NIP IT IN THE BUD!

How to Prevent Common Claim Denials

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Key Topics

- Why is this important?
- Strategies for preventing denials
  - Getting everyone involved
  - Policies and procedures
  - QC reports
- Common denial reasons
  - Medicaid
  - IPRS
The Time Value of Money

- A dollar today is worth more than a dollar a year from now
- At 5% inflation, $100,000 will be worth $95,000 in 365 days
- Maximize your purchasing power!!!
Every economic decision has a cost
The decision to worry about claim denials after they happen costs you the opportunity to maximize your purchasing power
Opportunity Costs

- Inefficient use of staff time
- Inefficient use of computer resources
- Inefficient use of credit lines to cover expected revenue
- Payroll issues
- Delay of capital purchases
- Cost of aspirin to get rid of headaches!
Don’t Do This to Your AR Staff!
Successful Billing is a Team Effort

- Intake Staff
- Authorization Staff
- Clinical Staff
- Quality Improvement Staff
- Information Technology Staff
- Human Resources Staff
- Billing Staff
Billing Begins at the Front Door

- Front Desk staff and Intake staff are among the most important people in your organization
  - Determine the consumer’s funding source
  - Get the consumer’s policy number
  - Get a copy of the Medicaid, Medicare or Insurance Card
  - Determine if authorizations are necessary
  - Get the consumer’s CORRECT address and birth date
Front Desk staff and Intake staff are among the most important people in your organization

- Pay them accordingly
- Make sure they understand their responsibilities
- Hold them accountable
- Reward them for good work
Clinician Involvement is Critical

- Clinicians MUST understand the importance of bringing in revenue
  - Without revenue you can not stay in business and serve consumers
  - Case Managers play a key role in maintaining valid billing information on consumers
    - Medicaid eligibility
    - Health Choice eligibility
    - IPRS target populations
Clinician Involvement is Critical

- Clinicians MUST understand the importance of bringing in revenue
  - Timely and appropriate diagnosing is critical to successful billing
  - Understand that rendering a service without a required authorization means that you will not be paid
  - We are all in this business to serve the consumers, but without the business side, the clinical side cannot exist
How Does HR Impact Billing?

- Somebody has to track and coordinate key billing identifiers for clinicians
  - NPI Numbers
  - Taxonomy – or Specialty – Codes
  - Medicaid and Medicare Provider ID’s
  - Insurance Panels
  - NPI numbers must be mapped to Provider ID’s in State and Federal NPI databases
How Can QI Staff Help?

- Quality Improvement Does Not Just Apply to Clinical Business
  - Along with Finance Staff, review payment and denial trends
  - Develop WRITTEN policy and procedures for Intake, Authorizations, Diagnosing, NPI coordination
  - Develop measurable standards for key roles that impact billing
InfoTech Can Play a Big Role

Using a computer based Billing System can pay huge dividends

- You own your own data!
- Consistency in recording data
- Completeness in recording data
- Prevents duplicates
- Built-in edits can prevent denials
- Built-in authorization tracking
- “Connect” billing to clinical records
InfoTech Can Play a Big Role

- Electronic claims can make life easier
  - HIPAA compliant 837 files (electronic claim files) can be sent directly to the EDS server. No need to key into ECS!
  - EDS can provide a HIPAA compliant 835 file (electronic RA) that can be AUTOPOSTED in your billing system
  - Electronic systems can produce detailed denial reports and aging reports
InfoTech Can Play a Big Role

- Using a computer based Billing System can pay huge dividends
  - Trend analysis of payments and denials
    - By facility or clinician
    - By diagnosis range
    - By service
  - Quality Control reports
    - Missing or invalid data elements
    - Missing, depleted, or expired authorizations
InfoTech Can Play a Big Role

What kinds of systems are available?

- Simple desktop “Billing Only” systems, such as EZ Claim
- Web based systems that offer free software but charge to handle your billing, such as Alpha CM
- Web based systems that charge a monthly fee per user, such as Share Notes
- Server based practice management system, such as NetSmart or EchoData
Be Good to Your Billing Staff

- Empower your AR staff
  - When an AR staff member contacts a clinician for critical billing information, they should be taken seriously and answered in a timely manner
  - Listen to your AR staff. They can point out key problem areas.
  - AR Staff CAN NOT bring in revenue by themselves.
The Bottom Line

If...
- A funding source eligibility problem, or
- An authorization problem, or
- A diagnosis problem

Makes it to the point of billing...

