Effective Claim Denial Management

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Introduction

About S4CH

Since 2007, Solutions 4 Community Health (S4CH) has focused on management solutions to meet the complex needs of our clients in response to the constant changing healthcare landscape. S4CH's expertise is in Strategic Consulting, Practice Transformation, Revenue Cycle Enhancement, Analytics, HEDIS and Risk Contracting Performance Improvements.

S4CH focuses its work primarily federally qualified health centers (FQHCs) and health care organizations that serve predominantly low-income, uninsured, and at risk populations.

S4CH Revenue Cycle Management

We optimize & maximize revenue, ensure accurate billing and coding, and streamline the financial processes within organizations. We utilize the use of automation to help optimize revenue cycle processes. We work hand in hand with our clients to ensure timely and efficient billing practices.

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Outline-Effective Claim Denial Management

- ✓ Importance of Denial Management
- ✓ Complexities of Denial Management
- ✓ Common Denial Reasons
- ✓ Credentialing Process in Denial Management
- ✓ Patient Registration and Eligibility Verification
- ✓ Claim Submission
- ✓ Payments and Denial Posting
- ✓ Denial vs Rejection
- ✓ Claim Corrections and Appeals
- ✓ Key Metrics in Denial Management
- ✓ Improving Denial Management

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Importance of Proper Denial Management

Revenue cycle optimization: By actively managing denials, FQHCs can improve their revenue cycle by identifying recurring issues, implementing corrective actions, and preventing future claim rejections

Financial Impact: High denial rates can lead to significant financial losses for FQHCs, especially considering the large volume of patients they serve with complex insurance situations.

Patient access to care: Proper denial management ensures FQHCs receive adequate funding to maintain quality healthcare services for their patient population.

Complex billing environment: FQHCs often face complex billing regulations and diverse payer types, making denial management even more critical.

Proactive approach: Effective denial management involves not just resolving individual denials but also analyzing trends to proactively address common causes of claim rejections

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Complexity of Denial Management

State-Specific Requirements

Credentialing:

- Lengthy process- Solution is to streamline the process by starting the credentialing process as soon as possible and frequently following up with payer
- Re-credentialing requirements- solution is to track re-cred by setting up reminders and notifications

Managing multiple payers:

- **Different Billing Requirements**: Each payer has different codes, forms, and rules that must be followed for claims to be paid. Navigating this unprepared can result in billing errors and claim denials.
- **Timely Filing Deadlines**: Different payers have different deadlines for claim submission. Missing a deadline can result in the claim being denied and the FQHC losing out on reimbursement.
- **CAS codes and remark codes** are used in different ways for the same denials.

Specific Coding Rules

Example telehealth

Medicare FQHC Billing Codes

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Common Reasons for Denial

- **Incomplete or Incorrect Patient Information**
- **Lack of Prior Authorization or Referrals**
- **Coding Errors**
- **Medical Necessity Denials**
- **Timely Filing Issues**
- **Duplicate Claims**
- **Coordination of Benefits (COB) Errors**
- **Patient Eligibility Issues**

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Polling Question

Does your organization have a Denial Management Process?

