Common Denials and How to Avoid Them

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Disclaimer
The information in this presentation was current at the time the presentation was compiled and does not include specific payer policies or contract language. Always consult CPT®, CMS, and your payers for specific guidance in reporting services. The views expressed in this presentation are simply my interpretations of information I have read, compiled and studied. Much of the information is directly from the AMA, AAPC, CMS literature and other reputable sources.

Keeping The Pulse Alive
• The practice is a Business
• Start off on the right foot
• Financial Policy – Stick to it, set the rule on getting paid
• Set up collection goals – weekly, monthly, quarterly, annually
• Know your surroundings
• Get patients involved early
• Offer different methods for payments
• Know when to cut your losses
• Know who you are contracted with – VERY important when scheduling
Introduction

• Medical billing cycle processes
• Most common deficiencies in documentation
• The importance of linking the codes correctly
• Missing elements during charge entry
• How to handle denials and tools to use
• Putting all the pieces of the revenue cycle together

Ten Step Process

• Ten Step Process
• Four Crucial/Key Steps
  – Insurance Verification
  – Provider Documentation
  – Coding
  – Billing
Insurance Verification

- The first step/First contact with patient – Cycle starts
  - The MOST important step in process, but often most ignored
- Determine if the provider is in network
- Inform patient prior to service of problems with insurance coverage
- New patient vs. established patient
- No time
- Loss of revenue
- Identify if prior authorization/precertification and/or referral are needed
- ABN required
- Determine the referring provider
- What questions to ask?

Insurance Verification

- Insurance verification
  - Questions to ask:
    - Does the patient have a deductible?
      - Has it been met?
    - Does the patient have co-insurance/What is the percentage?
    - Does the patient have a Co-Pay/How much is it?
    - Coverage start and end dates

Scenario 1 - Insurance Verification

Scenario:
Practice has two patients, one named Rafael Lewis Gonzales and the other Rafael Luis Gonzales. Both born 8/4/1990.

Rafael Luis Gonzales was was seen today; however, no one noticed that the charge ticket the receptionist filled out was for Rafael Lewis Gonzales.

Now the office billed for the wrong patient.
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Insurance Verification

A GYN provider is often considered a PCP, not a specialist. If you collect the specialist fee, but a particular carrier views the GYN as PCP, you are placing your practice at risk because you have collected more than what you were entitled to.

Patient Demographics

• Review intake form to ensure the information is accurate
• Did the patient sign the financial policy?
• Make a copy of the insurance card – front and back
• Make a copy of patient ID – front and back
• Are ALL forms signed and dated?
• Collect copay, deductible, and/or co-insurance
• Update intake forms annually
• Start and end dates for insurance carriers – REQUIRE IT
• Review at each visit – also review ID for changes

Insurance Verification

THE SAINT BARNABAS SYSTEM HEALTH PLAN
EXCLUSIVE

Group Number: 49545

Member ID: 123456789
DOB: 05/05/1985
Gender: F

Copy: CV D01: Spec OV 009 001 001

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Copy: CV D01: Spec OV 009 001 001
Documentation
• Lack of patient signature on all proper documentation:
  – ABN not signed
  – financial policy not signed
• Physician missing, or wrong date of service
• Missing and/or not properly appended CPT®/HCPCS Level II modifiers
• Clinical significance/medical necessity for lab orders
• Increased use of EMRs:
  – Cloned documentation

Impact on Compliance and Reimbursement
• Lost revenue
• Payment disputes (with patient and carriers)
• Audit risks
• Compliance risks

Missed Charges = Lost Revenue
• We often see money left on the table
• Missing charges for supplies
• Missing charges for services & procedures
• Missing charges for devices
• Not collecting payment at time of services (e.g., copays or self pays)
• Established patient vs. New patient
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Missed Charges = Lost Revenue

- Most common service/procedure missed are vaccination administration and venipuncture charges
- Small charges add up
- Let's take a look at the flu vaccine...

Carrier Policies Determine Billing Codes

- Commercial carrier:
  90658 – Flu Vaccine
  90471 – Administration of vaccine
- Changes if it was the FluMist

Carrier Policies Determine Billing Codes

The flu vaccine can be billed a number of ways:
- Medicare (depending on your Medicare Carrier)
  Q2037 – Flu Vaccine (Q code depends on the ACTUAL vaccine administered to patient)
  G0008 – Administration of Flu Vaccine
Scenario 2

- In the course of an office visit, Dr. Johnson orders a flu shot which is subsequently (during the same visit) administered by MA Stick.

