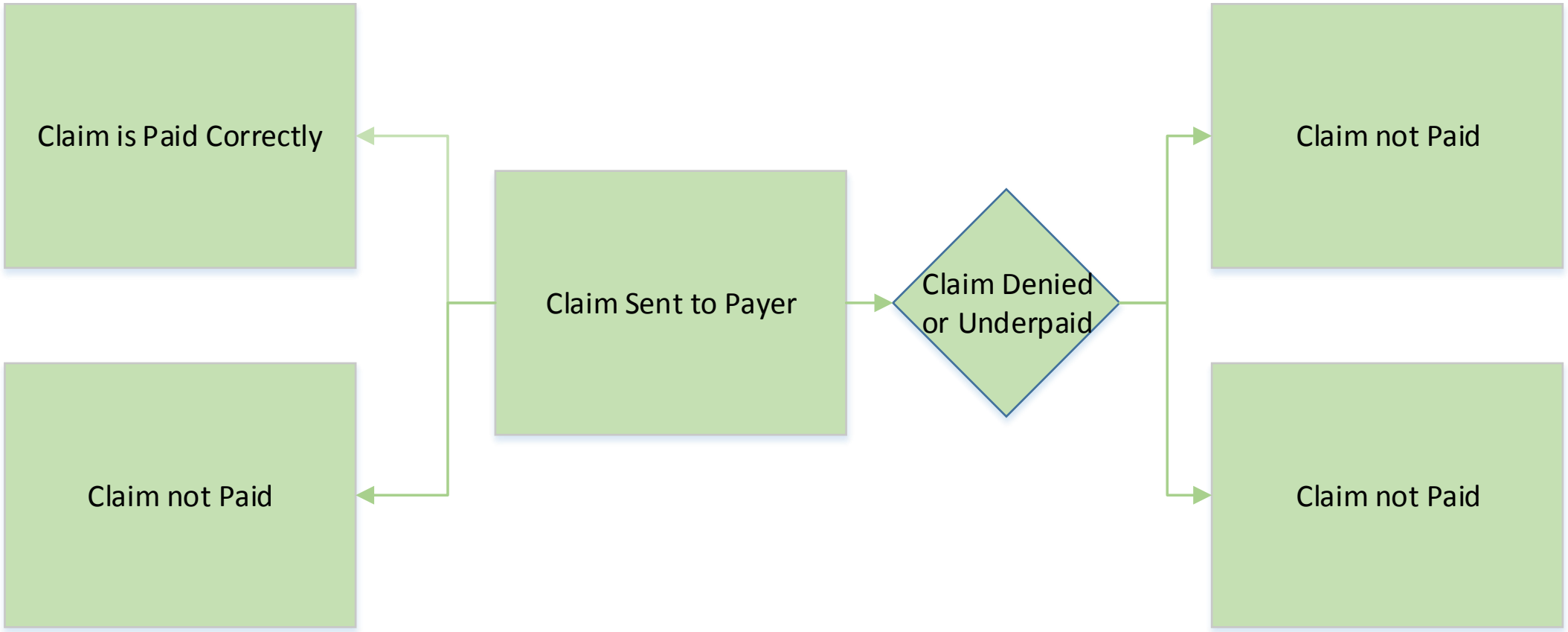
# Denial Defined

The refusal of a payer to honor a request by provider or individual to pay for health care services obtained from a health care professional.

# Denial Expectations

- Payer's claim process has changed
- Payers expect only providers will not follow up
- Interpreting EOB's is becoming more difficult
- Finding trained staff is becoming harder and harder

# Claims Process - Our View



# Claim Facts

- 12.8 billion claims per year in US
  - 30% are rejected
  - 50% never resubmitted (15% total)
- (HCFA) CMS data
  - Rejects 26% of services processed
  - 40% are never rebilled to Medicare
- MGMA's Performance and Practices of Successful Medical Groups, 2013
  - Better performing practices = 5% of initial claims
  - Average MGMA practices = 4%

# Top 10 Reasons Claims Are Denied

# 1 - Incorrect patient identifier information

- Name spelled incorrectly
- Date of birth does not match
- Subscriber number missing or invalid
- Insured group number missing or invalid

# 1 - Incorrect patient identifier information

- ✓Create checklists to mistake proof front-end
- ✓Different strategy for inpatient/referral based specialties
- ✓Involve patient/employer early in the denial process
- ✓When is the ROI a negative effort?
- ✓Define performance expectations with staff

# 2 - Coverage terminated

- Verify insurance benefits prior to services being rendered
- Check eligibility prior to appointment
- Check benefits

# 3 - Requires Prior Authorization or Precertification

- No authorization obtained prior to patient visit
- You can attempt to file an appeal but most payers will not reverse their decision
- HOWEVER, payers are not perfect, make sure they did not just miss it before writing it off!

