Practice Management Alert

Claims and Denials: Eliminate These Common Practices to Reduce Denials

Avoid these top problems to get your claims paid.

Many practices have issues getting their claims paid by payers, but, from the payers' perspective, providers may not be dotting the requisite i's or crossing the t's.

Payers aren't seeing much of a learning curve in terms of how providers prepare claims, so the denials keep coming, says **Terry Fletcher, BS, CPC, CCC, CEMC, CCS, CCS-P, CMC, CMCSC, CMCS, ACS-CA, SCP-CA**, owner of Terry Fletcher Consulting Inc. and consultant, auditor, educator, author, and podcaster at Code Cast, in Laguna Niguel, California.

Institute these simple fixes to stop denials and get paid.

Consider how Automation may be Harmful

There's a lot of room for automation in healthcare, but some uses may compound problems and cause more headaches than fixes.

If you are being told by payers that your office is submitting duplicate claims, check your computer system. Some practices set their computer systems to automatically resubmit a claim after a certain period of time if reimbursement has not yet been received, Fletcher says. This causes a few issues: Your office may receive duplicate payment or the payer will mark the claim as a duplicate. This is one situation where it's good to have a human eye keeping track of accounts receivable so someone knows what payments have or have not been received, Fletcher says. Avoid the convenience of automation if you're getting dinged for duplicate denials.

Keep Insurance Records Updated

If your office sees patients routinely, your front-desk staff may take a laissez-faire approach to checking in about insurance. However, a lot of denials can stem from a patient's health coverage ending or changing, Fletcher says. Train your front-desk staff to ask each patient upon check-in about whether they have any address, phone, or insurance changes, she says. It may seem inconvenient, but you can take the verification process a step further by asking to see the patient's insurance card during every check-in.

Know Which Services are Bundled

You may be bungling your claims if you're trying to submit multiple claims for services that are actually bundled. Lab profiles with multiple tests may not qualify for separate reimbursements, Fletcher says, as an example. If a service like a minor procedure includes the procedure itself, as well as preoperative and postoperative visits, payers will pay providers one combined payment, she says.

Whether you're a coder, a biller, or in charge of collecting payments, you should understand your payers' bundling services and keep on top of any changes or expirations, Fletcher says.

Avoid Beneficiary Max-outs

Medicare has a cap for some services, and some private payers do as well. Knowing the policy information and limitations can help you avoid denials for services that simply won't be covered. One common example: There's a

defined window for colonoscopies for high-risk patients, and submitting claims for multiple services within this window may result in denials.

Watch for Paperwork Mistakes

Modifiers are the key to your reimbursement, Fletcher says. "You can really make a huge impact on your reimbursement if you know how to use your modifiers in the healthcare field."

Unsurprisingly, misusing modifiers can have a big impact, too- in a bad way. Knowing how and when to use modifiers for your service claims is crucial.

Attention to detail is also significant in compiling claims. Watch out for any mismatches between the diagnosis provided and the service performed, Fletcher says.

Make sure that patient information is correct - and ensure that you have your most persnickety error-spotting staff looking over information as they enter it into your system. A misspelled name or incorrect birth date can haunt your practice's coffers if your claims are denied for these seemingly minor errors. Focus your attention-to-detail people here, Fletcher says.

Stay on top of Timelines

Another common reason for denials is a lag in when a provider performs a service and when the office submits the claim. If a claim is submitted outside of the window as specified by the contract, then the claim will likely be rejected, Fletcher says. Stay on top of clinicians to make sure that they're including their signatures, authenticating the record, and keeping the paperwork moving so the practice can work toward reimbursement in a timely manner.

Still Stumped? Check These Patient Coverage Issues

Even though a patient's deductible balance won't affect a denial, per se, it's worth mentioning because your office still may not be getting paid. There are different software and websites your practice can use to check these numbers on your end. Also look into whether a patient has dual coverage, she says, and whether the insurance information you have on file is primary or secondary coverage.