REVENUE CYCLE MANAGEMENT Q&A

# Optimize Revenue with Improved Claims Denials Management

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No matter how diligent your billing staff is about billing charges out correctly, it is inevitable that you will receive claim denials from payers, whether they are justified or not. A claim denial means that no payment is being received for the service, and unless you have someone (or technology) analyze the denial to determine if the denial is appropriate or not, you will not receive payment for the service(s) rendered .

Denials come in different forms and can typically be classified into one of the following types and examples:

- Demographic denials
  - Incorrect member information including identification number, date of birth, participant name, guarantor information
- Coding denials
  - Diagnosis inconsistent with patient's age or sex, date inconsistencies, unbundling
- Benefit denials
  - Insurance ineligibility, preauthorization not performed, noncovered services, lack of medical necessity
- Backend billing denials
  - Duplicate claims, timely filing, failure to send requested documentation, credentialing

If you have someone analyze the denial, are you pulling resources from a billing team whose main purpose is to bill out new claims, or do you have someone who is dedicated to working the denials? Technology can also help automate root cause analysis and resolution workflow. All of these options are better than just billing the patient and hoping for the best.

Your first line of defense, obviously, is making sure your front desk staff is collecting the correct insurance data and verifying coverage. This is especially important in the Medicare and Medicaid population for managed care plans. That also includes understanding any payers that require preauthorization for the patient to be seen in your clinic. Getting the correct insurance information up front will help prevent denials for ineligibility or incorrect member/participant information; these are avoidable denials when the information is input correctly the first time.

Do you have a policy in place for Medicare patients and when Advance Beneficiary Notices (ABNs) are necessary? Having an ABN in place when services are not covered allows you to collect the payment from the patient since Medicare will not pay for them.

Questions to ask yourself include:

- Does your staff have a strategy in place to analyze the denials in order to target avoidable issues on future claims? If not, you could be delaying or even missing revenue.
- What are the most common denials your practice receives? A good start in developing a denials management process is understanding what those denials are—possibly for each payer since payers have different rules for filing claims. However, if you are just putting a process in place, you might want to start with a few payers at first to help develop the process. Decide how long you want to track denials, initially (eg, 3 months), to get a baseline ratio of denials to charges. Once you have a baseline, you can devise a plan of action to address the issues in order to prevent future denials.
- You can track denials automatically or manually utilizing the electronic remittance advice (ERA) or the explanation of benefits (EOB). While there are many different software companies that specialize in accounts-receivable management, it could be more cost-effective to work with your practice management system vendor to find out what is already offered that you might not be aware of.

Whatever method you use, make sure you have a solid plan with dedicated people reviewing the data on a regular basis. If a denial is preventable, put policies in place for employees to follow to avoid the denial in the first place.

A denials-management team should have a solid under-

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standing of the most common claim adjustment reason codes (CARC). The CARCs are standardized codes used by all payers and can be found at http://www.x12.org/codes/claim-adjustment-reason-codes/.

Of all of the denial reasons, the worst, and probably the most avoidable, is CARC 29, "the time limit for filing has expired." Billing staff should know what the timely filing limits are for all payers in and out of network, and make sure claims for the payers with the shortest timely filing periods are worked first. (Of course, best practice is to make sure claims for all visits are billed within just a few days of the visit, if not sooner.)

Mismanaging claims denials is not the only way you could be losing out on revenue. Another area you want to review regularly is claims reimbursement, making sure that you are being reimbursed appropriately according to your contracts with payers. Again, having dedicated staff reviewing and analyzing payment data is ideal.

If you do not have a claims denial process or team in place, you are probably missing out on revenue. If you do have a process in place, it might be a good time to review it with several departments to make sure you are covering all areas where denials could be coming from. ■

### How Medicare Explains ABNs to Consumers

It may be helpful to understand how Medicare explains the concept of ABNs to their members. On a member-facing page within the Medicare website, ABNs are explained thusly:

- You may get a written notice called an 'Advance Beneficiary Notice of Noncoverage' (ABN) from your doctor, other healthcare provider, or supplier if both of these apply:
  - You have Original Medicare
  - Your doctor, other healthcare provider, or supplier thinks Medicare probably (or certainly) won't pay for the items or services you got

However, an ABN isn't required for items or services that Medicare never covers. The ABN lists:

- The items or services that Medicare isn't expected to pay for
- An estimate of the costs for the items and services
- The reasons why Medicare may not pay

The ABN gives you information to make an informed choice about whether or not to get items or services, understanding that you may have to accept responsibility for payment."

To read the entire discussion, visit https://www.medicare.gov/claims-appeals/your-medicare-rights/advance-beneficiary-notice-of-noncoverage

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