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Meet the Presenter…

On the topic:
Top 10 Billing and Coding Errors that Cause Claims Denials/Rejections

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A Biller’s Goal…..

- Touch a claim once!
  - Bill it
  - Receive it
  - Post it
  - Close it

In order to achieve this goal, processes must be in place to ensure that claims are filed “clean and error free.”

It is much more efficient to spend extra time on the front end and get it right, than to chase denials and rejections.

Offices operating at optimum efficiency statistically have less than a 4% rejection/denial rate. For every 100 claims, you send, do more than 4 get rejected at the clearinghouse or denied? If yes, there’s work to be done!
Time Management

• It is estimated that a biller will spend the majority of their time on 10-20% of their claims (Denial Management).
• Billers often come into the picture at the point of transmission/filing, so they are relying on office staff, doctors, and coders to provide the data needed to file clean claims.
• If billers want to reduce time spent on denial management, they MUST take a hands-on approach and vet all the data that is sent to them PRIOR to transmitting/filing claims.

Scrubbing and Scouring

• Spending time on this process reduces work on the back end by 75%.
• Average time spent scrubbing an incorrect claim, and fixing errors prior to transmission: 5-10 min
• Average time appealing a claim that has been filed, and then pended or denied due to errors: 30-45 min
• If you are “just the biller,” and you are not responsible for coding the claims, you are STILL responsible! All billers should have basic coding knowledge to recognize coding errors.
Scrubbing and Scouring

The Scrubbing and Scouring Process

- Preview claims batch – look for missing/incorrect info.
- Do not rely solely on your software to catch the errors!
- Preview claims batch – make corrections. If you are waiting on information from provider/coder, extract the claim from the batch an send the ones that are clean and error free.
- Preview claims batch – verify with provider that there is documentation to support the encounter (signed SOAP/OP notes).

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Scrubbing and Scouring

The Scrubbing and Scouring Process (continued)

- Transmit to clearinghouse or direct bill electronically to carrier.
- Check clearinghouse DAILY for reports from the clearinghouse and payer.
- Look for Level 1 (Clearinghouse Rejections). Usually within minutes to 24 hours from transmission. CORRECT ERRORS AND RE-SEND.
- Look for Level 2 (Carrier Rejections). These come from the carrier back to the clearinghouse. Usually within 24-72 hours. KEEP CHECKING BACK!! CORRECT ERRORS AND RE-SEND.
Common Errors That Cause Level 1 Rejections

1. MISSING INFORMATION:
   a) Missing Patient ID – CMS 1500 form, box 1a
   b) Missing Carrier Payer ID
   c) Missing/Incorrect Patient relationship to Insured – box 6
   d) Missing onset and/or acute manifestation date – box 14, box 15
   e) Missing Referring Provider ID/NPI – box 17, 17b
   f) Missing dx codes – box 21
   g) Dx codes not keyed to highest level of specificity – box 21 (not all clearinghouses catch this)
   h) Missing prior auth information, if authorization/referral required - box 23
   i) Missing modifiers (not all clearinghouses catch this)
   j) Missing rendering provider NPI – Box 24j

Common Errors That Cause Level 2 Rejections

2. INCORRECT/INVALID/OUTDATED SUBSCRIBER INFORMATION - “Subscriber cannot be identified as our insured”:
   a) Incorrect patient/insured NAME – box 2, 4  Patient’s/Insured’s NAME must match EXACTLY the name on the INSURANCE CARD. Do not use nick names. If patient recently married, make sure they have updated this info with the carrier, or use name prior to marriage until they update info.
   b) Incorrect Patient ID – box 1a  Usually due to data entry error, leaving a number off, transposing 2 numbers, etc. Some carriers change ID’s when an employee group contract is renewed, fairly common with BCBS. Patient may not have their new card yet, or clinic did not obtain copy of most recent insurance card.
   c) Incorrect Patient relationship to Insured – box 6  Sometimes the patient is NOT the insured, but information on the Insured was not keyed in
   d) Policy TERMINATED. Rejection will usually specify this.
Common Errors That Cause Level 2 Rejections

3. INCORRECT/INVALID/PROVIDER INFORMATION - “Unable to identify provider” “Provider/TIN Crosswalk Invalid” “Provider/TIN Mismatch”:
   a) Incorrect provider NPI in box 24j – the provider who RENDERED the service should have their NPI in box 24j. If “incident to” billing is done, the supervising physician’s NPI should be in 24j. If physician was not on hand to supervise mid-level provider, the mid-level provider’s NPI should be in 24j. Medicare will reimburse at 85%. The group NPI should NEVER be in box 24j.
   b) TIN in box 25 does not match up to the NPI in box 33a.
   c) Sometimes physicians will be credentialed with some carriers under their individual NPI, and with other carriers under their GROUP’S NPI. Verify with credentialing department how physician in box 24j is credentialed with the carrier, or if they are even listed as a provider under the TAX ID/NPI in boxes 25/33a.

Common Errors That Cause Level 2 Rejections

4. CLAIM SENT TO THE WRONG PAYER “Unable to identify subscriber” “Payer invalid for this subscriber” “Policy Terminated” “Claim sent to wrong Payer”
   a) Office did not obtain a new insurance card.
   b) Some carriers have TPA’s that administer claims (Third Party Administrators). Sometimes these claims must be sent to the TPA vs. the Insurance Carrier.
   c) Sometimes the rejection will specify which TPA/Sub Carrier the claims should be submitted through, sometimes you will have to kick back to business office for reverification of benefits and confirmation of claims address/payer ID.
   d) Medicare claims – if you are submitting for procedures and DME supplies, you must submit to the MAC and the DMERC separately.
The Difference Between Rejections and Denials...

