Common Reasons for Claim Denials and Ways to Avoid Them

The lifeblood of any thriving medical practice is a steady cash flow. It is, therefore, of upmost importance to recognize trends in payer denials as they can directly and significantly impact your bottom line. Getting reimbursed for the services you provide *should* be straightforward: provide a service, submit a claim and receive payment. While it sounds simple enough, much can go wrong. Mistakes can be as simple as coding and data entry errors or as complex as coding edits made by your payers. For many practices, maintaining an acceptable revenue level while minimizing denials remains a struggle. This article will help you to understand the most common reasons that claims are denied and to avoid denials in the future.

According to the American Academy of Family Physicians (AAFP), the average practice has a claim denial rate between five and 10 percent, with rates less than five percent indicative of the most efficient revenue cycles. More alarming, is that as many as 50 to 65 percent of denials are never re-worked.

The costs and administrative burden associated with correcting denied claims can be substantial. A study by the Medical Group Management Association (MGMA) found that the cost to rework a denied claim is approximately $25, depending on the volume and provider specialty. For many practices, costs can edge even higher. A 2014 survey by RACmonitor, a website detailing information on third-party contract auditors, found that more than half of respondents had denials-resolution expenses at $30 per claim, while 38 percent experienced costs of $40 or more per claim. If a practice has 30 denied claims per month, the annual cost to rework may quickly surpass $9,000.

It is important to consider the impact of these expenses on a practice's cash flow. When a claim is denied, the only money associated with that claim coming comes from patient co-payments or from patient's paying out-of-pocket. Since most of a practice's gross income is generated from billing commercial and governmental payers – about 94 percent according to a recent MGMA Cost Survey – the result of correcting denied claims can be detrimental. An average practice could easily lose as much as $20,000 annually in revenue in addition to staffing expenses associated with achieving the resolution.

Failure to properly address denials can lead to additional unintended consequences, such as worsening relationships with patients. For example, patients do not like receiving bills months past their visit. A 2015 study by NextGen Healthcare found that billing issues accounted for 35 percent of incoming patient calls. Such calls often place an even greater burden on staff and negatively impact the patient-provider relationship if billing concerns aren't handled to patient's satisfaction.

Excessive denials can lead to strained payer relations as well. Practices may blame payers for billing issues and the resulting loss of revenue, thereby causing unnecessary friction when attempts to dispute or appeal claims are made. Even worse, without intervention, staff may repeatedly make the same billing mistakes, creating a cycle of higher denials, lower revenues and more precarious relations with both patients and payers.

Avoiding claims denials should be the responsibility of everyone in the practice: The scheduler must collect accurate demographic and insurance information; Registration must verify the patient's information; Nurses must accurately enter the patient's medical data in the electronic health record; Clinical or support staff must note potentially non-covered services and obtain advance beneficiary notices from Medicare patients and non-covered services notices from commercial health plan

enrollees; Physicians must ensure their documentation reflects services performed; Coding and billing staff must translate documentation into diagnosis codes, procedure codes, modifiers and other claims data; and the billing office must submit claims in a timely manner and interpret remittance advices for appropriate and efficient correction of any issues. For a more in-depth discussion of the roles of each of these positions, review chapter 2 of *Strategies for Coding, Billing and Getting Paid Appropriately*.

For practices seeking to minimize payer denials and boost their bottom lines, implementing staff training and expanded use of third-party technology can offer a viable solution. First, though, practices must fully understand *why* their claims are being denied.

Why are your claims being denied?

While denial rates can vary between practices and specialty types, the most common reasons for denial can be grouped into ten areas:

1. **Exceeding timely filing limits.** When practices do not submit the initial claim, corrected claim or appeal within a specific timeframe, a timely filing denial can result. Filing deadlines often range from 90 days to one year from the date of service, but can also be as short as 15-30 days for some HMO plans. Failing to submit a claim within the required period, forces your practice to write off those charges as patients generally cannot be billed once a practice has missed the payer submission deadline.