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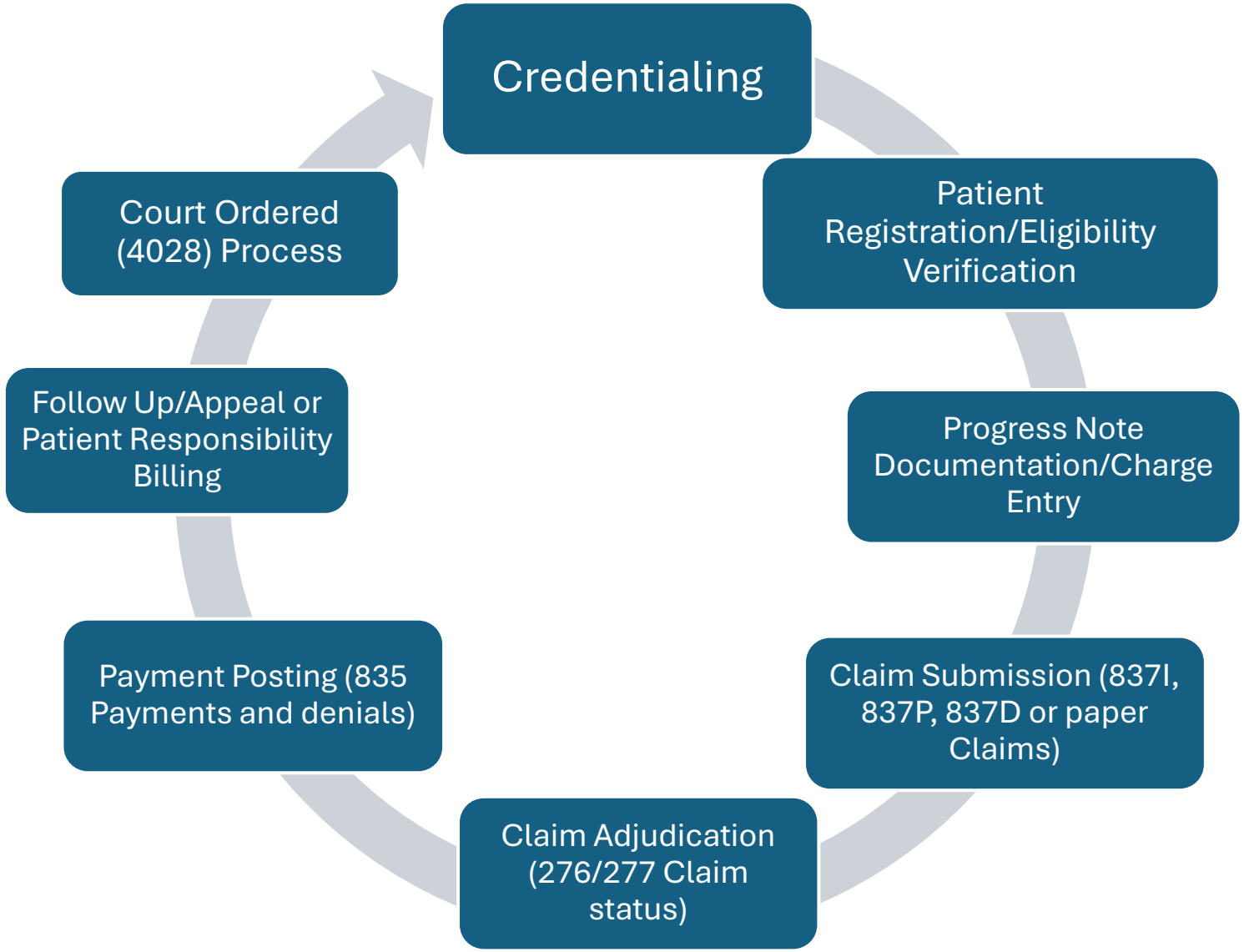
Claim Billing Cycle



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Credentialing and Denial Management

Here are tips to avoid credentialing type denials:

- Start credentialing process as soon as possible.
- Know the credentialing and re-credentialing process for each payer.
- Credentialing and billing departments should work collaboratively on provider denials such as:
  - Denied Non-Participating
  - Denied Provider ID
  - Denied Provider Specialty
- Know your contracts per plan and line of business. Understand the impact to denials based on the contracts.

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Patient Registration/Eligibility Verification

- Review patient completed registration forms to make sure EMR patient demographics information is accurate.
- Verify patient eligibility with insurance company.
  - Incorrect line of business will not deny a claim
- Scan copies of patient's insurance card(s) in EMR.
- Collect copays, deductibles and/or co-insurances at the time of service.
- Collect sliding scale documentation.

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Claim Submission

- Timely claim submission is critical to minimize denials.
- Utilize system edits for clean submission.
- Ensure all required documentation is complete and accurate.
- Ensure coding is accurate.
- Utilize electronic submission methods for efficiency.
- Regularly review and update submission processes.
- Training staff on best practices enhances submission success.

