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Presents



**Stop Denials in Their Tracks:
Get Paid the First Time by
Health Care Insurers**

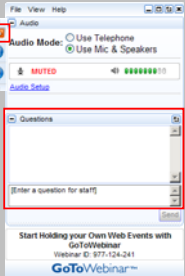
Beginning now...
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Today's Program

- **Introduction**
- **Presentation:**
Betsy Nicoletti, M.S., CPC
- **Kareo Special Offer:**
Tadd Dombart, Account Executive, Kareo
- **Questions**

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How to Participate Today




- Arrow = Open/close your panel
- Questions = Submit text questions

Follow-up email with video link within 24 hours

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**Stop Denials in Their Tracks:
Get Paid the First Time by
Health Care Insurers**


Betsy Nicoletti, M.S., CPC
www.mpconsulting.org
www.codapedia.com



**You Can Collect More Cash by
Decreasing Payer Denials**


- Increase cash into the practice
- Do less work, and re-work
- Lower write offs




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**System for Denial Tracking,
Reduction**


- Measuring and monitor denial rate
- Understanding the reasons for denials
 - Fix individual claims, re-submit
- Develop process improvements
- Measure and monitor



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Measuring Denials

- Calculate your denial rate
- Number of claims or line items submitted
- Number of claims or line items denied
 - Whichever metric is easier for your system to calculate
 - Be consistent
 - Calculate your baseline rate for a month

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Denial Posting Process

- When a line item is denied, post it into your practice management system with a reason code, and a \$0 payment
- Reason codes should be specific enough to provide information but not too detailed
- Start with broad categories, and add more specificity if you need it

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Denial Reason Codes

- Registration
 - Not eligible, incorrect demographic info
- Authorization
 - No referral, no pre-authorization, no referring physician
- Coding
 - Modifiers, bundling, linking

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Denial Reason Codes


- Enrollment
 - Not enrolled, files set up incorrectly
- Timely filing
 - Should be zero, in a perfect world
- Medical necessity
 - Diagnosis code, frequency, policy
- Payer processing rules
 - Not following NCCI or CPT rules

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Measure by Reason


- Once set up in practice management system, run monthly report
- Consider exporting or transferring data to Excel
- An Excel sheet allows further analysis
 - Number of instances, dollar value, physician, location, type of service



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Measure, Monitor

- Look at the summary information, then detail
- High level oversight of denials
- Baseline as you start the process, then monitoring to show progress

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Sample Clearinghouse Reports

View Clearinghouse Report (160894)

File Name: 0200009-194540-0029110.XML
Received: 11/2/2010 7:36:26 PM

Payor Daily Claim Verification Report (R12 / 4355.00 R17 / 41,034.00) 11/2/2010 7:36:14 PM

Provider Tax ID: 393164339 - HOLY CRP 122,201

Kareo PCB	Patient Name	DOB	Charge	Payer	Payer Reference	Medicaid Tracer
2608221530	HARKNO, GAIL	08/27/2010	119.00	04271	408617642813332	
	INPALED MBR/PATIENT BIRTH DATE	INPALED MBR/PATIENT BIRTH DATE				
2608221530	HARKNO, GAIL	08/27/2010	151.00	04271	408617642813332	
	INPALED MBR/PATIENT BIRTH DATE	INPALED MBR/PATIENT BIRTH DATE				
2608221530	HARKNO, GAIL	08/29/2010	151.00	04271	408617642813332	
	INPALED MBR/PATIENT BIRTH DATE	INPALED MBR/PATIENT BIRTH DATE				

Print Close Mark As Reviewed

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Understand the Reason for Denials

- Requires detective work and mindreading skills!
- Critical to re-submitting that individual claim, and improving the process to prevent future claims

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Beginning the Detective Process

- Next few slides are examples of types of denials, and possible reasons
- May require a call to the payer
- Standard list of reason codes



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Billed for a Hgba1c—Why Was It Denied?

- Diagnostic tests typically have one of two reasons for denials
- Non-covered indication
 - Did you link correct diagnosis code to the test, that established the medical necessity?
 - Medicare Coverage Determinations
- Frequency
 - How often are you performing the service?

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Phone Calls, Case Management—Why Denied?

- CPT codes but no payment
- Check Medicare Fee Schedule for status indicator
 - Many payers follow Medicare's status indicators
 - Some CPT codes have status indicator of B—bundled or N—non-covered

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Medicare Secondary Payer—Why Denied?

- Patients over 65 who work for an employer with health insurance, whose employer has 21 or more employees
- Spouses
- Critical to ask to see all of the patient's insurance cards

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Coding Errors on Our Part

- Modifier added to wrong CPT code
- Modifier 59 added to a procedure that can not be unbundled
- Laceration repair billed individually when the lengths should be added
- Lesion excision lengths added when they should be billed individually

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Solutions to Coding Errors

- Often found hidden in plain site in editorial comments of CPT book—start there
- Read complete description of code and editorial comments
- Specialty societies can provide information and supporting documentation
 - Often membership brings a few free coding questions per year

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Payment Amounts


- Were you paid according to contract?
- Requires you to load allowed amounts in practice management system, and check payments against allowances
- Important for two or three biggest commercial payers

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Preventable Errors


- Registration errors
 - Wrong insurance, keying error, wrong subscriber
- Authorization errors
 - No referral, pre-authorization in file, not on claim
- Timely filing
 - Usually coordination of benefit issue
 - Should have close to zero tolerance

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Fix Each One


- Resubmitting without understanding a waste of cyber energy
- Resubmitting without learning a waste of our energy
- Be sure denials are not automatically written off



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Duplicate Submission


- Usually the result of batch resubmission
- Old claims, let's just re-submit them all
- Payer may have requested information that was not received
- Claim may have been denied, but denial not posted

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Let's Learn and Improve


- Start with your reports: what are the top reasons claims are denied?
- Select a few claims from the top three reasons and trace back the history



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Claim Denied: Date of Accident

- Urgent Care Center found that top reason for claim denials was date of accident not on claim form
- Major problem, since accidents were significant part of business
- Re-submitted, but caused claim delays and re-work

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What Happened?

