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THE CURE FOR CLAIMS DENIALS

HERE ARE SIX REASONS YOUR CLAIMS MIGHT BE GETTING DENIED AND WHAT YOU AND YOUR STAFF CAN DO TO PREVENT IT.

Getting reimbursed for the services you provide *should* be fairly straightforward: provide a service, submit a claim, and receive payment. It sounds simple enough, but a lot can go wrong in this process, from coding and data entry errors made by your practice to complex coding edits made by your payers.

The American Medical Association's most recent National Health Insurer Report Card found that the major payers return up to 29 percent of claim lines with \$0 for payment – most commonly because the patient is responsible for the balance but also because of claim edits (up to 7 percent) or other denials (up to 5 percent).¹ Denied claims can be reworked and resubmitted, but there is a cost to your practice. A study by the Medical Group Management Association found the cost to rework a denied claim is approximately \$25, and more than 50 percent of denied claims are never reworked.² (See “The potential financial impact of denials” on page 8.)

Poor management of the claims process can be detrimental to the financial health and sustainability of a practice, so avoiding claims denials should be the responsibility of everyone in the practice. The scheduler must collect accurate demographic and insurance information. Registration must verify the patient's information. Nurses must accurately enter the patient's medical data in the electronic health record. Clinical or support staff must note potentially noncovered



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FOR EVERY 15 DENIALS A PRACTICE PREVENTS EACH MONTH, IT SAVES \$4,500 PER YEAR ON COSTS ASSOCIATED WITH CORRECTING THOSE CLAIMS.

services and obtain advance beneficiary notices from Medicare patients. Physicians must ensure their documentation reflects services performed. Coding and billing staff must translate documentation into diagnosis codes, procedure codes, modifiers, and other claims data. And the billing office must submit claims in a timely manner and interpret remittance advices for appropriate and efficient correction of any issues.

Six common reasons for denied claims

To help your practice avoid claims denials, let's take a look at six common reasons your claims may not be paid.

1. Timely filing. Each payer defines its own time frame during which a claim must be submitted to be considered for payment. Filing deadlines often range from 90 days to one year from the date of service but may be as short as 15 to 30 days. Failing to submit a claim within the required period results in your practice having to write off those charges; patients generally cannot be billed when a practice has missed the deadline to submit a claim to a payer.

Practices miss filing deadlines for a number of reasons. Superbills, or charge tickets, may not be completed or may get lost in a practice's workflow; therefore, the billing office never enters or submits those charges. Practices can prevent these denials by using

their practice management system to produce a missing ticket or missing bill report, which can identify scheduled appointments for which no corresponding charges or claims have been entered. With this report, a practice can identify claims that have not been transmitted to the billing office for coding and charge entry. When a missing superbill is identified early, the provider or staff can complete it more easily based on memory and a quick review of the medical record, allowing charges to be submitted in a timely manner. If an automated report is not available, a practice could manually compare providers' schedules to patient accounts to verify that charges have been entered for all visits. Practices should perform this process regularly enough to identify unbilled claims under the practice's shortest filing deadline.

Corrected claims may be denied for exceeding filing periods even if the original submission was timely. For example, errors may be identified in a claim submitted through a provider's clearinghouse. If the corrected claim is not submitted promptly, the claim may be denied for exceeding timely filing limitations. Payer contracts will determine whether such claims may be paid based upon the original claim filing date.

Before writing off charges for a claim that is denied because filing deadlines were missed, the provider should review the account to determine if a claim was submitted in a timely

manner and, if so, provide the payer with proof. Supporting evidence may include the practice management system's report showing the claim submission date, the clearinghouse's acknowledgment of receipt and submission to the payer, or the payer's own acknowledgment of receipt of the original claim.

2. Invalid subscriber identification. Errors in the

Claims denials can be costly, so everyone in the practice should be involved in preventing them.

A common but avoidable reason for denials is not filing claims in a timely manner.