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Payments and Denial Posting

Here's a breakdown of the importance of payment and denial posting in an FQHC:

- Accurate Revenue Cycle Management
- Timely Follow-Up on Denials
- Improved Cash Flow
- Optimizing Reimbursement
- Effective Denial Management and Appeals
- Enhances Reporting and Analytics
- Reduced Write-Offs

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Denial vs Rejection

Denial: A claim denial applies to a claim that has been processed and found to be unpayable. This may be due to terms of the patient-payer contract or for other reasons that emerge during processing. (Also known as a back-end rejection via Ansi 835)

Rejection: A claim rejection occurs before the claim is processed and most often results from incorrect data. (Also known as a Front-End Rejection)

- Clearinghouse rejected, pending or insurance plan rejected vs. accepted via claim status Ansi 276/277

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Terminology in Denial Management

- Remittance Advice/Explanation of Benefits
- 835 Electronic Remittance File
- ANSI code
- Claim Adjustment Reason Codes (CARC)
- Remittance Advice Remark Code (RARC)
- Gross Charges
- Contractual
- Net Charge
- National Correct Coding Initiative (NCCI) Edits

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Corrected vs. Appeal

- Corrections fix simple errors in claims or documentation.
- Corrections are typically faster to process than appeals.
- Appeals are requests to reconsider denials received from the insurance company.
- Appeals typically involve submitting additional documentation, medical records or justification from a physician to prove why the service should be covered.
- Understanding both processes is essential for effective denial management.

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Explanation of Benefits (EOB)

- An EOB or Remittance Advice (RA) is a document issued by the payer stating the status of the claim; whether it is paid or denied in whole or portion.
- 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 due to a denial.
- Claim Adjustment Reason Codes (CARC)
  - CO-Contractual Obligation
  - OA-Other Adjustment
  - PR-Patient Responsibility
- Remittance Advice Remark Code (RARC)
- Gives appeal information

Interpreting an EOB

Insurance Company
P.O. Box 4095
Baltimore, MA 12345-3350

Claim Questions: (800) 449-8977
Fax Number: (800) 332-5745
Website: InsuranceCompany.org

BILLING NPI NUMBER: 1234567899
PROVIDER NAME: HEALTH CENTER
PATIENT NAME: SMITH, JOHN
SUBSCRIBER NAME: SMITH, JOHN

RENDERING NPI NUMBER: 1234567899
PATIENT ACCOUNT: 123456
MEMBER ID: 896103524
PATIENT DOB: 01/01/1950

PAYER CLAIM NUMBER: 8102045602134560
CLAIM AMOUNT: $275.00
PAID AMOUNT: $80.00
CHECK NUMBER:0032165466
PT RESPONSIBILITY: $15.00

DATE OF SERVICE										
FROM	TO	SERVICE CODE	CHARGE	ALLOWED AMOUNT	DEDUCTIBLE	COPAY	CO-INSURANCE	PAID AMOUNT	ADJ AMOUNT	ADJ/REMARK REASON
9/17/2024	9/17/2024	99213	$165.00	$55.00	$ -	$15.00	$ -	$40.00	$95.00	CO-45; $95.00 PR2; 15.00
9/17/2024	9/17/2024	90471	$ 40.00	$ -				$ -	$40.00	M76
9/17/2024	9/17/2024	90656	$ 40.00	$40.00	$ -	$ -	$ -	$40.00	$ -	
9/17/2024	9/17/2024	99406	$ 30.00	$ -	$ -	$ -	$ -	$ -	$30.00	CO-97

ADJUSTMENT REASON CODES:
CO-45 CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED FEE ARRANGEMENT
CO-97 SEPARATLY BILLED SERVICES/TEST HAVE BEEN BUNDLED AS THEY ARE CONSIDERED COMPONENTS OF THE SAME PROCEDURE. SEPARATE PAYMENT IS NOT ALLOWED

REMARK CODES:
M76 MISSING/INCOMPLETE/INVALID PRINCIPAL DIAGNOSIS

Adverse claim decisions may be appealed in writing and sent to the address or fax number above. You should include any additional information that you may have. The additional information will be reviewed, using our internal appeals process. Appeals must be made within 180 days of this correspondence.

Follow Up and Appeal Process

- Understand the Denial Reason
- Follow the insurance company appeal deadline
- Strong Supporting Documentation
- Correct Coding and Billing Guidelines
- Clear and Persuasive Appeal Letters
- Follow Up on open appeals regularly
- Escalate if first appeal denied

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Court Approved Plan of Action

- Effective since 2013, NY FQHCs can bill Medicaid for unpaid Medicaid Managed Care qualifying visits with rate codes 4028, 4027, and 4026 which are equivalent to 4013, 4012, and 4011 respectively.
- FQHCs are reimbursed their PPS rate when the Medicaid Managed Care plan denies a claim with a qualifying reason.
- The claims which have a supplemental payment must be adjusted to receive the full PPS rate for the unpaid visit.
- If the Medicaid Managed Care plan pays then the court ordered claim needs to be adjusted.
- There is a 2 year filing limit on court ordered rate codes.
- Analytics must exist to identify these claims with a respective policy and procedure in place.

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Key Metrics of Denial Management

- Denial Rate
- First Pass Claim Rate
- Appeal Success Rate
- Denial Categorization
- Days in Account Receivable
- Denial Write Off Rate
- Reimbursement Rate
- Average Time to Appeal
- Root Cause Analysis

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Polling Question

Does your organization monitor staff appeal volume?

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Improving Denial Management

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Staff Training and Development

- Comprehensive training programs enhance staff competency.
- Regular workshops keep staff updated on best practices.
- Role-playing scenarios improve real-life application skills.
- Feedback mechanisms help tailor training to needs.
- Collaboration with experts ensures training relevance.

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Use of Automation and AI for Denials Management

- Automated Pre-Submission Checks
- Streamlined Appeals and Resubmission Workflows
- Reduced Administrative Burden
- AI reduces manual errors in claim submissions and processing.
- Automation speeds up denial identification and resolution.
- Predictive analytics can forecast denial trends effectively.

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Payer Communication

- Establishing clear communication channels is essential.
- Regular updates on claim status can reduce confusion.
- Understanding payer guidelines helps streamline processes.
- Proactive outreach can prevent misunderstandings.
- Documenting all interactions aids in future reference.

Medical Necessity Denial Scenario

Problem:	• A health center experienced a high volume of claim denials for imaging services from a major payer. The denials cited "lack of medical necessity" as the primary reason
Root Cause Identified:	• Documentation for medical necessity was inconsistent.
Actions Taken	
Audit and Analysis	• Conducted a thorough review of claims denied for medical necessity and identified patterns in documentation errors. • Consulted payer-specific guidelines for medical necessity requirements.
Staff Training	• Educated staff on proper coding and documentation practices. • Highlighted the importance of including detailed clinical notes to justify appeals.
Implementing Automation Tools	• Deployed a software solution to flag claims lacking required documentation before submission.
Payer Collaboration	• Reached out to the payer for clarity on specific denial codes and guidelines. • Worked collaboratively to appeal incorrectly denied claims

Prior Authorization Denial Scenario

Problem:	• A significant number of claims for procedures were being denied due to the absence of prior authorizations
Root Cause Identified:	• Inconsistent verification of payer authorization requirements during appointment scheduling and patient registration. • Lack of a clear protocol to obtain and document prior authorizations. • Limited communication between the administrative team and clinical staff regarding insurance guidelines
Actions Taken	
Process Audit & Mapping	• Conducted a comprehensive review of the patient registration and appointment scheduling processes. • Mapped out the workflow to identify where lapses in verifying authorization requirements were occurring.
Standardization of Pre-Service Checklists	• Developed a detailed pre-authorization checklist used at scheduling. • Implemented a standardized procedure for verifying insurance requirements before confirming appointments for services that typically need prior authorization.
Technology Integration	• Upgraded the electronic health record (EHR) system to include automated alerts when a service requiring prior authorization was scheduled.
Staff Training & Interdepartmental Collaboration	• Conducted targeted training sessions for front-desk personnel and clinical staff on payer-specific guidelines. • Established regular meetings between administrative teams and clinicians to review and update policies based on payer feedback.
Direct Payer Communication	• Engaged in discussions with major insurance payers to clarify authorization guidelines. • Developed quick-reference guides that summarized common requirements for each service type.

Modifier Denial Scenario

Problem:	•A significant volume of claims were being denied due to missing modifiers. The absence of these modifiers led to payment rejections and delayed reimbursements.
Root Cause Identified:	•Insufficient training on the proper usage of modifiers. •Lack of a checklist or formal pre-submission review process. •Poor communication between clinical staff, coders, and the billing department regarding payer-specific modifier requirements
Actions Taken	
Comprehensive Analysis and Audit	•An audit was conducted on a sample of denied claims. The review identified recurring issues—common gaps were noted in procedures where modifiers were essential for indicating separate or distinct services •The audit revealed that missing modifier issues were most common in high-volume procedures like E/M visits and physical therapy sessions.
Targeted Staff Training	•Organized mandatory training workshops for coding and billing staff focusing on the correct application and significance of modifiers and payer-specific guidelines for modifier usage. •Distributed quick-reference guides and cheat sheets highlighting when and why to use modifiers (e.g., Modifier 25 for significant separately identifiable E/M services on the same day).
Process Improvements	•Developed a standardized checklist that includes verifying the appropriate use of all necessary modifiers before claims submission. •Instituted a peer-review process where senior coders review claims that involve potentially complex modifier applications. •Facilitated regular meetings between clinical, coding, and billing teams to ensure clarity and consistency in modifier application and documentation.
Technology Integration	•Updated the electronic health records (EHR) and billing software to incorporate real-time alerts for claims missing standard modifiers. •Designed automated prompts within the billing system that flag procedures typically requiring modifiers, ensuring that the process is double-checked before claim submission.
Ongoing Monitoring and Feedback	•Established bi-weekly audit sessions to track modifier-related denials and to evaluate the effectiveness of the new processes. •Implemented a continuous feedback system where staff could report challenges and share best practices to further refine the process

Coordination of Benefits Denial Scenario

Problem:

- A significant portion of claims were being denied due to Coordination of Benefits (COB) errors. Errors included misidentifying the primary versus secondary insurer, incomplete insurance information, and inconsistencies between patient registration records and claim submissions.

Root Cause Identified:

- Registration Inefficiencies: Patient registration was inconsistent, and crucial details regarding multiple insurances were often missing or inaccurately recorded.
- Lack of Verification: There was no formalized process to verify primary and secondary insurance details at check-in.
- Communication Breakdown: Limited coordination existed between the registration staff, billing department, and the insurance-verification team, leading to a high rate of miscommunication on payer responsibilities.

Actions Taken

Comprehensive Analysis and Audit

- Conducted an in-depth review of denied claims to pinpoint common COB-related errors.
- Identified that most errors stemmed from incomplete patient forms and misinterpretation of which insurer should be billed first.

Standardization and Staff Training

- Redesigned registration forms to mandate accurate entry of all insurance details, including the identification of primary and secondary payers.
- Organized targeted training for registration and billing staff to emphasize the importance of verifying COB information. Training included refresher courses on payer-specific guidelines and best practices.

Technology Integration

- Upgraded the electronic health record (EHR) system to include automated alerts and cross-checks for patients with dual coverage.
- Implemented a real-time eligibility verification tool that flagged potential discrepancies between patient registration data and insurer records.

Regular Communication and Quality Assurance

- Held regular meetings involving registration, billing, and compliance teams to discuss recurring COB issues and refine processes.
- Established periodic COB-specific audits and feedback loops to continuously monitor and address errors before final claim submission

Thank You

Questions

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