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Claims Denial Management Tips

One of the ***most significant hurdles affecting cash flow*** are claim denials by payers. The *time and effort* required to **research the reason for a denial**, **correct and re-submit the claim**, **wait for payment** **or possibly** **appeal a second denial of the claim** and then send a bill to the patient for the balance owed can take longer then six months and cost more than the anticipated payment.

Even after all this effort, the claim can be denied and the account will have to be adjusted. If a balance is owed by the patient and it's been longer than 6 months, it's less likely to be paid.

Now that many billing offices are submitting claims for Covid-19 patients and telemedicine visits, the need to quickly and accurately submit claims is critical for cash flow. The rules for claim submission may be relaxed but **eligibility**, **incorrect ICD 10 coding** **or** **timely filing issues** are still among the top reasons for denials.

To keep denials to a minimum – **10% for initial denials – and less than 5% for final denials**, requires coordination between offices, providers and the billing office.

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Claims Denial Management Tip #1

Eligibililty

— **This is consistently the most common and costly reason for denial of a claim.** Review your process for determining eligibility and ensure the staff verifies eligibility at least 48 hours before an appointment — and at the time of scheduling for appointments that are scheduled 1-2 days before the planned visit.

Also, be sure you staff know how to read the reports that come back from the eligibility tool used by your organization. Patients may have coverage but not for the service being provided by your staff.

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Claims Denial Management Tip #2

Payer Rules

– Often, payer bulletins do not make it to the person responsible for reviewing and updating the staff about new rules for authorizations, claims submission, covered services, pharmaceuticals, etc.

Be sure the claims and correspondence addresses that your payers have on file for your organization are correct and designate the correct/appropriate staff member to review and disseminate the information to the affected areas.

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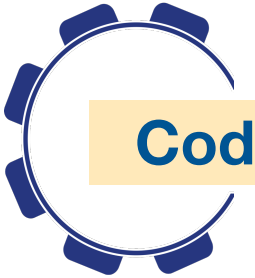
Claims Denial Management Tip #3



Coding Requirements

– Many providers and coders are not aware of the payer rules for coding. For example, providers may even have a set of favorite codes built into their workflow. **These "favorites" may be outdated or not specific enough to qualify the service for payment.** To get these services covered, a coder or a biller must contact the provider to get updated information before the claim can be submitted, which delays claim submission and payment.

Review claim denials to identify these issues and work with providers, practice managers, coders and billers to educate them and assist in updating their "favorites" if necessary.

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Claims Denial Management Tip #4

Rules Engine

– The rules engine determines where a claim goes after the provider has selected the CPT and ICD-10 codes. Depending on how they're written, simple corrections such as substituting a G code for CPT code for a Medicare claim can decrease the number of claims that have to be reviewed and facilitate timely and accurate claims submission.

Other rules determine where it goes if an issue is identified — to a coder, a work queue in the billing office or back to the provider for correction. **If the rules engine is not monitored and updated with a detailed list of the rules (and the reason for their existence maintained – a Rules Library), claims will go to work queues incorrectly or submitted to the payer and rejected.**

Create a team of software analysts, coders and billers to review the rules and maintain the library.

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Claims Denial Management Tip #5

Work Files

– Billing office staff are usually required to “work” or follow up on a certain number of accounts a day. They may be responsible for following up on denials, delayed payments or issues that are identified by the rules engine prior to claims submission. **If the number of accounts in each person’s work queue is consistently more than double what they are expected to work in a day, the ‘older and lower dollar’ accounts will eventually hit timely filing limits and become uncollectable.**

Monitor work queues and productivity expectations to identify workflow and systems issues. This also applies to work files that are the responsibility of office managers, coders, and providers.

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Claims Denial Management Tip #6

Interfaces

– Many organizations have developed interfaces to their EMR and billing system for services such like sleep studies, EKGs, laboratory tests, radiology services and specialties such as oncology and cardiology. **Often, when systems are upgraded or new interfaces are developed, adequate testing is not completed and the risk for services to be missed is significant.** ***High volume and low dollar services like EKGs are often the most at risk.***

To validate your interfaces are working correctly and services are crossing over to be billed, create a reconciliation tool or process that can alert the staff to problems before the volume of missed services becomes overwhelming and results in write offs for timely filing, etc.