# 4 – Medical necessity

- Appeal
  - Work with physicians
  - Develop standard appeal letters
  - Include patient in appeal effort

# 5 – Request for medical records

- Supply the medical record

# 6 - Coordination of benefits

- Claim is denied when insured is covered by another policy or coverage provided in a specific sequence if more than one policy covers the claim
- Other insurance is primary
- Missing EOB
- Member has not updated insurer with other insurance information

# 6 - Coordination of benefits

- Do your users know the rules?
  - Birthday Rule – parent with earlier birthday covers dependent child as primary payer for dual-employed spouses
  - Active employment – payer of active employee is primary over retired/inactive dependent (e.g. spouse)
  - Dependent – payer of guarantor is primary over family member classified as dependent (e.g. spouse)

# 7 - Bill liability carrier

- If the claim has been coded as an auto or work-related accident, some carriers will refuse to pay until the auto or worker's comp carrier has been billed

# 8 - Missing or invalid CPT or HCPCS Codes

- Know the national coding rules and how your payer differs from the national rules
- Modifiers/bundling/global are frequent causes of denials
- Use clinical scrubbing software to catch problems before the claim

# 9 - Timely Filing

- Be aware of timely filing deadlines for each payer
- Review contracts to include language that you are dependent on patient presenting correct and timely information and not bound to timely filing for those patients who do not present card or correct information

# 10 - No referral on file

- Some procedures require that the patient obtain a referral from their family physician prior to services being rendered

# Measuring Your Denials

# Zero Dollar Denials

- Post all denials
- EOB remark code vs. rejection
- Reportable vs. non-reportable
- Appealable vs. not appealable
  - Past appeal timely limits
  - Due to reason denied
  - Need write off protocol for tracking

# Posting claim denials and reporting

- All zero payments posted by line item via rejection subsystem (ERA and paper)
- Monthly: Denial rates calculated for each specialty and for total group
- Monthly: Denial frequency and dollars reported by major categories

# Using Transaction Message Categories

- Front End/Registrations
  - Incorrect Payer
  - No precert/auth/referral
  - Cannot identify patient
- Coding issues
  - Bundled services
  - Invalid CPT code/modifier
  - Medical necessity
- Business Office
  - Duplicate claims
  - Timely filing
  - Maximum exceeded
  - Non covered procedures/services
- Informational
  - Copay/co-insurance
  - Non-covered – patient responsible
- Eligibility
  - Coverage terminated

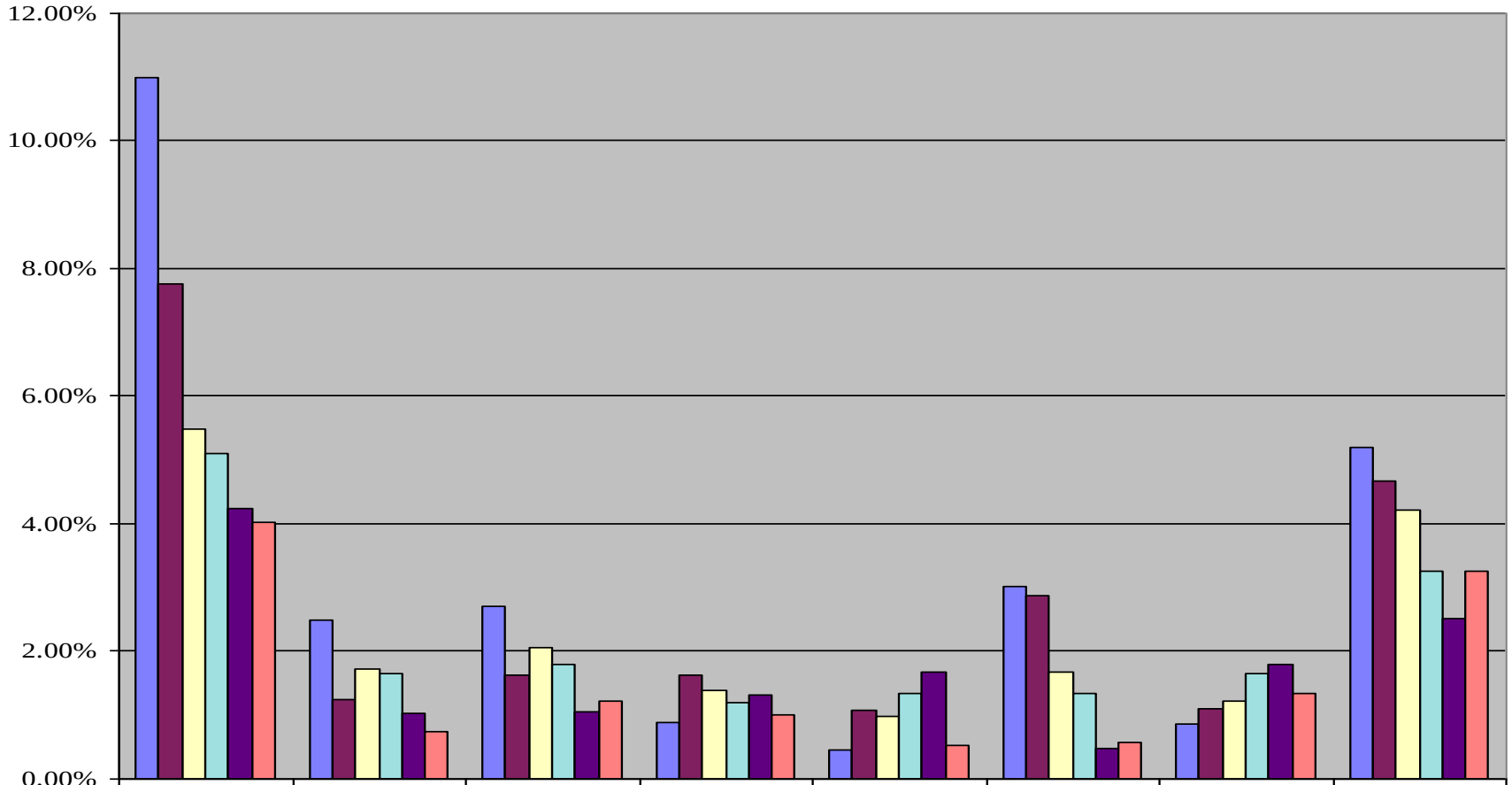
# What you need to measure and report:

- Percent of claims denied on initial submission
- Number of denials and dollar value
- Top 10 reasons claims are denied
- Denials by payer, location, specialty, provider
- Percent and dollars of reworked denied claims that are paid and written off

# What you need to measure and report:

- Average dollar per denial in each category
- Percent of denied claims reworked
- Staff time and cost dedicated to denial management
- Time lag between date of denial received and date the appeal was sent out

# Denials: Major Reasons




| | Reg and Ins Verif | Referrals & Auths | Charge Entry | Med Necessity | Credentialing | Past Filing Limits | Benefits & Noncovered | Other |
|---|---|---|---|---|---|---|---|---|
| Oct-Dec X02 | 11.00% | 2.50% | 2.70% | 0.88% | 0.46% | 3.01% | 0.87% | 5.20% |
| Oct-Dec 03 | 7.75% | 1.25% | 1.64% | 1.63% | 1.07% | 2.87% | 1.09% | 4.68% |
| Apr-Jun 04 | 5.49% | 1.72% | 2.05% | 1.40% | 0.98% | 1.67% | 1.23% | 4.21% |
| Jul-Sep 04 | 5.10% | 1.66% | 1.79% | 1.19% | 1.34% | 1.33% | 1.65% | 3.25% |
| Oct-Dec 04 | 4.23% | 1.04% | 1.05% | 1.32% | 1.68% | 0.48% | 1.80% | 2.51% |
| Jan-Dec 05 | 4.03% | 0.74% | 1.21% | 1.01% | 0.53% | 0.57% | 1.33% | 3.25% |

# Do it right the first time

Cost of rework  $20.00 - $25.00

Identify where the errors are occurring

Without increasing fees

Without breaking any laws

# Managing Denials

- Hosted Claims
- Claim Edits
- Contract Management
- Denial Management
- Open Claims
- Training

# Contract Management

- Do you know your contracts?
  - Allowables
    - Modifiers
    - Multiple procedures
    - Global
    - Bundling
    - Changes in fee schedules

# Contract Management Adjustments

- Who can write-off in your practice
  - Should be controlled
  - Contractual – non controllable
  - Non contractual – controllable
- Best practice
  - Exercise control or audit over who and how much can be written off

# Resources

- Business Performance Resource (www.bpir.com
- Medical Group Management Association (www.mgma.com)
- Practice Support Resources, Inc. (www.psrbooks.com)
- Healthcare Financial Management Association (www.hfma.org)
- Medical Group Management Association. *Performance and Practices of Successful Medical Groups. 2011 Report Based on 2010 Data.* MGMA 2011.
- Feltenberger, Gregory S. and Gans, David N. *Benchmarking Success.* MGMA 2008.
- Walker Keegan, Deborah, Woodcock, Elizabeth and Larch, Sara. *The Physician Billing Process Second Edition. MGMA 2009.*

# Questions?

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