IT IS PROBABLY TOO LATE TO DO ANYTHING ABOUT IT!
Common Claim Denial Issues

- Getting the consumer “connected” to the correct funding source
- Making sure the service and the diagnosis are appropriate for the consumer
- Making sure the appropriate authorizations are in place
- Making sure the appropriate staff render the service
- Dealing with duplicates
Funding Source Eligibility Denials

- Denial Reasons:
  - Client is not eligible on the date of service (835 code 177, N30)
  - Client has not met the eligibility requirements (RA code 11)

- Causes:
  - Consumer does not have the coverage you thought they had!
  - Consumer’s coverage has lapsed
Concerns:

- Slim chance of getting paid!
- If the consumer had other coverage that required an authorization, it is probably too late to get the authorization
- If the consumer had been eligible for IPRS coverage, it might be difficult to get retro enrollment into a target population and retro LME authorizations
Concerns:

- This is a claim header error, so all associated claim details will be denied
- If the problem is not caught and corrected, the dollars denied can be quite significant
Funding Source Eligibility Denials

- **Solutions:**
  - You must have a policy and procedure that identifies the consumer’s coverage or lack of coverage at **INTAKE**
  - If a consumer has no coverage, work with the LME to get the consumer into an IPRS target population
  - You must have a policy and procedure that periodically confirms the consumer’s coverage. Get Case Managers involved!
Funding Source Eligibility Denials

Solutions

- Use Medicaid’s toll free number to verify the consumer’s coverage
- Use Blue E to verify coverage
- Use a service such as Emdeon to check consumer coverages in batch
- Systematically check small batches of consumer coverages on a rotating basis, such as 25 different consumers per week
Funding Source Eligibility Denials

Solutions:

- If possible, use HIPAA compliant electronic files to check eligibility
  - HIPAA 270 file – Electronic request for eligibility verification
  - HIPAA 271 file – Electronic response for eligibility verification
- More and more software companies are beginning to use these files
Funding Source Eligibility Denials

**Solutions:**

- Educate your staff that identifying and maintaining coverage on consumers is absolutely critical to the success and survival of your organization
  - Administrative staff
  - Clinical staff
- Monitor your organization’s success and your staff’s success in identifying and maintaining consumer coverage. Make this an outcome measure
Incorrect Policy Number Denials

Denials:
- Patient can not be identified as our insured (835 code 31)
- Medicaid ID number is not on the State eligibility file (RA code 143)

Causes:
- Data entry errors
- Transposed numbers!
- Policy number formatting issues
Concerns:

- This is a claim header error, so all associated claim details will be denied
- If the problem is not caught and corrected, the dollars denied can be quite significant
Correct Policy Number Denials

Solutions:

- Make a copy of the consumer’s Medicaid, Medicare, or insurance card and put it in a designated place in the client record.
- You must have a policy and procedure to check and double check that the correct policy id number has been entered into your records.
- You must have a policy and procedure to periodically verify the consumer’s policy number.
Incorrect Policy Number Denials

Solutions

- Monitor your organization’s success and your staff’s success in verifying and periodically double checking the consumer’s policy number.
- Make this an regular outcome measure.
- Consider making this a specific performance measure for appropriate staff members.
Incorrect Name Denials

**Denials:**
- Patient health ID and name do not match (835 code 140)
- Medicaid ID does not match patient name (RA code 191)

**Causes:**
- Use of nicknames, initials, or middle names
- Last name changes (marriage or adoption)
- Data entry errors, misspelled names!!!
Incorrect Name Denials

Concerns:
- This is a claim header error, so all associated claim details will be denied
- If the problem is not caught and corrected, the dollars denied can be quite significant
Incorrect Name Denials

**Solutions:**

- Make a copy of the consumer’s Medicaid, Medicare, or insurance card and put it in a designated place in the client record.
- You must have a policy and procedure to check and double check that the correct name spelling has been entered into your records.
- You must have a policy and procedure to periodically verify the consumer’s name spelling.
Incorrect Name Denials

Solutions

- Develop a policy regarding the use of nicknames and initials
- Monitor your organization’s success and your staff’s success in verifying and periodically double checking the consumers name spelling. Make this an outcome measure. Consider making this a specific performance measure for appropriate staff members.
Diagnosis/Condition Related Denials