- Documentation
  - Office visit: 99213 supported in documentation for follow up on benign hypertension (401.1)
  - Injection: “Flu shot given”

Scenario 2 (cont.)

- Coder
  - Why was the flu shot administered?
  - What is the patient’s age?
  - Was the patient counseled on the immunization prior to it being administered?
  - Which flu shot (toxoid) was administered?
    - Method of administration (IM, SC, IN, etc)

Scenario 2 (cont.)

- Biller
  - Patient demographics
  - Who is the Referring Provider?
    - CMS-1500, Box 17a/b, may be Ordering Provider
  - Who is the Rendering Provider?
  - What insurance coverage does the patient have?
  - Was the product (toxoid) purchased or provided by a State program?
  - When was the patient’s last flu shot?
    - Is the patient considered high-risk
Scenario 2 (cont.)

- **Compliance Auditor / Officer**
  - Does the documentation encompass the federal requirements for immunizations?
  - [http://www.cdc.gov/vaccines/recs/immuniz-records.htm](http://www.cdc.gov/vaccines/recs/immuniz-records.htm)

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**Missed Charges = Lost Revenue**

- **Sample EOB Denial**
Scenario 2 (cont.)

• Payer
  – Primary Reasons for Denial
    • Claim submitted to incorrect insurance carrier
      – Medicare primary vs. secondary
      – Commercial vs. Medicare
    • First listed diagnosis
    • Correct code choice (HCPCS vs. CPT)

Missed Charges = Lost Revenue

• If we were to take the administration fee alone for a typical flu season – 250 patients – and multiple it by the reimbursement fee schedule for the administration

<table>
<thead>
<tr>
<th>State</th>
<th>Reimbursement Amt.</th>
<th>250 patients seen during the flu season</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Jersey 01</td>
<td>$29.80</td>
<td>$7,450.00</td>
</tr>
<tr>
<td>New Jersey 99</td>
<td>$28.48</td>
<td>$7,120.00</td>
</tr>
</tbody>
</table>

Denial Reason

• Payer
  – Primary Reasons for Denial
    • Claim submitted to incorrect insurance carrier
      – Medicare primary vs. secondary
      – Commercial vs. Medicare
    • First listed diagnosis
    • Correct code choice (HCPCS vs. CPT)
CPT® & ICD-9 Coding

- Coder is responsible to review for accuracy
- Don’t leave money on the table
- Medical billing and coding is like a puzzle – all pieces must link together accordingly
- Medical necessity must be met
- Know your carrier guidelines and policies

Applying Correct Modifiers

- Must be supported by documentation
- Fully describes the encounter
- Positive and negative effect on reimbursement

Carrier Policies Determine Billing Codes

<table>
<thead>
<tr>
<th>First Priority Life</th>
<th>Procedure code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not cover</td>
<td>S0610</td>
<td>Annual exam – new pt. report with dx. v72.31</td>
</tr>
<tr>
<td>99281-99397</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S0612</td>
<td></td>
<td>Annual exam – est. pt. report with dx. v72.31</td>
</tr>
</tbody>
</table>
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Carrier Policies Determine Billing Codes

Aetna – Billing for annual exam

**Routine GYN**  90610, 90612, 90613, 99381-99397, 99401-99404, 99201-99205, and 99211-99215 are considered to be preventive if the primary diagnosis code is: V72.3, V72.31, V72.6, V76.2, V76.46, V76.47, V84.02, or V84.04

Aetna – Billing for annual exam

**Pap Smear** - Preventive

G0101, G0123-G0124, G0141-G0148 and P3000, P3001, Q0091, 88141-88155, 88164-88167, and 88174-88175 are considered to be preventive if the primary diagnosis code is: V72.3, V72.31, V72.6, V76.2, V76.46, V76.47, V84.02, or V84.04

**Pelvic Exams**  G0101

Putting It All Together

• Enter all charges
• Review BEFORE submission
• Based on the provider’s documentation
• Review for lost revenue (administration, supplies, etc.)
• Samples of things to review:
  – NPI, referring provider information, onset date, DBB, DOS
  – Know payer policies for what is billed
  – Are any modifiers needed
  – Review provider documentation
Example

• How many billable charges are there?
• Is there anything missing?
• Will it require a modifier?
• Do you need a referring and/or ordering provider?
  – Why or why not?
• Does it make a difference if this is a Medicare pt. or a Commercial pt.?
  – Why or why not?
• Do we need to review documentation?
  – Why?

