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On the topic:

How to Reduce your Practice's Denial Rates

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How to Reduce your Practice's Denial Rates

Presented by
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Introduction

There are many reasons why claims are denied.

In many instances, practices are overwhelmed and do not have the staff or time to fight the denials and underpayments effectively.

Implementing an organized method in your practice to keep your staff “armed” with the resources necessary to understand the complexities of insurance coding, filing, and follow-up can help to insure that the practice will be operating more efficiently as we deal with reduced reimbursement.

Although many medical practices have time constraints that hinder their ability to keep updated with Medicare and private carrier changes on a regular basis, not establishing a mechanism for training and sharing this information in your offices could place your clinic in financial jeopardy.

Systematic Approach to Improve Denial Management

1. Pre-audit/vet claims before they are billed
2. Catch and fix mistakes at the clearinghouse.
3. Determine who will be responsible for claims auditing.
4. Conduct claims follow-up.
5. Collect health insurer’s auditing resources.
6. Identify the major reasons for denial.
7. Identify underpayments
8. Appeal denials.
9. Create a tracking/reporting process. Measure your performance over time.
10. Run accounts receivable (A/R) reports each month.
STEPS FOR SUCCESSFUL DENIAL MANAGEMENT

An Ounce of Prevention

• The most successful AR program is not to have one...
• GARBAGE IN…..GARBAGE OUT
  – Patient data/demographics keyed in correctly
  – Correct coding
  – Collect from Patient at TOS
  – Catch Billing errors BEFORE they go out
  – Monitor progress of claims continually
  – Jump on improperly paid claims as soon as you receive them
Vetting Your Bills/Claims

- Coders/Doctors
  - Before claims are sent to billing department for transmission, make sure you’ve coded properly
    • Correct Procedure Codes
    • Correct Number of Units
    • Correct Modifiers
    • Correct ICD-10 Codes

- Billers
  • Print/view a pre-billing report. Look for coding and claims errors…scour your claims first! Common errors
    • Missing patient information
    • Incorrect CPT/HCPCS Codes/modifiers
    • Missing CPT codes
    • Incorrect ICD codes

Vetting Your Bills/Claims

- Billers
  - VERIFY that the claim batch MATCHES the number of claims billed
  - VERIFY that the claims were all accepted by the clearinghouse. Correct Level 1 rejections immediately
  - VERIFY that the claims were all accepted by the carrier Correct Level 2 rejections immediately
    - It is important to go to the clearinghouse DAILY to find these reports. They don’t all come in at once.
  - Check for claims that need to be filed on paper (secondary, non crossover claims, auto/work comp claims, union policies, etc.)
Consequences of Bad Billing Procedures

- Once you have to touch an improperly paid/processed claim more than once, you will have to touch it at least FOUR times, maybe more. Your goal is to end the process at #2.
  1. Bill It
  2. Post Payment/correct denial – IF NOT PAID/DENIED PROPERLY, then
  3. Investigate
  4. Rebill/Appeal
  5. Possible Second Level appeal
  6. Post payment/denial
  7. Notify patient/provider

WHAT HAPPENS TO A CLAIM ONCE IT ‘LEAVES THE BUILDING’?
Typical Payer Administrative System Workflow

• **Step 1: Electronic claim received in system**
  – The payer may receive the claim directly from the provider or through an intermediary, such as a billing service or clearinghouse.
  – The claim is pre-screened for missing information. (CO-16 denial)

• **Step 2: Patient's eligibility and benefit level determined**
  – A patient’s benefit level, medical necessity, and covered and non-covered services and procedures are determined based on the patient’s health benefit plan.

• **Step 3: Contractual discount applied**
  – The payer then reduces the provider’s billed charges on the submitted claims to their individually-contracted discounted fee-schedule rate or “maximum allowed payment.”

• **Step 4: Payer payment rules and claim edits applied**
  – The payer further adjusts the payment by applying “payment rules,” such as adjustment for modifiers, taxonomy, multiple procedures or global payment rules that either increase or decrease the payment amount.
  – Simultaneously, the payer makes adjustments to the claim using payer claim edits that include customized payer-specific edits. These claim edits determine which of the specific codes listed on a claim are eligible for payment and which will be denied.