- Is date of accident recorded somewhere in chart?
 - Where is there redundancy? Registration? Medical Assistant?
- Is date of accident entered into practice management system?
 - In narrative? In structured field?

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Track Ten Denials


- For each one, look at the what happened
 - Didn't collect date of accident
 - Recorded in free text, not in structured field
 - Not entered into correct field in practice management system
 - No edit in place

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Two Services, One Payment


- E/M service and procedure submitted, only one paid
- Line item with \$0 payment: review these



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What Happened?

- Look at documentation: were both services performed and documented?
- Was modifier 25 appended to the E/M service
 - If different diagnoses, were they linked correctly?
- Who entered the CPT codes? Who appended the modifier?
- System edits?

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Goal of Exercise


- Not to assign blame
- Review the cause of the error, fix the process
 - Education
 - Written procedures
 - Adding an edit to claims processing

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Pay Attention to Unpaid Line Items—Assuming One Paid Line


- For each one, ask and answer these questions
 - Was it a valid charge, not bundled?
 - Was the diagnosis code correct and linked?
 - Were modifiers used correctly?



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Use Technology

- Batch verification of eligibility
- Batch verification of benefits
 - Including: deductible amount, patient due amount by benefit type
- Clearinghouse and coding edits
- Claims estimators
- Electronic remittance advice/payments

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Verify Insurance and Benefits Prior to Visit

- Manually, (growing old on hold)
- On the payer's website, one by one (better)
- Batch and on demand verification through clearinghouse
 - Not all payers, not all benefits
 - Available for many major payers
 - Allows a discussion with patient prior to providing the service



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Coding Programs

- Integrated in software or stand alone
- Check for bundling
- Check diagnosis code congruence
- Is a modifier allowed, and if so, what modifiers
 - Warning at posting
- Review of national and local coverage determinations



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Cross Training: Walk a Mile in Her Shoes


- Inherent tension between front office and back office functions
- Clinical staff often not interested in coding and billing
- Cross train, job shadow, buddy system



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Policies


- Written policies and procedures for registration
- Full registration at time of appointment
- Policy about verification of insurance and benefits

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Coding Policies


- Trained coding staff
- Review of denials by a second set of eyes
 - Difficult in a small office
- Use of NCCI/bundling edits for procedures



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Denial Prevention


- Measure denial rate
 - Use reason codes, post all denials
- Understand the reason for denials
 - Research, fix claim fix process
- Develop policies, use technology, cross train
- Measure and monitor

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Thank You/Contact


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Todd Dombart
Account Executive


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- 2** Dashboards
- 3** Special Offer

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1 Code Scrubbing

Dashboards


Special Offer

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Code Scrubbing

2 Dashboards


Special Offer

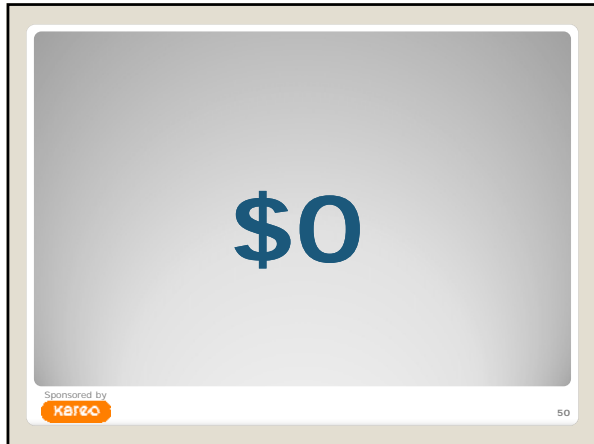
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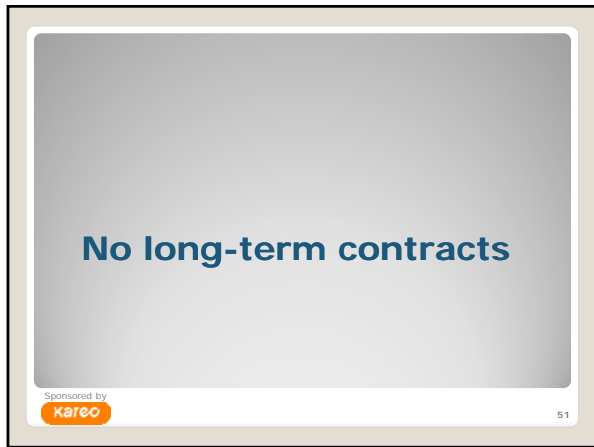
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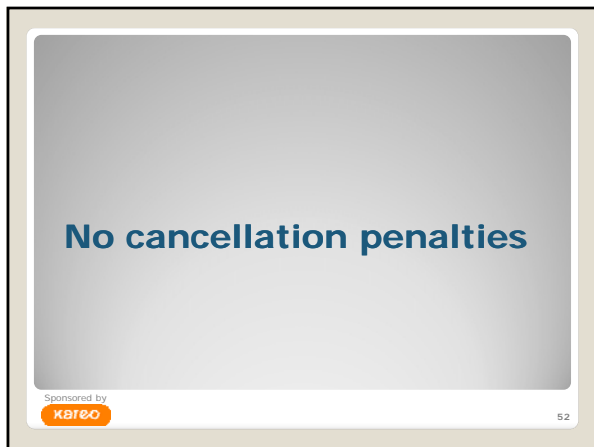
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3 Special Offer


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