Verifying patients' insurance at each visit is essential to preventing denials due to invalid subscriber identification.

THE POTENTIAL FINANCIAL IMPACT OF DENIALS*

Denied claims per physician per month	44
Rework cost per claim	\$25
Rework cost per month	\$1,100
Annual rework cost	\$13,200

*This example assumes 370 visits per month, one claim line per claim, and a denial rate of 12 percent.

insurance ID number submitted on a claim may be the result of inaccurate data collection or entry. Subscriber ID numbers from old insurance cards may no longer be recognized by the payer. Staff members must collect or verify the patients' current information at each visit. Manually entering the information can create errors if letters or numbers are transposed, so practices should train employees on techniques for careful data entry, such as improving their typing skills, managing distractions, and double checking the data.

There may also be technological methods for reducing insurance ID denials. For example, if a particular payer consistently uses three alpha characters to begin a subscriber identification number, as Blue Cross Blue Shield plans tend to do, check with your practice management system vendor to see whether the system is capable of generating alerts when the user enters a number, rather than a letter, in the first three characters of the patient's subscriber ID field. Similar methods could be used to alert users when too few or too many digits have been entered. A report that lists subscriber IDs by payer may be used to identify the patterns that the alerts could be designed to address.

3. Noncovered services. Denials for noncovered services may be the result of numerous underlying causes. A service may not be considered medically necessary according to payer policy because of the diagnosis submitted on the claim form for that service. The patient may in fact have received a covered service based on the provider's documentation, but the proper diagnosis was not communicated to coding and billing staff on the charge ticket. Coders and billers should become familiar with the services their providers render and the common diagnoses associated with those services. When charge tickets or superbills list services without one of the expected diagnoses, the coding and billing staff can pull the provider's documentation or ask the nursing staff to investigate whether a different diagnosis should be used.

Lab studies are a common source of denials due to noncovered service. Patients presenting for wellness exams or for periodic follow-up on their chronic conditions may have a number of labs drawn during their visit. It is critical for providers and billing staff to differentiate screening studies from lab tests

performed to diagnose or monitor known conditions. A lipid profile performed during an annual wellness visit to evaluate the cholesterol levels of a patient with no known heart conditions or lipid disorders, for example, may be a screening study. Screening studies should be billed with the appropriate CPT code linked to a "V" code to communicate to the payer that the service was a screening service; frequently the patient's deductible, copayment, and coinsurance rates are waived for screening services. Many lab tests, however, are not covered as screening studies. Vitamin D lab studies are a growing source of denials when billed as screening studies, for example.

To manage noncovered services under Medicare, a practice's staff must anticipate the need for an Advance Beneficiary Notice (ABN), which explains the practice's expectation that Medicare will deny payment and informs the patient of his or her potential financial responsibility. In addition, billing staff must know when an ABN form has been issued and communicate this fact on the claim form through the use of an appropriate modifier, such as GA for a required ABN or GX for a voluntary ABN.

4. Bundled services. In certain instances, a service should not be separately reported because the work has already been captured as part of another service being billed. For example, many payers consider pulse oximetry, which has its own CPT code, to be part of the evaluation and management (E/M) services represented by the office visit codes and will not pay for it separately. The denial would likely state that pulse oximetry is bundled into another service on the claim, the office visit. Similarly, an E/M service performed on the same day as a procedure will likely be denied and bundled into the procedure code unless an appropriate modifier (i.e., modifier 25) has been added to the E/M service to indicate that the service is significant enough to warrant separate payment. Billing staff should be familiar with these bundling policies.

Correct coding initiative edits are another common source of bundling denials. Each quarter, Medicare publishes files of pairs of codes that generally should not be billed together because they are mutually exclusive or one is more comprehensive than the other. For example, CPT codes 11719 (trimming of nondystrophic nails, any number) and 11721

Denials for non-covered services may be traced to improper diagnosis coding.

Some denials can be avoided by becoming more familiar with which services payers bundle and which can be billed separately.