• **Rejected claims** have not been processed by the carrier, even if they were received (CO-16).
  – These claims are considered UNBILLED.
  – You are on the clock for timely filing.
  – You may correct and resubmit – no need to indicate CORRECTED CLAIM.
  – No need to file an appeal.

The Difference Between Rejections and Denials...

• **Denied claims** are encounters that were accepted by the carrier for adjudication, and denied, primarily as “not medically necessary.” There are other reasons for denials, but the CO-50 denial is the most common.
  – Denials require initiation of a reconsideration, redetermination or appeal.
  – Refer to carrier rules on how to have claim reconsidered or how to appeal.
  – Denial are much more lengthy and time intensive to correct...

...HOW TO AVOID????
Understanding Denial Codes

- **RARC** = Remittance Advice Reason Codes
  - Gives info on why a claim was denied
- **CARC** = Claim Adjustment Reason Code
  - Gives info on why a payment was adjusted
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- **CO** = Contractual Obligation
- **PR** = Patient Responsibility
- **OA** = Other Adjustment
  - Remark code will be followed by a number to give a full description of the explanation or denial.
### Most Common Reasons for Denials

#### 5. TIMELY FILING DENIAL (CO-29)

| a) The time limit for filing has expired |
| b) THE WORST!! Because it's the most preventable! |
| c) Really there is no excuse for TF denials. |
| d) Understanding that just because a claim is showing as BILLED from your software, does NOT mean it has been received in to the adjudication system by your carrier. |
| e) Most of the time there are no appeal rights. |
| f) Complete write off – and refund patient money. |
| g) Sometimes TF denials are the patient's fault. They did not inform you of new insurance. Or do not provide you with new insurance info when you find out that their old insurance has lapsed. Appeal for reconsideration to either pay or make patient responsible (PR-29). |

#### 6. DUPLICATE CLAIM (OA-18)

| a) Exact duplicate claim/service |
| b) These actually count against your claim submission error rates |
| c) Biller just “rebills” a claim that is showing up on the AR instead of checking status first. |
| d) Biller submits a claim batch twice by accident |
| e) Payers may inadvertently pay on a duplicate claim, leading to recoupments later, and possibly triggering an audit |
| f) Some clearinghouses have dup filters that prevent a duplicate claim from accidentally being sent |
| g) If you have to correct a claim under appeal and re-send, find out from carrier AND clearinghouse how to avoid the claim from being denied as a duplicate. |
## Most Common Reasons for Denials

### 7. DEDUCTIBLE/COINSURANCE/COPAY AMOUNT (PR-1, PR-2, PR3)

- a) This is not actually a DENIAL, but one of the most common reasons why a claim will have a zero or reduced pay from the carrier.
- b) VERY IMPORTANT that you POST a zero pay claim and transfer responsibility to PATIENT.
- c) This will then come off your insurance AR.
- d) Collect unpaid balance from patient PROMPTLY.
- e) The longer you let the patient balance go uncollected, the harder it will be to close the claim.
- f) Some billers put zero pay “PR” claims at the bottom of priority list. This could be a very costly mistake.

### 8. MISSING/INCORRECT MODIFIERS (CO-4)

- a) The procedure code is inconsistent with the modifier used or a required modifier is missing.
- b) If multiple procedures are involved, it could cause the procedures to be BUNDLED and paid at a lower rate.
- c) Sometimes the entire claim will be denied outright.
- d) Usually modifier errors and/or omissions can be corrected with a telephone reopening/redetermination.
- e) If not, and claim needs to be corrected, make sure you know the carrier’s procedure for sending corrected claim so it won’t flag as duplicate (CO-18).
Most Common Reasons for Denials

9. INCORRECT ASSIGNMENT OF PRIMARY/SECONDARY CARRIERS (OA-22)
   a) This care may be covered by another payer per coordination of benefits.
   b) Understanding COB rules is imperative!!
      a) SPOUSE/SPOUSE – Patient’s insurance is usually primary/spouse’s secondary.
      b) Parent/Child – Birthday rule applies – if child is covered by both parents under separate policies, the parent whose birth month comes first is primary.
   c) Sometimes the patient needs to get involved. Track this carefully to avoid timely filing/appeal issues.
   d) This is becoming more of a common denial with Medicare. Patient’s charges are filed under Medicare B, but the patient actually has a Medicare Advantage Policy.

Most Common Reasons for Denials

10. INCORRECT PROCEDURE/DX CODE MATCH, NOT MEDICALLY NECESSARY (CO-11, CO-50).
    a) The diagnosis is inconsistent with the procedure.
    b) These are non-covered services because this is not deemed a 'medical necessity' by the payer
    c) CO-50 denial is a “catch all” code that requires additional explanation/information from the carrier. It’s very time consuming to check on and appeal.
    d) Most CO-50 denials are due to DX coding errors.
       a) Not coding to highest level of specificity
       b) Not coding in correct sequence
       c) Using an old dx code on a new encounter, not reviewing prior to billing
       d) Using a DX code that is not routinely associated with your medical specialty/taxonomy (There is actually a specific denial code for this, but sometimes, the CO-50 code is used.)
If Your Claim Is Denied for Med Necessity….

- Look at EOB carefully, and see if there are multiple reason/remark codes that can help you understand why the claim was denied.
- If Medicare claim, consult your LCD or NCD and verify that dx code on the approved list, and that you are following any billing and sequencing rules contained therein.
- Contact carrier – some carriers have specific guidelines on how they want dx codes listed, sequenced, etc. Find out process for redetermination and/or appeal.
- Track any activity and document in patient’s database.

Questions?

Thank you for your attendance!

Get your questions answered on PMI’s Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp