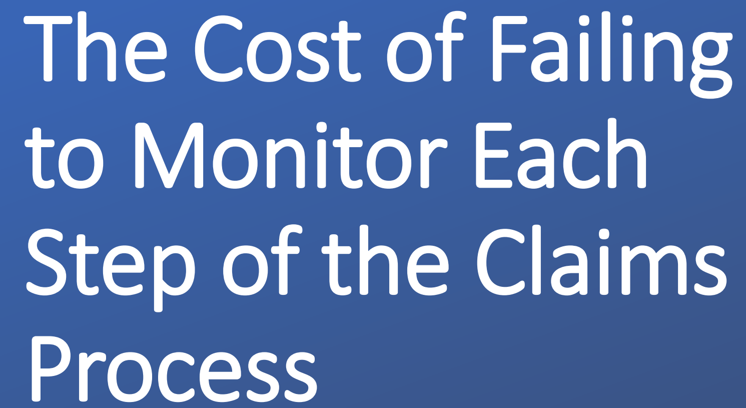

The Cost of Failing to Monitor Each Step of the Claims Process

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Objectives

Discuss definition and types of claim denials

Identify reasons for claim denials

Discuss processes for handling claim denials

Learn how to effectively communicate with various payers

Learn how to effectively communicate with coding staff

Learn ways to track and manage claim denials and appeals

An EOB or Remittance Advice (RA) is a document issued by the payer stating the status of the claim; whether it is paid, suspended (pending), rejected, or denied.

The purpose is to provide detailed payment information relative to the claim and, if applicable, to describe why the total original charges have not been paid in full.

- **General Information** – patient and provider information including group #, member name, member ID, claim #, provider name, and payment reference ID
- **Message Codes** – a set of three characters that indicate reasons as to why the total charges were not paid in full

Interpreting an EOB

- **Service/product description** – services the patient received from the provider
- **Dates of service** – when the patient received services
- **Charges** – amount billed to the patient and healthcare plan
- **Provider fee adjustment** – difference between charges billed by the provider and the amount the provider has agreed to accept as full payment
- **Copay** – the amount the patient pays the provider for a visit/service
- **Deductible** – the amount the patient pays toward covered services each year before the third party payer starts paying for services
- **Amount not covered** – the amount of services/products not covered by the plan

Total amount eligible for benefits – charges billed by the provider minus the provider fee adjustment minus patient copay, deductible, or amount not covered

% – percentage level of benefits for covered services/products

Coinsurance – what the patient must pay the health plan after the health plan pays the covered percentage

Adjustment – A change that relates to how a claim is paid differently from the original billing

Total paid by health plan – total amount eligible for benefits minus coinsurance amount

Patient responsibility – what the patient must pay of the billed charges after the plan benefits have paid