Denials:
- Missing/incomplete/invalid diagnosis or condition (835 code 125, M76 or 146, M76)
- Diagnosis code missing or invalid (RA code 27)

Causes:
- Primary diagnosis has not been entered into the client record
- Diagnosis has incorrect number of digits
- Data entry errors
Diagnosis/Condition Related Denials

Denials:
- Missing/incomplete/invalid procedure code (835 code 125, M76, MA66)
- Diagnosis or service invalid for recipient age, MID, diagnosis, procedure code, or modifier (RA code 10)

Causes:
- The procedure or modifier is not appropriate for the consumer’s age (HA vs. HB!)
- The diagnosis is inappropriate for the age
Diagnosis/Condition Related Denials

Denials:
- The diagnosis is inconsistent with the procedure (835 code 11)
- Service is not consistent with or not covered by this diagnosis (RA code 82)

Causes:
- The payer simply does not cover the service under the diagnosis entered
- Dually diagnosed consumers
- “V” codes and “not otherwise specified” diagnosis codes
Concerns:

- In many cases, these are claim header errors, so all associated claim details will be denied.
- If the problem is not caught and corrected, the dollars denied can be quite significant.
Diagnosis/Condition Related Denials

Solutions:
- Diagnosing consumers is not an administrative function; clinicians must take responsibility
- Educate clinical staff about the direct connection between diagnoses and dollars
  - Make training part of new staff orientation
  - Offer/require periodic diagnosis classes
  - Hold staff accountable
Solutions:

- If you have dually diagnosed consumers, make sure the appropriate diagnosis is attached to the service
- If you have practice management software or a billing software, try to build in edits that will identify inappropriate diagnoses and modifiers
- Develop policies and procedures to ensure that presenting diagnoses, V codes, NOS diagnoses are updated to billable codes
Diagnosis/Condition Related Denials

Solutions:

- Make sure that data entry staff understand the importance of using the correct number of digits per diagnosis; provide staff an “official” list
- Make sure that clinical staff and data entry staff understand the appropriate use of modifiers, particularly HA and HB
- Include appropriate diagnosing/successful revenue generation in your outcome measures
Authorization Denials

Denials:
- Claim information is inconsistent with pre-certification/authorized services (835 code 198, N54)
- Service requires prior approval (RA code 23)

Causes:
- You did not get an authorization!
- Authorization has expired or units are depleted
Authorization Denials

**Concerns:**
- Without authorizations, it is very difficult to get paid
- Retro-authorizations are practically impossible to get
- Small time gaps between authorizations and re-authorizations can add up to significant dollars
- Small delays between initial service delivery and initial authorizations can add up to significant dollars
Authorization Denials

Solutions:

- Dedicate administrative staff to track and help clinicians secure authorizations.
- Educate staff – particularly clinicians – on the connection between authorizations and dollars.
- Develop policies and procedures to ensure that initial authorizations and re-authorizations are secured in a timely manner.
Solutions:

- Do not rely too heavily on un-managed units; consider getting authorizations from unit number one.
- Develop QC reports or “tickler” files to help you know when authorizations are running out of units or nearing their expiration dates.
- Include authorization/revenue success in your outcome measures; consider including such measures in your annual staff reviews.
Proc Code Service Date Issues

- **Denials:**
  - Procedure Code or procedure /modifier code combination is not covered for the date of service (RA Code 537)
  - Payment adjusted because this procedure code was invalid on the date of service (835 Code 181)

- **Causes:**
  - Procedure codes have been eliminated or changed
  - Modifiers have been added or changed
  - Procedure code entry errors
Proc Code Service Date Issues

- **Concerns:**
  - Never will get paid on this one!

