Outpatient Facility Coding Alert

Quick-Start Guide To Reducing Denials In Your Outpatient Facility

Use this step-by-step system for how to spot, solve and stop revenue leaks.

In June, Outpatient Coding Alert covered "7 Revenue Busters That Are Destroying Your Facility's Profits." Revenue Buster No. 5 was "no one in the business office is working denials." Of course you'll want to appeal any of the denials you can, but the biggest win is preventing denials in the first place to reduce the costs associated with reworking claims.

If you are an HOPD, consider this eye-opening statistic: it costs hospitals an average of $118 per claim to appeal, according to a recently published analysis from Change Healthcare. Nine percent of hospital claims are initially denied, according to the same Change Healthcare analysis.

Your outpatient facility should aim for a denials rates of less than five percent of claims submitted, said **Maggie Fortin**, citing a Health Care Financial Association benchmark. Fortin, Senior Manager at Baker Newman Noyes, presented at the American Academy of Professional Coders' Healthcon meeting earlier this year.

To prevent denials from happening in the first place, you've got to sift through all the data you have about your denials and do a root cause analysis. "It's not one claim denial" you're looking at," Fortin said. "It's many claims denials for a common reason."

It's especially common for smaller facilities to overlook root cause analysis for denials, Fortin tells Outpatient Coding & Billing Alert. But even smaller facilities can develop systems and processes that help them spot and solve root causes for denials, impacting the bottom line much more than traditional individual account recovery.

To uncover the common reasons for your denial troubles, you've got to be part Nancy Drew, part number cruncher, and part spreadsheet jockey. But hey, you're in health care RCM, so you've **got** this.

Here's the step-by-step process Fortin recommends.

Step #1: Start by downloading Electronic Remittance Advice files your "835s" from your payers. You can translate electronic remittance advice files "into readable formats using software such as Easy Print, PC Print, vendor applications, or home-grown processes," says Fortin.

Resource: To download Medicare Remit Easy Print (MREP) software for free from CMS, go to: https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/MedicareRemitEasyPrint.html. To download free PC Print software from CMS, go here: http://www.edissweb.com/cgp/software/pcprint.html.

Step #2: Look for claim adjustment reason codes (CARCs) to understand why the payer didn't pay your facility as you would have liked.

Resource: For a key to CARCs, go to: http://www.x12.org/codes/claim-adjustment-reason-codes/.

Step #3: Look for remark codes associated with the CARCs. Not all CARCs will have them, but sometimes you'll see them along with CARCs providing additional information about why the claim was denied.

Resource: The key to all the remark codes (updated tri-annually) and is available at: http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/.

Step #4: Look for the group code, which describes who has financial responsibility for the charge that's been denied.

According to CMS, CO (Contractual Obligation) assigns responsibility to the provider, PR (Patient Responsibility) means the patient must pay, for example.

Step #5: Compile your data into a denial trend report that lists reason codes, remark codes, and group codes. Sort your report by reason code so that you can quickly spot denial trends at your facility, Fortin suggests.

Step #6: Once you spot denial patterns, you can find the root cause for why they are happening so that you can educate staff or tweak systems. You'll find your root causes in one or more of the following areas, says Fortin.

- Patient Access and Registration, including Pre-Authorizations
- Clinical Encounter Documentation
- Charge Capture/Entry
- HIM: CPT® and ICD-10 Coding
- Claims Preparation and Submission
- Account Reconciliation and Posting

Once you've uncovered denial trends and root cause in your facility, you can take steps to reverse them. This may involve educating staff, educating clinicians, beefing up your ABN procedures, redesigning workflows, reviewing NCDs and LCDs, or refining your ICD-10 coding to better express medical necessity, according to Fortin.

Common Reasons for Denials in Outpatient Facilities

Fortin outlined some common reasons for denials, where they happen, and how to begin to stop them at your facility.

Claim hasn't identified the correct payer that's liable for the services Worker's comp or Medicare secondary payer, for example.

Look for: Reason code 22.
Look at: Patient Access and Registration.

There is an E/M service reported along with a procedure, but no modifier 25 is reported.

Look for: Reason code 4.
Look at: HIM/coding.

Tip: "Look at the the chargemaster or charge capture processes," suggests **Sarah L. Goodman**, MBA, CHCAF, COC, CCP, FCS. "Sometimes modifiers are hard-coded in the CDM and/or appended/selected by ancillary department staff," Goodman adds.

Claim is missing information for example, an EPO claim might be missing value codes 48 or 49.

Look for: Reason code 16.
Look at: HIM/coding.

You might also check Patient Financial Services, says Goodman.. Sometimes missing codes may originate from incorrect file maintenance.

Claim has been denied because of another service or procedure performed on the same date.

Look for: Reason code 236.
Look at: HIM/coding, NCCI edits.

Diagnosis reported did not meet LCD/NCD guidelines.

Look for: Reason code 50.
Look at: Clinical documentation and/or HIM/coding.

Duplicate billing.

Look for: Reason code 18.
Look at: Patient Financial Services. Billing system may be failing to detect duplicate claims.