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!!!

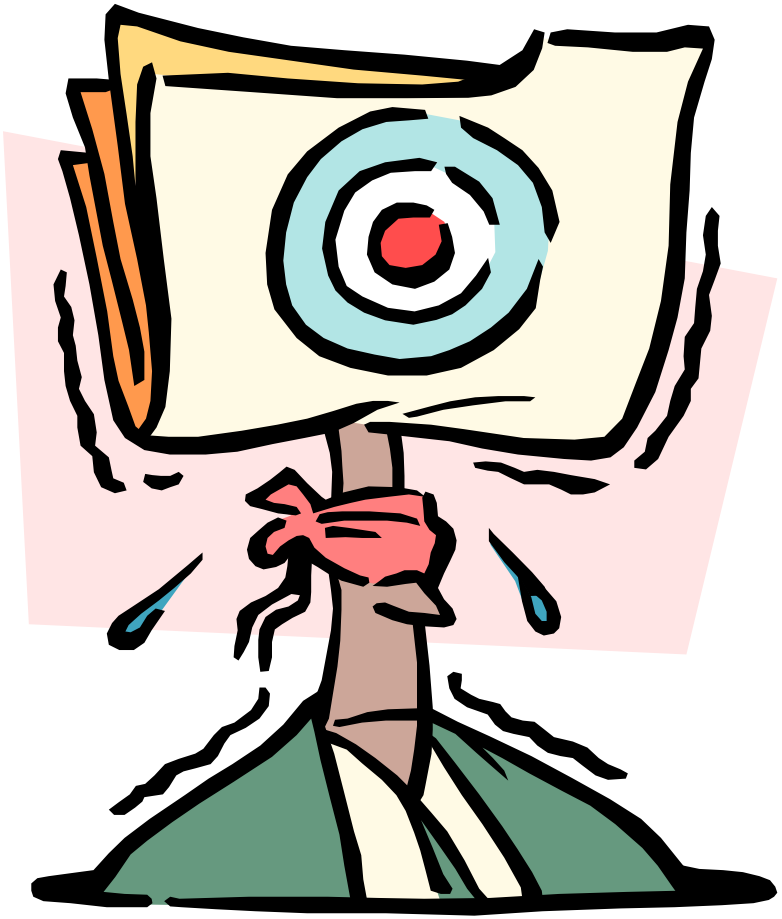
Opportunity Costs

- 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

Billing Begins at the Front Door

- 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 can not 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

Funding Source Eligibility Denials

- 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

Funding Source Eligibility 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

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

Incorrect Policy Number 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 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

Diagnosis/Condition Related Denials

- 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

Diagnosis/Condition Related Denials

- 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

Authorization Denials

- 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

Provider ID/Provider Type Denials

- 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

Provider ID/Provider Type Denials

- 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

Summary

- CELEBRATE YOUR SUCCESS AND ACKNOWLEDGE GOOD WORK!!!

Resources

- www.wpc-edi.com for detailed definitions of HIPAA compliant denial codes
- www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm for information on IPRS covered services and diagnoses
- vjoyce@e3informatics.com if I may be of any assistance
- Vince Joyce, E3 Informatics LLC

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