Overcoming Code Denials in Healthcare

Denial rates are rising because of numerous factors, including the increasing complexity of coding guidelines, increased workloads and staff shortage, adoption of AI and automation in payor claim reviews, increasingly sophisticated remittance processes, and more. However, taking a more granular review of your claims may help avoid significant revenue hurdles or other more serious headaches, like audits.

Traditionally, providers were not as concerned with the initial diagnosis, as under a fee-for-service model. What was important was getting the CPT accurate for provider billing and the final DRG for facility billing. With the shift to value-based care and risk-based contracts, accurately documenting all diagnoses is critical as capitated payments are based on an accurate picture of the entire patient's health; therefore, capturing everything up front is vital to ensuring maximum reimbursement. Clinical Documentation Integrity (CDI) can help alleviate some of that burden but requires an investment in CDIS resources. The best method is to capture it at the time of service.

Without painting too dramatic a picture, the average cost to rework a claim or appeal a denial averages $25 per claim for practices and a whopping $117 per claim for hospitals. Therefore, failing to properly document, code, and submit a clean claim will impact revenue by either lost revenue for the denied claim or the costs to rework the claims. A couple of dozen dollars is a trifle for a large organization, yet a multitude of such can cascade quickly into substantial loss in revenue and an increase in operational costs to rework claims.

This is why it is crucial to understand the details and risks and determine whether or not you might be well served by developing and following proven strategies for processing encounters, avoiding denials whenever possible, and engaging the services of outsourced claims support should your internal processes be flawed or too much to handle in-house.

However, processing encounters is more than considering best practices and reducing revenue impingements. Factors outside a hospital's realm of influence can compromise patient health and the financial health of the organization serving the patient.

Addressing and Appealing Code Denials

Coding is a responsibility shared by the coder, provider, and CDI specialist to create a clinical picture of a patient encounter, so it's essential to document conditions to the fullest extent possible to demonstrate clinical knowledge of a patient's health. The coder must assign diagnosis codes to be as specific as possible. Billers only detect errors once payers notify them in the form of a denial. However, billers can manage denials by monitoring denial trends and reporting coding issues back to the HIM department.

Understanding the denial trends, they can identify the most common causes for coding-related denials and educate HIM.

There are other factors to consider, including:

Avoid missing information in the claim – Missing information may result in a denied claim, so be sure to include the date of onset, medical emergency, or accident. In addition, scrutinize every claim for missing fields and required documentation. Inaccuracies in patient information can also lead to denials, so ensure the accuracy of a patient's name, date of birth, sex, insurance payer, and policy number.

- **File in a timely manner –** Do not miss the filing window. Some deadlines are as short as 30 days.
- **Eliminate duplicate billing –** Duplicate filings account for the most significant percentage of denials. Keep a firm handle on your claims inventory to avoid duplicate filing. Ensure everyone sees what actions have already been taken to prevent this issue.
- **Ensure the service is covered –** This is one of the top reasons for denials. Ensure pre-authorizations are completed as appropriate. Insurance information changes, so verify patient eligibility at each visit. Sometimes, services are not covered or authorized by a particular plan. For example, a member's coverage may be terminated, or maximum benefits have already been met. Check a patient's policy status, look for plan exclusions, and check for referral or pre-authorization requirements. Checking eligibility includes checking plan exclusions, out-of-pocket expenses, and payable benefits.
- **Include patient financial counseling where appropriate.** Incorporating a process to review what the payer will cover, patient out-of-pocket, and even establishing a patient payment plan helps to improve self-pay collections.

Additional Code-Clearing Cues to Keep in Mind

Keep a keen eye on coding. For example, the diagnosis code may cause a denial because it is inconsistent with a procedure. If a denial occurs, check to see if there was a typo to ensure a diagnosis was not accidentally left out. In that case, correct the claim and resubmit it.

Denials also happen when expenses occur after a patient's coverage is terminated. Prevent this whenever possible by verifying a patient's benefits before rendering service.

Double-check termination dates to determine if you need to bill the patient directly. Also, check to see if the patient has other coverage that can be used for the time of service.

Has the filing time limit expired? This is another huge reason for denials. All payers have deadlines for filing, and if claims are not submitted within their time frame, you'll see a denial code. Be aware of each insurer's deadlines for filing.

For example:

- Physicians may have 90 days to file a claim.
- Hospitals may take up to a year to file a claim.
- An out-of-network provider may get 180 days after service to submit a claim.

Closing Thoughts

Sometimes, a diagnosis is not covered, resulting in claim denial. Prevent such denials by getting this information in advance. This will help you avoid cutting into your practice's profits.

Incorporate denial prevention strategies into the daily workflow to avoid denials and keep revenue flowing. Unfortunately, it is not uncommon to have claims denied, so know and understand the most common denial reason codes to prevent them.

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