Common Billing Errors

• The patient cannot be identified
• Address for the place of service, including a valid ZIP code
• E/M procedure code and place of service do not match
• NPI missing or invalid
• Diagnosis codes invalid or truncated
Common Billing Errors

• Procedure code/modifier invalid
• Information needed when Medicare is a secondary payer

Claims Follow Up

• Do not set to auto rebill every 30 days
• Run reports from practice management system
• Assign staff for claims follow up - make accountable

Claims Follow-Up

• Follow-up - Most important to manage the A/R
• Must be able to research and know where to search
• Insurance Aging
• Patient Aging
• Work weekly, monthly, quarterly, yearly
• Pick up the phone – it still works
• Document your follow-up attempts, notes, letters, phone calls, etc.
Payment Posting

• Monitor payments to make sure they are correct

• Post adjustments so that A/R is not inflated

• Post zero payments with the denial remark codes

Payment Posting

• All payments must be posted – EVEN your ZERO dollar EOBs, even if you are going to work the denial/rejection, post it

• Know your denial codes such as CO50, CO45, PR204, etc

• Use notes in your system – important

• Document all communication with carriers – date, time and person you spoke to

Denial Management

1. Review all documentations, such as:
   a) patient registration form
   b) patient insurance card, front and back
   c) provider’s documentation
   d) charge ticket and charge entry
   e) Explanation of benefit/remittance advice
   f) posted denial and/or rejection message into system
Denial Management

2. For a simple data entry error, you may be able to:
   a) correct claim and resubmit

3. If the wrong code and/or patient was billed:
   a) Draft and submit a letter of explanation with a corrected claim
   b) If provider was paid in error, send a letter to carrier to retract payment

Denial Management

- In many cases, practice denials represent internal errors
- Loss of revenue or delayed revenue
- Track denials
- Train staff on payer policies, coding, billing (your findings)
- Monitor
- Make staff members accountable

Denial Management

- Clearinghouse Dashboards
- Gives complete summary (accepted /denials)
- Overview of your top rejections
- Use as training tool
- Share your findings with staff and providers
- Inform provider, not everything gets paid
Cost For NOT Working Denials

- 90 claims per day at $90 per claim = $8,100
- If 10% denied = $810 in denial per day
- If only 1 in 10 denials are appealed it = $729.00 per day
- 52 weeks x 5 days – 20 day (vacations and holidays) = 240 working days,
- 240 days x $729.00 = $174,960 lost per year

Timely Filing Guidelines

<table>
<thead>
<tr>
<th>Carrier</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Health Care</td>
<td>90 Days from date of service</td>
</tr>
<tr>
<td>Oxford</td>
<td>90 Days from Date of Service</td>
</tr>
<tr>
<td>Aetna</td>
<td>180 Days from Date of Service</td>
</tr>
<tr>
<td>Cigna</td>
<td>90 Days from Date of Service</td>
</tr>
<tr>
<td>Cigna Great West</td>
<td>15 months</td>
</tr>
<tr>
<td>Medicare</td>
<td>12 months (Calendar)</td>
</tr>
</tbody>
</table>

This will differ if the provider is NON PAR. For example Cigna is 180 Days
Proof of Timely Filing

- Most carriers want your EDI reports to show claims accepted and acknowledged by Payer
- **Some Carriers REQUIRE you use their forms to appeal**
- It's not enough to have an acceptance from your clearinghouse. They want acknowledgement that THEY received it.
- If you mailed your claims, then you should have mailed certified with return receipt.

Corrected Claims Guidelines

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<tr>
<td>Cigna</td>
<td>180 Days from date of remit</td>
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Some may require that you use THEIR forms, other may allow you to simply write a request. Forms may vary depending on State where provider is located.

Should ALWAYS BE SENT CERTIFIED WITH RETURN RECEIPT. Keep a file and/or log so you can track.

Appeals-Steps for Success

1. Analyze the reason for the denial
   - Is there a trend with this payer (or all payers)?
2. Keep documentation of every correspondence with the payer
3. Don’t stop with “no”
Reporting

• Monitor A/R
• Common reports:
  – Aging
    • Payer type
    • Dollar amount
  – A/R Analysis

Useful Reports

• Practice Analysis
• Insurance Aging (90, 120, 151)
• Secondary Aging (medigap claims)
• Procedure Analysis
• Diagnosis Analysis
• Patient Aging
• Denial Report