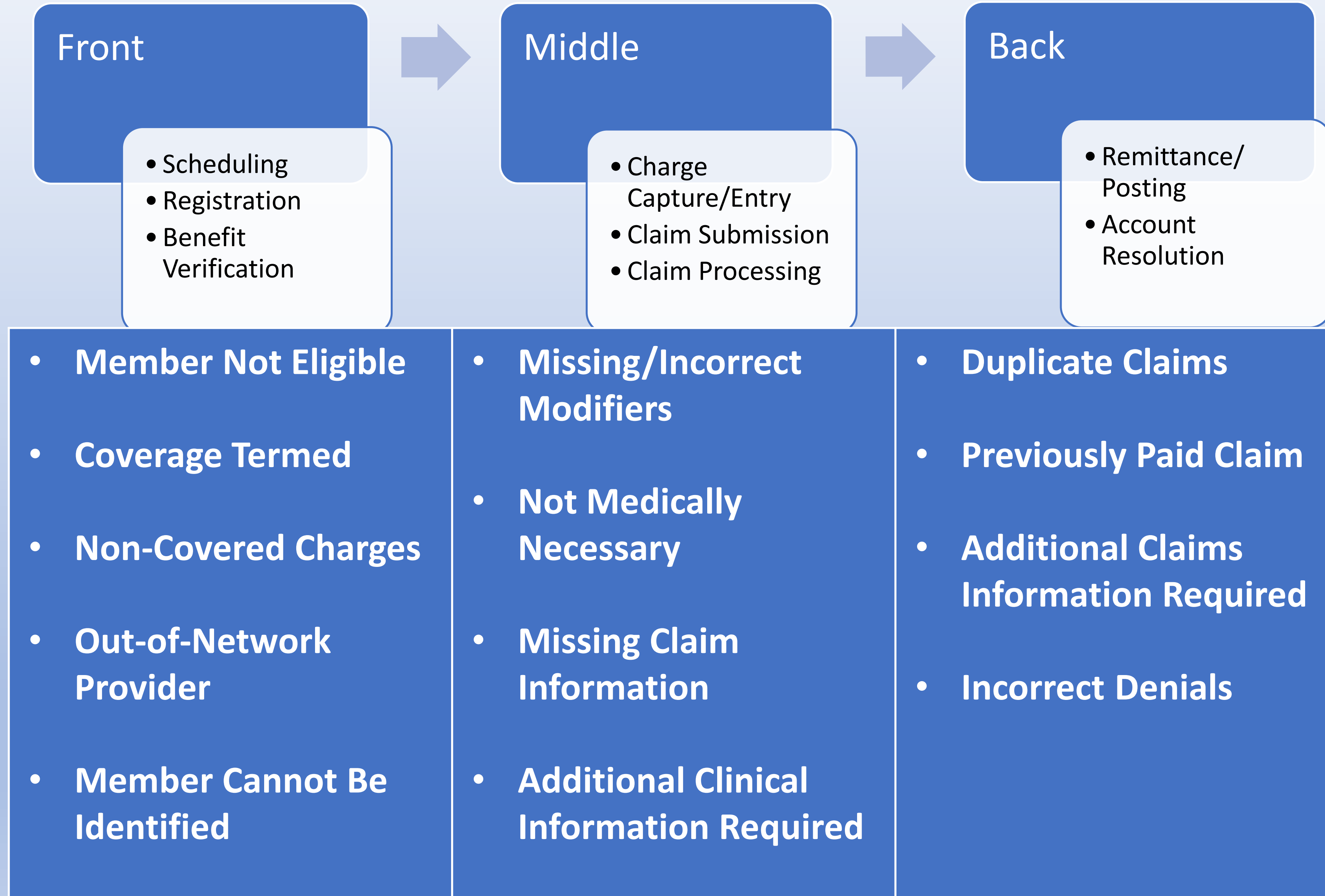
Health care industry does not have one universal definition of a claim denial:

- “Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers’ technical guidelines, or failure to consistently document for the services provided.” (HFMA)
- “A claim line item or service line item that results in no payment including rejected claims.”*

Why Is Denials Management So Difficult?

- Complexity of third-party denials
- Denial information provided by third-party payers is not standardized
- Perceived inability to capture the denial data
- Constantly changing information
- Requires coordination throughout the revenue cycle
- Challenging appeals process

Claim Denials Across Revenue Cycle



Common Reasons for Claim Denials

- Non-participating provider
- Medicare EOB required
- Incorrect dates of service
- Termination of coverage
- Failure to obtain pre-authorization
- Non-covered benefit
- Untimely filing
- Out-of-network provider utilized
- Procedure or service not medically necessary
- Additional Information Needed
- Coding Errors
- Incorrect Demographic information

Types of Denial

Hard Denials

(Appeal Necessary)

- Timely filing
- Not financially responsible
- No pre-authorization

Soft Denials

(Additional Information)

- Missing/inaccurate information
- Charge/coding issues
- Secondary payment pending receipt of primary EOB
- Pending receipt of itemized bill

Types of Denial, cont.

Clinical

- Medical Necessity
- Delay in Discharge/Procedure
- Alternate Setting
- LOS exceeds Authorization

Administrative

- Failure to pre-certify care
- Lack of clinical information
- Lack of benefit
- Exclusion denials

Understanding Denial Reason Codes

Challenges in understanding denials

- Variance in denial reason codes by payer
- Denial reason does not necessarily identify the real issue
- Inconsistently applied codes even with same payer
- Missing denial codes
- Denial codes that don’t fit the reason the claim was denied

Always best to call the payer for explanation. Some payers offer live online assistance through chat windows on their website.