• **Step 5: Auto-adjudication completed**
  – The final payment on the claim is determined

• **Step 6: EOB or ERA generated and payment sent**
  – An Explanation of Benefits (EOB) or Electronic Remittance Advice (ERA) is sent to both the provider and the patient, detailing the paid amount for the medical service.
Common reasons insurance companies deny, delay, or partially pay a claim include:

- Medical practice processing error(s) and/or lack of supporting documentation
- Insurance company processing errors
- Application of a CPT® modifier, code, or guideline for each procedure/service performed
- Application of fee schedule allowance when a contract exists
- Application of a PPO discount when no contract exists
- Medical necessity

Each office should develop policies and procedures on how to address insurance claims processing errors that should include:

1. Requests for additional documentation
2. Identification of a claims processing error
3. Bundling
4. Lack of CPT® modifier recognition
Common Denial Codes

• There are several standardized payer explanation code sets that are used by most carriers

CARC: Claim Adjustment Reason Codes
  • Claim adjustment reason codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO</td>
<td>Contractual Obligation</td>
</tr>
<tr>
<td>CR</td>
<td>Corrections and Reversal</td>
</tr>
<tr>
<td>OA</td>
<td>Other Adjustment</td>
</tr>
<tr>
<td>PI</td>
<td>Payer Initiated Reductions</td>
</tr>
<tr>
<td>PR</td>
<td>Patient Responsibility</td>
</tr>
</tbody>
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Common Denial Codes

• Claim Adjustment Group Codes-attached in front of a CARC code to indicate responsibility
1. Deductible Amount (PR-1)
   - Usually preceded by PR
   - Patient responsibility

2. Coinurance Amount (PR-2)

3. Co-payment Amount (PR-3)

4. The procedure code is inconsistent with the modifier used or a required modifier is missing. (CO-4)
   - Will usually be preceded by CO
   - Contractual Obligation

11. The diagnosis is inconsistent with the procedure.

16. Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

18. Exact duplicate claim/service (OA-18)
   - Usually preceded by OA
   - Other Adjustment

22. This care may be covered by another payer per coordination of benefits. (OA-22)
   - Expenses incurred after coverage terminated.

27. The time limit for filing has expired.

29. Patient cannot be identified as our insured.
Common Denial Codes

RARC: Remittance Advice Remark Codes.

- Remittance Advice Remark Codes (RARCs) are used to provide additional explanation for an adjustment already described by a Claim Adjustment Reason Code (CARC) or to convey information about remittance processing. Each RARC identifies a specific message as shown in the Remittance Advice Remark Code List.

RARC EXAMPLES

M14
No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.

M15
Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

M86
Service denied because payment already made for same/similar procedure within set time frame.

MA130
Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Usually accompanies a CO-16 denial
Carc and Rarc Code Set

- Maintained by Washington Publishing Company- to obtain full sets, go to
- Also publishes Healthcare Claim Status Codes (used on both Remittance and at the Clearinghouse level)

Entity acknowledges receipt of claim/encounter. Note: This code requires use of an Entity Code.

Claims Appeals Process
• It is important to fully analyze and understand the reason, adjustment and remark codes on an EOB, so that you can move forward with the correct steps to rebill or appeal the claim
  – Who is responsible (PR, CO). Is that correct?
  – Is the claim unprocessable? Can I correct and rebill, or do I need to do a claim correction/claim reopening?

Appeals

• An appeal is a request to change a previous adverse decision made by a third-party payer. Medical practices should appeal inappropriately-denied claims through the insurer’s appeals process.

• If you need to submit a corrected claim, note on the claim that this is a corrected claim when sending via paper or attach a letter stating what the corrections were.
Requests for an appeal should include:

1. An appeal letter. When submitting a letter, include all the information that is requested on forms provided by the insurance carrier.

2. A copy of the original claim and explanation of benefit (EOB), or initial adverse decision letter, if applicable.

3. Any documentation supporting your appeal.

4. Send the appeal by certified or registered mail to ensure it is received by the payer.

5. All appeals should be submitted in a timely fashion.

DO NOT…..

- If you have a claim that comes back processed and denied, and it is correctable/appealable, DO NOT correct and rebill. Will just come back as a duplicate bill
  - Find out from the carrier what the procedure is for a corrected bill
  - Remember that each carrier may have their own rules
  - CO-16 denials were never processed, can be rebilled
Seven Steps in the Appeals Process

1. Examine the EOB.
2. Determine steps to rebill/reprocess/appeal
3. Notify the patient.
4. Document all correspondence.
5. Follow up on appeal – set a future task for follow up
6. When investigation is complete, document outcome
7. If all previous efforts fail, engage patient. Suggest they file complaint with State Insurance Department

Medicare Appeals Process

Once an initial claim determination is made, beneficiaries, providers, and suppliers have the right to appeal Medicare coverage and payment decisions. There are five levels in the Medicare Part A and Part B appeals process. The levels are:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Level of Appeal</td>
<td>Redetermination by a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC)</td>
</tr>
<tr>
<td>Second Level of Appeal</td>
<td>Reconsideration by a Qualified Independent Contractor (QIC)</td>
</tr>
<tr>
<td>Third Level of Appeal</td>
<td>Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals</td>
</tr>
<tr>
<td>Fourth Level of Appeal</td>
<td>Review by the Medicare Appeals Council</td>
</tr>
<tr>
<td>Fifth Level of Appeal</td>
<td>Judicial Review in Federal District Court</td>
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Appeal Letters

Sometimes a letter of Appeal is necessary. When writing your appeal letter you should include:

- You identification
- The reason for the denial that they explained in the denial letter
- The correct information
- Why you believe the decision was wrong
- What you are asking the insurance company to do

Investigation – Unpaid Claims

Have a game plan/procedure for investigating unpaid claims. Many times, a phone call is not necessary.
Investigation – Unpaid Claims

• If you have a claims that has not been paid:
  1. Go to Practice Management Software
     a) Was claim billed correctly from the software (has it left the building)?
     b) Are there already notes in the account about this claim? Don’t repeat your work, take good notes, and document your efforts!
  2. Go to the Clearinghouse
     a) Was claim received at Clearinghouse?
     b) Was claim rejected at Clearinghouse (Level 1)?
     c) Was claim rejected back to Clearinghouse (Level 2)?
     d) Is Remit waiting at Clearinghouse?
  3. If you direct bill to Carrier:
     a) Check carrier sites for the same types of reports/rejects/payments as you would the Clearinghouse.

• If you have a claims that has not been paid:
  4. Carrier Site
     a) Go to Carrier Site and look for claim status.
     b) No claim on record:
        1. Go back to Clearinghouse, look for acceptance report from payer. If no acceptance report, work you way backward until you find out where the claim got hung up.
     c) Claim on record:
        1. If paid, download Remit.
        2. If pending with anticipated pay day, follow up when indicated.
        3. If pending with no explanation, call Carrier.
Carrier Phone Calls

• Get Organized!
  – Multiple claims investigations in one call
    • Different patients, same carrier
    • Same patient, multiple DOS
  – WHEN are you going to do this?
    • Allocate certain hours each week to do NOTHING but calls.
    • Uninterrupted time
    • Cannot be done at the front desk
    • Cannot be done if you are floating.
    • Do not disturb!

Carrier Phone Calls

• Documentation system
  – Have all paperwork and documentation handy
    • AR Report
    • Clearinghouse Reports
    • Carrier Reports
    • Past EOBs
    • Documentation previously requested by carrier
  – Write down EVERYTHING you are told.
    • Time of call
    • Name of representative
    • Reference Number
  – Don’t just ask about status:
    • Where is my claim?
    • Why wasn’t it paid? (if applicable)
    • What do I need to do about it? (if applicable)
Call Guidelines/Advice

• The person on the other end of the line has probably been having a bad day. BE NICE if you can – you will get more out of them
• Use the same conversation format for each call so you don’t miss any key information. You don’t want to have to call back!
• Call on as many patients/claims at once as possible
• Find similar claims (if possible) that were paid correctly for comparison
• Ask for immediate transfer if you don’t understand them
• Ask for supervisor if you are not getting the answers you want or representative is not being helpful
• Document conversation/results of investigation in a way AND PLACE that is easy for EVERYONE to understand. The margins of the AR report are NOT the place!
• Document TIME spent on each call

Follow-Up System – Office/Billing Manager

• **Daily**: Check tasks for follow up calls and/or activities that are due. Leave task open for follow up on the next working day
• **Weekly**: Make sure billing has been done, and all issues in clearinghouse have been resolved
• **Weekly**: Make sure patient accounts, including insurance demographics, dx codes, etc. are current
Follow-Up System – Office/Billing Manager

• **Weekly**: Go to clearinghouse and carrier websites to pull all EOB’s delivered electronically
• **Weekly**: Print/View Unpaid claims reports, look for claims that should have been paid by now
• **Monthly**: Print AR each month and look for claims with NO activity that have aged over 30 days.

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Remember: Don’t Give Up!

The bottom line is that healthcare providers need to be reimbursed for the services being rendered. So be sure to:

• **Know each payer’s guidelines,**
• **Review all EOBs thoroughly,** and
• **APPEAL with an effective and powerful letter.**
Questions?

Thank you for your attendance!

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