   This should be one of the easiest denials to avoid. However, with so many payers and their differing timelines, it can be easy to miss a deadline. According to *Medical Economics'* 2017 Payer Scorecard survey, the average practice is contracted with 13 payers and nearly 25 percent of practices are contracted with more than 20 payers. To avoid these unnecessary denials, it is crucial to create a list of each payer's filing deadlines that can be used for frequent reference.

   Practices miss filing deadlines for a number of reasons. Superbill (the itemized form used by healthcare providers for reflecting rendered services, for example, may get lost in a practice's workflow and therefore may never be entered or submitted by the billing office. Practices can prevent these denials by using their practice management system to produce a missing ticket or missing bill report to identify scheduled appointments for which no corresponding charges or claims have been entered. With this report, a practice can identify claims that have not been transmitted to the billing office for coding and charge entry. When a missing superbill is identified early, the provider or staff can complete it more easily based on memory and a quick review of the medical record, allowing charges to be submitted in a timely manner. If an automated report is not available, a practice could manually compare providers' schedules to patient accounts to verify that charges have been entered for all visits. Practices should perform this process regularly, enough to identify unbilled claims under the practice's shortest filing deadline.

   Denials can also occur when a patient's insurance coverage or coordination of benefits changes and/or when patients do not have a valid referral. In cases like these, if the changes are not caught in time, the practice will need to pursue and bill the patient's current insurance—a much longer process, especially when responses are slow.

Practices may also run into timely filing issues when they neglect to verify coverage prior to submission, and as a result, incorrectly file with the wrong primary payer. Patients often change insurance providers and forget to tell the practice of their new coverage. It is often only after the denial that the practice realizes the coverage has been terminated and then must contact the patient for the new insurance. It is imperative that the practice have a policy of verifying insurance coverage each time the patient comes into the office. Staff must be held accountable for enforcing this policy.

Corrected claims may be denied for exceeding filing periods even if the original submission was timely. For example, when errors are identified in a claim submitted through a provider's clearinghouse, they are sent back to the provider to be corrected. If the corrected claim is not submitted promptly, it may be denied for exceeding timely filing limitations. It is important that the billing office review their claims submission reports from the practice management system and/or clearinghouse *daily* and make any corrections needed to ensure that the claim is re-submitted and accepted by the health insurance plan. If denials aren't reviewed regularly and resubmitted prior to the filing deadline, the practice may have to write off the remaining balance.

Before writing off charges for a claim denied due to missing a filing deadline, the provider should first review the account to determine if a claim was submitted in a timely manner and, if so, provide the payer with proof. Supporting evidence may include the practice management system's report showing the claim submission date, the clearinghouse's acknowledgment of receipt and submission to the payer or the payer's own acknowledgement of receipt of the original claim.

2. **Inaccurate claim information.** Payers may also deny claims when the information provided, especially demographic data, does not match their records or is otherwise deemed inaccurate. A 2015 Revenue cycle Benchmarking Survey by The Advisory Board, a global health care research and consulting firm, found that 61 percent of initial claim denials and 42 percent of denial write-offs are due to missing or incorrect demographic information or technical errors.

   Demographic discrepancies can occur at any point while filing a claim, as the patient's personal health information passes through the hands of several practice employees. Front-desk staff, for example, may enter a patient's name or date of birth incorrectly. Entering a shortened first name as opposed to the legal name on file with the payer or transposing a few digits in the date of birth may cause the claim to be denied. Manually entering the information can create errors if letters or numbers are transposed, so practices should train employees on techniques for careful data entry, such as improving their typing skills, managing distractions and double checking the data.

   There may also be technological methods for reducing insurance ID denials. For example, if a particular payer consistently uses three alpha characters to begin a subscriber identification number, as Blue Cross and/or Blue Shield plans tend to do, check with your practice management system vendor to see whether the system is capable of generating alerts when the user enters a number, rather than a letter, in the first three characters of the patient's subscriber ID field. Similar methods could be implemented to alert users when too few or too

many digits have been entered. A report that lists subscriber IDs by payer can potentially identify patterns that could influence how alerts are designed.

Lastly, denials due to inaccurate information can occur when the Healthcare Common Procedure Coding System (HCPCS) codes are missing or invalid. Since each payer may have specific rules surrounding HCPCS billing, it is important for practices to know how the requirements may vary to avoid those denials.

3. **Lack of Specificity.** This payer denial can occur when practices fail to code to the highest level of specificity. The transition to ICD-10 has resulted in a massive expansion of available procedure and diagnosis codes. A code may require up to seven characters as well as the inclusion of both alpha and numeric placeholders, which can increase the potential for coding errors.

   With the advent of ICD-10-CM, physicians are required to specify the diagnosis to the highest level possible regardless of whether the chart or superbill accurately reflects such specificity. If billers and office staff do not take the time to do this research the claim may be denied. Failure to include other required claim information, such as the incident date related to an injury or accident, can prompt similar denials.

4. **Non-covered services.** Depending on the patient's insurance plan, there may be restrictions on the types of procedures or treatments that can be covered. Services such as fertility treatments and cosmetic procedures are frequently non-covered services. Other services or treatments may be covered, but are either limited in scope or can only be provided a specific number of times such as "annual" services/exams/screenings.

   A service may not be considered medically necessary according to payer policy if the diagnosis submitted on the claim for that service indicates a non-covered service. Even if the provider's documentation indicates that the patient received a covered service, if the proper diagnosis was not communicated to the coding and billing staff on the charge ticket the code used may be denied for providing a non-covered service. Coders and billers should become familiar with the services their providers render and the common diagnoses associated with those services. When charge tickets or superbills list services without one of the expected diagnoses, the coding and billing staff should pull the provider's documentation or ask the nursing staff to investigate whether a different diagnosis should be used.

   Lab studies are a common source of non-covered service denials. Patients presenting for wellness exams or for periodic follow-up on their chronic conditions may, for example, have a few labs drawn during their visit. It is critical for providers and billing staff to then differentiate screening studies from lab tests performed to monitor known conditions. Screening studies should be billed with the appropriate CPT code linked to a "Z" diagnosis code to let the payer know that the service was a screening service.

   To manage non-covered services under Medicare, a practice's staff must anticipate the need for an Advance Beneficiary Notice (ABN), which explains the practice's expectations that Medicare will deny payment and informs the patient of his or her potential financial responsibility. In addition, billing staff must know when a ABN form has been issued and communicate this fact on the claim form with an appropriate modifier such as GA, for a required ABN, or GX for a

voluntary ABN. Commercial health plans often require a similar notice of nonpayment for the patient to be billed directly for those services.

5. **Bundled services.** In certain instances, a service should not be separately reported when the work has already been captured as part of another service being billed. For example, many payers consider pulse oximetry, which has its own CPT code, to be part of the evaluation and management (E/M) services represented by an office visit code and therefore will not pay for it separately. The denial would likely state that pulse oximetry is bundled in the office visit code.

   Similarly, an E/M service performed on the same day as a procedure will likely be denied and bundled into the procedure code unless an appropriate modifier (i.e., modifier 25) has been added to the E/M service to indicate that the service is **significant enough** to warrant separate payment. Billing staff should be familiar with these bundling policies.

   Correct coding initiative edits are another common source of bundling denials. Each quarter, Medicare publishes pairs of codes that generally should not be billed together because they are mutually exclusive or because one is more comprehensive than the other. Billing staff must understand these edits to properly assign codes for services and avoid overbilling.