Medicare publishes a file of coding edits – pairs of codes that generally should not be billed together.

(debridement of nails any method, six or more) may commonly be performed at the same time, but the latter, less comprehensive service should generally not be reported. Billing staff must understand these edits to properly assign codes for services and avoid overbilling.

5. Incorrect use of modifiers. Two of the most common modifiers are 25 and 59. Modifier 25, representing a significant, separately identifiable E/M service provided on the same day as another procedure or service, can only be attached to codes found within the E/M section of the CPT book. Modifier 59 indicates that a procedure or service is distinct from another procedure or service because it occurred during a separate encounter, was performed on a separate organ/structure, was performed by a different provider, or does not overlap usual components of the main service. (Note: There is so much confusion around the 59 modifier that Medicare recently established four new HCPCS modifiers to define subsets of 59; for more information, see “Medicare plans new coding modifiers for 2015,” *FPM* Getting Paid blog, <http://bit.ly/1Cgib9D>.)

When modifiers are used incorrectly, the services to which these modifiers are appended will be denied. Practices can help prevent these denials by making sure coding and billing staff are educated on the appropriate and inappropriate uses of common modifiers. Many practice management systems can also assist in reducing these denials by enabling the practice to establish error alerts when codes have been used incorrectly. For example, a practice may create an alert that will warn the coder when modifier 25 has been incorrectly added to a code between 10000 and 69999, which represent procedures.

6. Data discrepancies. Inconsistency in data submitted on a claim will result in denial of services. Examples include a diagnosis specific to female conditions used on a male patient, a flu vaccine billed with a diagnosis describing a pneumococcal vaccine, and a procedure code for neonates billed for an adult patient. Frequently, these denials are the result of transposed numbers or inadvertent data entry errors. To prevent them, practice management systems may have the ability to issue alerts to warn data entry staff when a discrepancy has occurred. For example, a practice may define diagnosis codes related to pregnancy and childbirth as female-only

codes. If a diagnosis related to pregnancy or childbirth is entered for a male patient, the coder will see an error alert and the claim will not be submitted until the issue is corrected.

Steps you can take

A practice's efforts to reduce denials should begin with an understanding of its greatest source of denials. To identify the source, run reports of denials for a period of time, such as a week or a month. The reports should display denial reasons, procedure codes reported, modifiers, diagnosis codes, and payers. You can then sort the report by each of these fields to determine whether your practice can achieve the greatest improvement by focusing on a particular payer, a particular service, or a particular coding issue.

The next steps are to provide staff members with education (perhaps start by having them read this article), implement practice management alerts, and put other corrective measures into place. To make the process of filing corrected claims more efficient, consider using a standardized claim correction form. (Download *FPM*'s claim correction form at <http://bit.ly/1LFxMT7>.) Next, monitor your practice's progress periodically and provide feedback to those involved in correcting the denials. You may consider setting incremental goals for your most significant denials and then celebrating improved performance.

Ultimately, for every 15 denials a practice prevents each month, it not only receives reimbursement sooner but also saves \$4,500 per year on costs associated with correcting those claims. In the world of decreasing reimbursement rates, this potential for cost savings and improved cash flow can dramatically improve a practice's financial health in a relatively short time. **FPM**

1. 2013 National Health Insurer Report Card. Chicago: American Medical Association; 2013. <https://download.ama-assn.org/resources/doc/psa/2013-nhirc-results.pdf>.
2. Graham T. You might be losing thousands of dollars per month in 'unclean' claims. *MGMA Connex*. 2014;14(2):37-38.

Send comments to fpmedit@aafp.org, or add your comments to the article at <http://www.aafp.org/fpm/2015/0300/p7.html>.

Coding and billing staff should educate themselves on the correct use of modifiers, particularly 25 and 59.

Simple mistakes like transposed numbers can cause denials due to data discrepancies, so staff should be alert to these errors.

Once you identify the greatest source of denials in your practice, you can educate staff and leverage technology to help prevent them.