Coding Denial Workflows

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Objectives

Our goals for this session include:

- Identify common coding related denials that occur during the revenue cycle process.
- Understand the Claims Adjustment Reason Codes and Remittance Advice Reason Codes associated with the denial reasons and what they mean.
- Apply a denials review process to fix these errors and resubmit to the payer to minimize lost revenue.
- Identify opportunities for avoiding basic denials by making small process changes.

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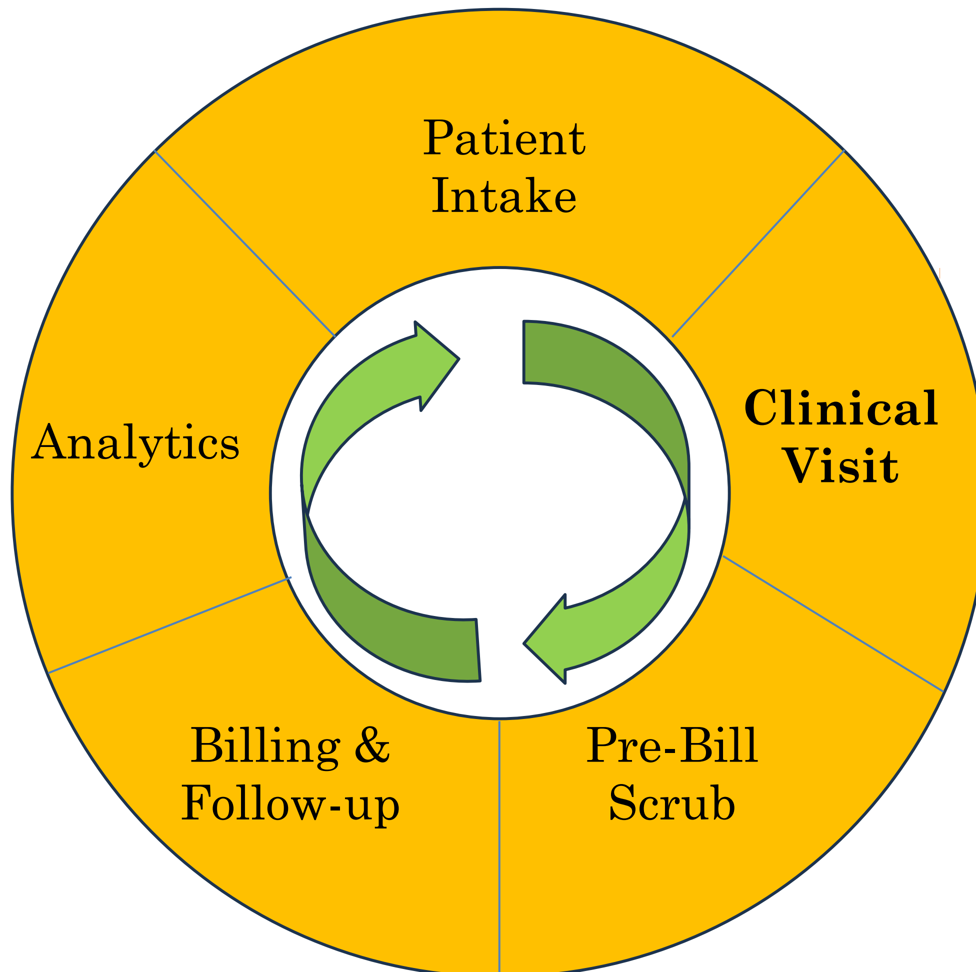
Simple Revenue Cycle Review



- Patient Intake
  - Scheduling
  - Eligibility
  - Authorization
  - Copay Collections
- **Clinical Visit**
  - **Diagnosis coding**
  - **Procedural Coding**
  - **Proper Evaluation/Management**
- Pre-Bill Scrub
  - Payer edits
  - Code validation
  - Clean claim generation
- Billing & Follow-up (Denials)
  - Claims submission & processing
  - Payment posting
  - Denials management
- Analytics
  - Data review
  - Analytics
  - KPI

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Denials Review Process

Identifying the correct solution requires creating a routine for claims review. Mastering this process will take practice and repetition and in some cases trial and error.

Claims Detail	Entire claim or Line-Item Denial	Denial Code Review	Impacted Revenue Cycle Process
Provider, Insurance, CPT, ICD-10 Codes	CPT specific or complete claim issue	Missing information, incorrect coding, timely filing	Intake, clinical information, claim/payer rules

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Common Coding Denial Reasons

Denial Reason	CARC	RARC	Explanation
Medical necessity	50	N661	• Payer deems visit not necessary. • Diagnosis and procedure are not consistent .
Patient status	306	MA43	• Coding not consistent with P.O.S.
Leveling	150, 186	N188, N610, N839, M25, M26, M81,	• Documentation does not support the level of care assigned
Procedure not covered by Payor/ Prior authorization issues	152, 256, 294,259, 284	N578, M80, M82, N356, N383, N429, N431, N525, N567, N569, N623, N674,	• Non-covered services. • Procedure bundled with another procedure. • Procedure or diagnosis code does not match authorization.
Diagnosis/CPT invalid for this date	146,181, 182	M20, M50, M51, M64, M67, M79, M119	• Diagnosis or procedure code were not valid for that date of service. (Expired or changed)
Service not covered by Payor	49,59,97	N536, N584, MA14,	• The patient's policy does not cover this service or the service for this diagnosis code.

All codes can be found here: https://x12.org/codes

Clinical Denial Resolution

Medical Necessity

- Review payor-specific policies for rules
- Identify the need for payor-specific modifier
- Review the National CCI edits for code combinations

Patient Status

- Review medical record for proper place of service
- Review orders, transfers, and discharge status
- Understand payor policies on observation and outpatient services

Leveling

- Review medical records for proper coding
- Identify any ambiguity in the record
- Review for uncommon abbreviations

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Clinical Denial Resolution

Procedure not covered by Payor / Prior Authorization Issues

- Review authorization documentation
- Review payor guidance regarding authorizations
- Review record for proper coding (CPT & Dx)

Diagnosis / Invalid CPT for this Date

- Review CPT and/or diagnosis code updates from the year of the claim
- Review payor guidance for any code crosswalks
- Ensure there are no errors in code selection

Service Not Covered by Payor

- Review payor-specific policies and rules
- Review coding to ensure there are no payor-specific codes (Subsequent Payors)
- Confirm it is not a specialty policy (Ex. Dental)

Mitigation Strategies

Part of denials management is prevention; Some clinical claim issues can be reduced by identifying standardized payor policies, and ensuring coders are aware.

CDM	Authorizations	Medical Record
• Ensure all codes are up to date • Payor policies are loaded • Crosswalks are up to date	• Authorizations are loaded and available for review • All dates are correct, and policy understood	• Establish audit structures for providers and coders • Implement selective CDI process

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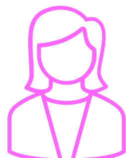
Careers

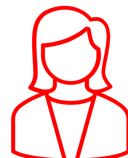
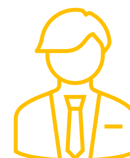
Clinical Specialist

- Coding Specialist
- CDI Specialist
- Chargemaster Analyst

Data Analytics

- Data Analyst
- Data Query Specialist
- Chief Date Officer



Review

- The most common coding denials are related to code selection and system setup.
- Utilize a review process of each denial to determine the correct course of action.
- Common denials have multiple CARC/RARC combinations that must be reviewed to ensure an understanding of the denial logic.
- Small changes to current processes can go a long way to preventing future denials.

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- Certifications
- Job Roles
- Online Education
- Communities
- Resources

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THANK YOU FOR JOINING!

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