6. **Incorrect use of modifiers.** Two of the most common modifiers are 25 and 59. Modifier 25 represents a significant, separately identifiable E/M service provided on the same day as another procedure or service and can only be attached to codes found within the E/M section of the CPT book. Modifier 59 indicates that a procedure or service is distinct from another procedure or service either because it occurred during a separate encounter, was performed on a separate organ/structure, was performed by a different provider or does not overlap usual components of the main service. There was so much confusion around the 59 modifier that in 2015 Medicare established four new HPCPCS modifiers to define subsets of 59. For more information on the use of these modifiers from Medicare, ensure you or your staff review a recent presentation from Noridian Healthcare Solutions.

   When modifiers are used incorrectly, the services to which these modifiers are appended will be denied. Practices can help prevent these denials by ensuring their coding and billing staff are educated on the appropriate uses of common modifiers. Practice management systems may also be able to assist in reducing these denials by establishing error alerts when codes have been used incorrectly. For example, a practice may design an alert that will warn the coder when modifier 25 has been incorrectly added to a code between the 10000 and 69999 procedure codes.

7. **Data discrepancies.** Inconsistency in data submitted on a claim will result in denial of services. Examples include a diagnosis specific to female conditions used on a male patient, or a service for a child billed for an adult patient (e.g., well exams). These types of denials are frequently the result of transposed numbers or data entry errors.

   To prevent this, practice management systems may have the ability to issue alerts to warn data entry staff when a discrepancy has occurred. A practice, for example, may define diagnosis codes related to pregnancy and childbirth as female-only codes. If a diagnosis related to

pregnancy or childbirth is entered for a male patient, the coder will see an error alert and the claim will not be submitted until the issue is corrected.

8. **Illegible claims.** Payers may receive claims that are illegible and, therefore, are unable to be processed without submission of a corrected claim.

   Manual claim forms that are handwritten or printed on an inkjet printer can be smudged. Printed claims can also be illegible should the printer run out of ink or toner, leading to incomplete characters or blank fields on the form.

   Every practice should be submitting claims electronically to avoid these situations. Many commercial payers allow claims to be submitted online and this should be considered if your practice does not submit claims electronically.

9. **Selecting wrong procedure codes.** With more than 75,000 CPT codes, plus Level II HCPCS codes, it is easy to select an incorrect procedure code. Incomplete or inaccurate code descriptions on encounter forms, cheat sheets and electronic charge systems are a significant source of error. Failing to ready the editorial comments at the start of the section of the CPT book or the notes near the code is another source for this type of error.

10. **Failing to link diagnosis codes.** A CPT or HCPCS code tells the payer what service was performed. The diagnosis code tells the payer the reason for the service. Some patients present for more than one condition and may require unrelated services. Other patients may receive a service that is only covered for a specific indication. For example, a patient presents to a family physician for hypertension, but has a wart destroyed at the same visit. The code for the office visit must be linked to hypertension, and the code for the wart destruction must be linked to the diagnosis code for warts.

Avoid Common Denials Through Staff Training

A practice's efforts to reduce denials should begin with an understanding of its greatest source of denials. To identify the source, run reports of denials for a period, such as a week or a month. The reports should display denial reasons, procedure codes reported, modifiers, diagnosis codes and payers. You can then sort the report by each of these fields to determine where your practice can achieve the greatest improvements either by focusing on a particular payer, a particular service or a particular coding issue.

The next steps are to provide staff members with education, implement practice management alerts and put other corrective measures into place. When denials do happen, each staff member must know how to respond. While simple demographic errors may be handled by the front desk, other issues may require specific expertise. A "medical necessity" issue may need to involve the provider to assist with the appeal. The revenue cycle really depends on the entire team.

To ensure staff is clear on the claim filing process, a standardized billing and coding policy should be created. To keep up with payer changes, practices should be encouraged to review the policy regularly and update both the policy and staff as needed.

. *Mary Jean Sage is the Founding Principal and Senior Consultant of The Sage Associates. She has extensive experience as a health care management specialist and is a coding and practice management consultant.*