Tips to Prevent Denied Claims

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Denied claims cost your practice both time and money. Employees spend precious hours researching and processing denials, only to find that payers are unresponsive or unwilling to overturn their decision. Given the complexity of our reimbursement system, denied claims will always exist. However, there are certainly opportunities to reduce their prevalence, thereby decreasing their adverse impact on your practice's bottom line. Here are five strategies to address denial prevention.

1. Get to the root of the problem. Why are services being denied? When you can clearly answer this question, then you can address and – hopefully - fix the issue. To do so, look carefully at the remittance; you'll see a code – or several – that gives you the source of the problem. Be sure to address denials at the line item level, as a single claim may have multiple services – all of which may be denied for different reasons. Gather intelligence about the reason for denial; you might need to hone in on registration or authorization issues, or perhaps there are coding discrepancies. Ultimately, you can't fix the problem until you understand where it begins.

2. Verify insurance and benefits. Regardless of specialty, the majority of denials emanate from registration-related issues. Patients change insurance coverage on a frequent basis and often present with expired insurance. Verify active coverage and benefits eligibility for every patient, including those for whom you've rendered care outside of the office. Make every effort to confirm the patient's insurance prior to submitting the claim, and, ideally, before you've rendered the service.

3. Train, train, train. After you've gained some intelligence about the reasons related to denials, train physicians and advanced practice providers on why claims are being denied and how they can help. Consider choosing a "denial champion" – a provider who can be your partner in performance improvement. Host ongoing training for administrative and business office employees to ensure they are up to date on the latest information and procedures. This is a great chance to review terminology, coding issues, the appeals process, and the importance of preventing denied claims.

4. Create an appeals team. Although some denials can be addressed with a simple correction, many require the surgical precision of an expert. Assign a team to review and handle denials that require appeals; a team approach allows you to leverage the collective skills and expertise of the group. While a business office employee may still be the point person for processing, the team can meet every other week to resolve issues, provide guidance, and track efficacy.

5. Report denials. There's no doubt that denial prevention requires an understanding of the source of your denials. Delve deep, reporting denials by reason, as well as payer, provider, and procedure code. By examining data at this level of detail, you may spot trends such as the consistent denial of payment for a service by a particular payer. This discovery may lead to conferring with patients prior to the service being rendered, if it is considered non-covered or experimental, or addressing it directly with the payer during contract negotiations.

Developing internal expertise to manage denials you commonly receive is vital to the success of your revenue cycle. While many practices seek to resolve denied claims, the true goal should be preventing them entirely.

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The electronic remittance advice (ERA) from a payer includes codes that indicate the reason for a denial or partial payment. These codes are the claim adjustment reason codes (CARCs), which may be accompanied by further detail via remittance advice remark codes (RARCs). Ten common CARCs are listed here:

PR1 Deductible amount

CO11 The diagnosis is inconsistent with the procedure

CO15 The authorization number is missing, invalid, or does not apply to the billed services or provider

CO16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

CO18 Exact duplicate claim/service

CO22 This care may be covered by another payer per coordination of benefits

CO29 The time limit for filing has expired

CO31 Patient cannot be identified as our insured

CO55 Procedure/treatment is deemed experimental/investigational by the payer

PR119 Benefit maximum for this time period or occurrence has been reached

Notes:

PR=patient responsibility

CO=contractual obligation

See this page for a complete listing of the codes