Denials - Best Practices

- Early Intervention
  - Respond to denials immediately
  - Establish a timeline for working denials
  - Focus on effective communication with payer and internal departments
- Safety Net for Appeals
  - Monitor and act upon unresolved denials
  - Follow-up on all levels of appeals process
  - Measure denials and appeal results
  - Trend issues by payer and reason
- Impact of Best Practices
  - Improved cash flow due to an increase in clean claims and a reduction in denials

Payer Communication

Effective and continual communication with payers is essential

- Develop standards for what information is required
- Read the EOB carefully
- Understand payer specific guidelines
- Call the payer if a denial reason needs clarification
- Develop individual relationships with payers through calls, e-mail, and scheduled teleconferences
- Develop process for receiving policy updates
- Establish procedures for documenting communications

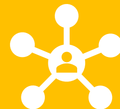
Payer Communication, cont.

- When speaking with the payer, be sure to ask:
  - What data was missing or inaccurate on the claim which caused the denial?
  - How long you have to resubmit the claim?
  - Does the payer needs any additional documentation sent with the claim?
  - Does the payer require any specific indicators on a claim when it is re-sent to indicate that it is a corrected claim?
  - Where does the information need to be sent?
  - Is there a reference number for this phone call?
  - If payer representative is not helpful, ask to speak with a supervisor

Communication Between Billers and Coders

Accurate coding is necessary for receiving payment

Build relationships with coders so clean claims can be produced



Build good relationships with your Patient Administration Directorate (PAD) and clinical staff

Billers and coders need to share and communicate processes so that both parties have some cross training

Process For Handling Claim Denials

Interpret the EOB to ensure that a valid denial reason has been received

Determine if it needs to be written off or billed to the patient

Determine if denial can be corrected and resubmitted or if the claim requires an appeal

Develop a communication plan

Engage appropriate departments

Establish goals for follow-up

Develop your case based on the payer’s guidelines

Monitor corrected or appealed claims

Appealing Denials

- Denied claims should be pursued aggressively
  - Denied claims should be prioritized based on date and dollar amount
  - Aggressive does not mean calling every day
  - Scrutinize all denied claims for incorrect information
  - Disputed claims should be communicated to the payer in writing
  - Aggressively appealing denials has been shown to reduce
- denial rates

Follow-up on Appeals

Insurance companies frequently do not pay what they approve

They have no incentive to ensure that everything is paid appropriately

Track payments for approvals or overturns

- When a payer accepts an appeals argument and agrees to reverse their decision on a claim denial

Develop system for logging all payer approvals and be able to submit documentation of the overturn back to the payer in the case of a dispute

What About Upheld Denials?

Request the payer send supporting documentation

For incorrect payments, request a copy of the fee schedule

- A list of CPT codes and dollar amounts a payer will allow for a particular medical service

Tips for Tracking Denials

- Why track denials?
  - Defines where breakdowns are in the process to identify opportunities for performance improvement
  - Identifies unreasonable payer practices
  - Collaborative effort appeals are easier to handle in the future
  - Identifies areas where denial management efforts have been successful
  - Allows UBO to develop future goals and opportunities for preventing future denials

Tips for Tracking Denials, cont.

- Grouping claim denials
  - Payer and type
  - Reason
  - Develop denial categories
  - Status for follow up
  - Identify services and areas that result in the majority of denials
  - Show impact on revenue
  - Evaluate weekly what is being denied
  - Monitor action taken on denials
  - Communicate to leadership

Summary

Be sure to understand the denial codes on the EOB

Focus on effective communication with payers

Develop a strategic plan for managing individual claim denials

Develop a method for tracking claim denials and appeals

Make sure claims are “clean” before they are sent

Contact your Service or NCR MD Program Manager for Service or NCR MD specific guidance