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Medical Billing & Consulting

Shifting the Focus to Denial Prevention: Tips and Perspectives from our experience

Cyndi Walker, CMC, CHBC

Did you know?

Over 30% of your claim denials are preventable. Providers do not appeal or correct over 65% of denied claims.

Are you dumping bad data in your claim files? You may have the dumping syndrome!

Millions of dollars are lost by medical providers across the country each year due to preventable errors. Each year, we all hear the numbers and increase our AR staff to work errors and turn around the denials daily. The problem is we are waiting up to 90 days to get paid once a claim denies and statistics show we do not always have the staff to correct all errors monthly, and many of the claims never get paid. What about getting the claim in clean the first time and getting paid!

The payers have enhanced screening data in your claims files with sophisticated programs that identify any data fields that are not correct. The payer denies the claim when any data field has errors. Statistics tell us the payers are finding lots of errors. We have to turn this around to keep our practices financially viable.

Here is the list that causes the top 30% of rejections:

1. Invalid Insurance

You billed the wrong plan. The correct payer number was not identified during the provider's office check-in process.

Medicare eligibility does not mean you always file the claim to Medicare.

Replacement Plans

Checking for Medicare and Medicaid Replacement Plans should be part of your front-office process.

Most Medicare patients do not present their Medicare replacement plan at the time of service. It is very common for the patient to provide their original card and not their Medicare replacement plan. The patient's Medicare ID will verify that coverage for part B is active, so the front desk fails to check to see if there is a replacement plan. Reading the benefits first in detail will give you a clue that the patient has another primary payer. Medicare tells you they are not primary on the eligibility report.

Medicaid eligibility does not mean you always file the claim to Medicaid.

Many Medicaid programs have replacement plans. The eligibility check will tell you the patient is Medicaid eligible, but you must look at the details to know if the patient has a Medicaid replacement plan. The claim will be denied if filed with regular Medicaid.

Stop filing claims to terminated Insurance plans.

Start enforcing benefits verification every visit.

Billing to the active policy is how you get paid, so verify every insurance **every time** and read the detailed report supplied by the payer.

2. Terminated Insurance

Cause - You billed a plan that is no longer active. The check-in staff failed to verify coverage was active. The patients change plans often, and the old plan is terminated. Our check-in process does not identify the primary payer has changed. Busy managers are not able to carve out time for a daily management review to make sure everyone gets a green thumbs up. Someone has to do this important task daily, and if this doesn't happen, you are losing money.

3. Invalid patient demographics (Box 1 through 13 of the claim)

Most of these mistakes are simple but expensive. Cause - You used the patient's nickname, spelled the name incorrectly, and did not properly identify the insured. Example: A note from the check-in office on the patient's first name (Robert -Bob) will cause the claim to be kicked out. Adding dashes on the name will get you a denial every time. You cannot use symbols or dashes on claim demographics. The name goes electronically to the payer on the claim. This is not a note section for staff. Forgetting to add the insured's date of birth on the billing profile will win you a denial every time.

4. Lack of authorization (Box 23 of the claim)

Cause– Authorization was required for the service, and no authorization was attached to the claim. The service was performed without authorization. Staff added dashes to the authorization number. The Authorization number has typos or missing digits.

5. Lack of referral for care (Box 17 of the claim)

The cause-The plan required the patient to get a referral to see a specialist. No one noticed this was needed, the referral was not done, or the referring provider's name was not attached to Block 17 of the claim. The NPI was not attached to the provider's name as required in Block 17b of the claim.

6. The admit date is missing from the claim (Box 18 of the claim)

Cause-Box 18 for the claim must contain the admit date of any inpatient procedure or stay. Leave the dates blank and win a denial.

Which of the above rejections are created in the provider's office before the claim goes out the door? All of Them

Nothing I am telling you above seems too difficult, right? I promise you the majority of your denials are simple, easy fixes that are preventable with a little extra time upfront.

It's all preventable, so why not prevent them with a corrective plan. Let's investigate the prevention plan.

With the average provider showing 25k in denials per month, the answer must be **NO**! Let's improve the upfront process!

Look at your unpaid accounts as a learning process to improve. You can do this starting now and enhance your income in 30 days with some good data about your denials and a little training.

How do you determine the reasons why you did not get paid on the first claim filing?

Look at your rejections in a new format!

The only way to identify the number one reasons we don't get paid the first time is to review your claims that do not get paid the first time they were filed, identify the denial, and map them to excel by category. You will have a clear picture of the problem.

Analyze your unpaid claims! You must run your Accounts Receivable on an excel spreadsheet each month and categorize your denials. We don't know why we don't get paid. Finding the answer to this question is critical to the financial health of the healthcare provider.

"Driving down the same road everyday will get you to the same place." Take a different road!

-Grandma

Once you identify why the claim was denied, trace back to the original cause and train your staff.

Act Now! Follow these steps:

1) Prepare data reports with denials and success stories each month.
2) Give the denials for invalid insurance, terminated insurance, and demographic errors back to check-in staff for correction, so they know the errors cause rejections and lost revenue. Your staff may not be aware of the rejections at check-in if you don't show them. This is great training!
3) Return the denials for authorizations and referrals to the department that is responsible for these tasks. Ask them to call and see if they can backdate the authorization and, if not, learn that these errors cause lost revenue. You did not get paid because this was missed. Staff needs feedback, good and bad.
4) When you stop adding more staff to correct the errors and start a prevention plan, you will see an improvement in your collections in 30 days. This is a monthly process, and in my opinion, essential to running a tight ship.

Ask your billing staff to start analyzing the rejections today or hire a professional to do this for you. The accounts receivable that mounts up monthly will no longer be a mystery. The results will be worth the effort.

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