- **Solutions:**
  - Make sure your staff members are aware of procedure code changes and their effective dates.
  - Computerized billing system generally have effective dates attached to procedure codes, so the system would prevent invalid procedure code/date of service combinations.
MQB Denials

Denials:
- Patient is a Medicaid/Qualified Medicare Beneficiary (835 code 109, N192)
- Individual has restricted coverage – Medicaid only covers Medicare B premium (RA code 953)

Cause:
- The consumer has a special type of Medicaid called “Medicaid for Qualified Beneficiaries” (MQB).
MQB Denials

**Concerns:**
- MQB Medicaid will not pay for services; it will only pay the consumer’s Medicare B premiums

**Solutions:**
- Look carefully at the consumer’s Medicaid card to identify the consumer’s Medicaid type
- If possible, bill Medicare B
Denials

- Missing/incomplete/invalid attending provider identifier (835 code 125, MA130, N272)
- Attending provider id is required (RA code 8326)
- Attending provider id is invalid (RA code 8327)
- Attending provider not eligible on date of service (RA code 8328)
Provider ID/Provider Type Denials

Causes:

- Inappropriate use of the generic “enhanced service” provider id’s
- When reporting outpatient services, the clinician’s individual provider number was not included on the claim
- The individual clinician identifier is not mapped to the appropriate group provider number
- NPI issues
Concerns:

- The attending provider must be appropriately identified or your claim will not be paid.
- The HIPAA guidelines for electronic claims (837) are very specific about how billing providers and attending providers must be named and identified.
Provider ID/Provider Type Denials

Solutions:

- Educate your staff – administrative and clinical – about the differences between billing “enhanced services” and outpatient services
- Make sure that clinicians who deliver outpatient services have an attending provider number before they begin delivering services
Provider ID/Provider Type Denials

Solutions:

- Make sure your licensed clinicians are mapped to the appropriate group number.
- Make sure that your facilities and clinicians have NPI numbers and appropriate taxonomy (specialty) codes.
- Consider having designated staff responsible for securing provider id’s, NPI numbers, and taxonomy codes (HR?)
Duplicate Denials

Denials:
- Service denied because payment already made for similar procedure within time frame (835 code 18, M86)
- Duplicate of claim system (RA code 22)

Causes:
- True duplicates – data entry errors
- Services delivered to the same consumer on the same day by the same clinician were not bundled into a single claim detail
**Duplicate Denials**

**Concerns:**

- If you have a lot of true duplicates, staff time is being wasted on non-revenue producing activities.
- If you have non-bundled service details, you must pay back the paid amount and then bill the complete bundled claim; or if you have the ability, you may file an electronic (837) replacement claim. In either case, it is tedious and time consuming.
Duplicate Denials

**Solutions:**

- Develop a system for “checking off” entered claims
- Develop QC reports to identify duplicates before billing occurs
- Make sure that staff members turn in or enter service data in a timely manner so that same day services can be bundled in the same bill batch
IPRS Specific Denials

**Denials:**
- Target population does not cover service

**Causes:**
- IPRS target populations cover specific services and specific diagnoses
- Initially consumers might be placed into an “assertive outreach” population for assessment, but if the consumer begins to receive treatment, the target population must be upgraded to a “treatment” target population
IPRS Specific Denials

Concerns:
- If a service is provided outside of the target population benefit plan, then you will not get paid

Solutions:
- Educate staff about IPRS target populations and the services and diagnoses covered by each one
- Educate staff about Assertive Outreach versus Treatment Target Populations
- Make sure the consumer’s target population is current and valid
- Some computer systems can verify covered services and diagnoses by benefit plans
IPRS Specific Denials

Denials:
- Charges Exceed Provider Agreement Limit

Causes:
- Your LME contract for this population and/or service has run out of money
- IPRS money is limited and often runs out before year end
IPRS Specific Denials

Concerns:
- Need to get paid, but also want to ensure continuity of care

Solutions:
- Track your IPRS service delivery and contract dollars. When you get close to earning your contract dollars, ask the LME for a contract amendment.
- Use data to justify request for higher contract dollars next year
Summary

- Get everyone involved
- Educate, educate, educate!
- Develop written policies and procedures
- Consider using a computerized practice management system
- Build a database to analyze your denials
- Develop QC reports and tickler files
- Make successful revenue generation part of your outcome measures
- Hold staff accountable
CELEBRATE YOUR SUCCESS AND ACKNOWLEDGE GOOD WORK!!!
Resources

- [www.wpc-edi.com](http://www.wpc-edi.com) for detailed definitions of HIPAA compliant denial codes
- [www.dhhs.state.nc.us/mhddssas/iprsmenu/index.htm](http://www.dhhs.state.nc.us/mhddssas/iprsmenu/index.htm) for information on IPRS covered services and diagnoses
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