Denials Management Process

Kenneth Voll, RHIT

Director - Strategic Revenue Cycle Associates

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What is a Denial?

Denials can negatively impact a provider's cashflow and risk potential loss of revenue unnecessarily.

A refusal by a third-party payer to pay all or a portion on an insurance claim submitted by a medical services provider

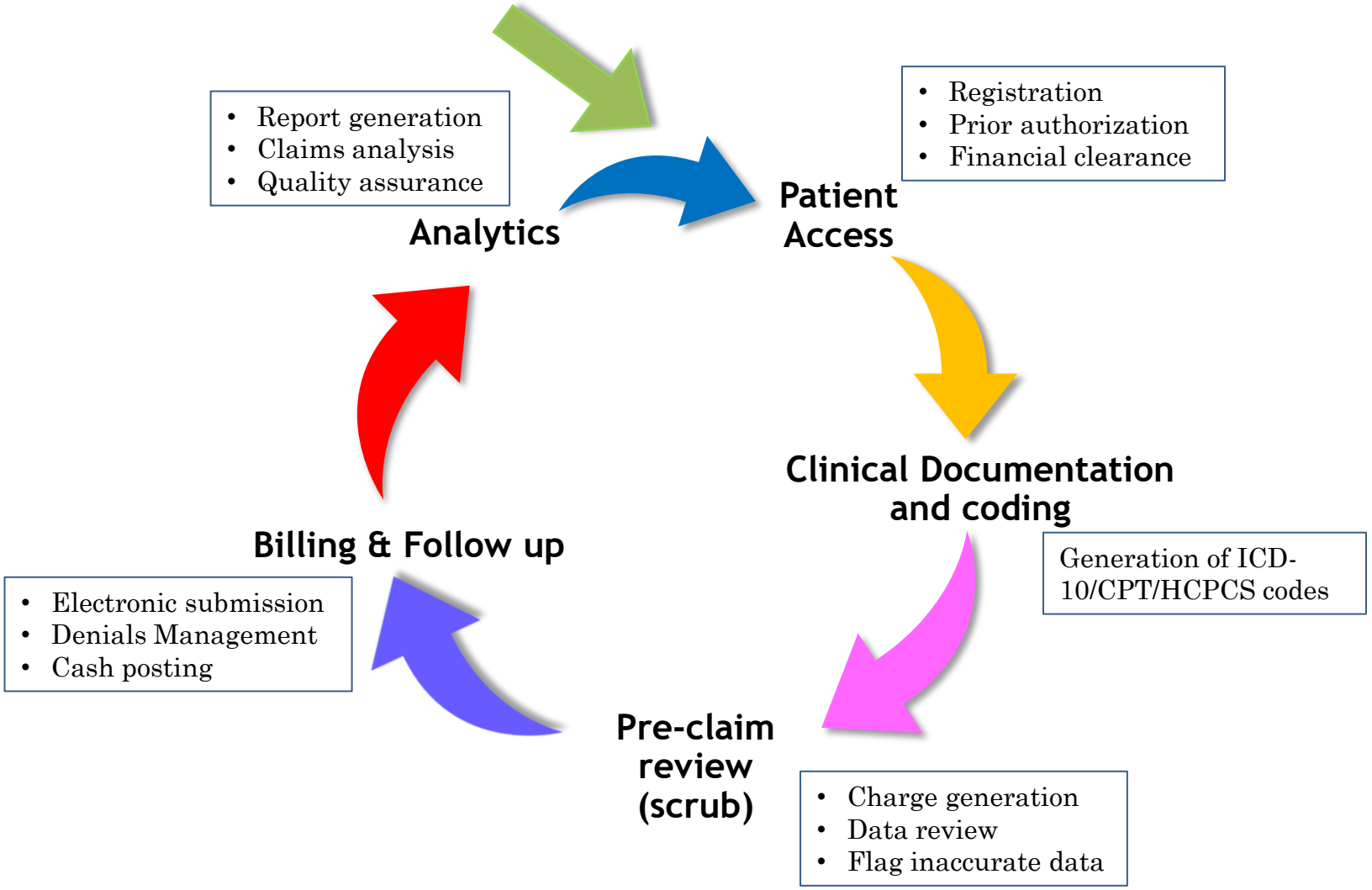
It is generated from the information submitted or not submitted on the selected claim form

Negatively impacts a provider's cash flow and increase bad debt expenditures

Denials & Rejections: What's the Difference

	When	Impact
Denial	• Occurs after the payer has accepted the claim • Payer has assigned a claim number • Claim has gone through the adjudication process	• Begins an appeal or resubmission timeline (Normally 90-180 days) • Payer rules and policies have been applied
Rejection	• Claim does not make it into the payer system • An Internal Claim Number (ICN) has not been assigned • There has been no adjudication in payer system	• Payer timely filing rules apply (normally 30-90 days) • The payer does not like a format issue with claim (Invalid ID, standardized claim issue, etc.)

Understanding the Revenue Cycle Process



The revenue cycle represents the life cycle of the patient's invoice and a denial can occur from within many of the processes that make up this cycle.

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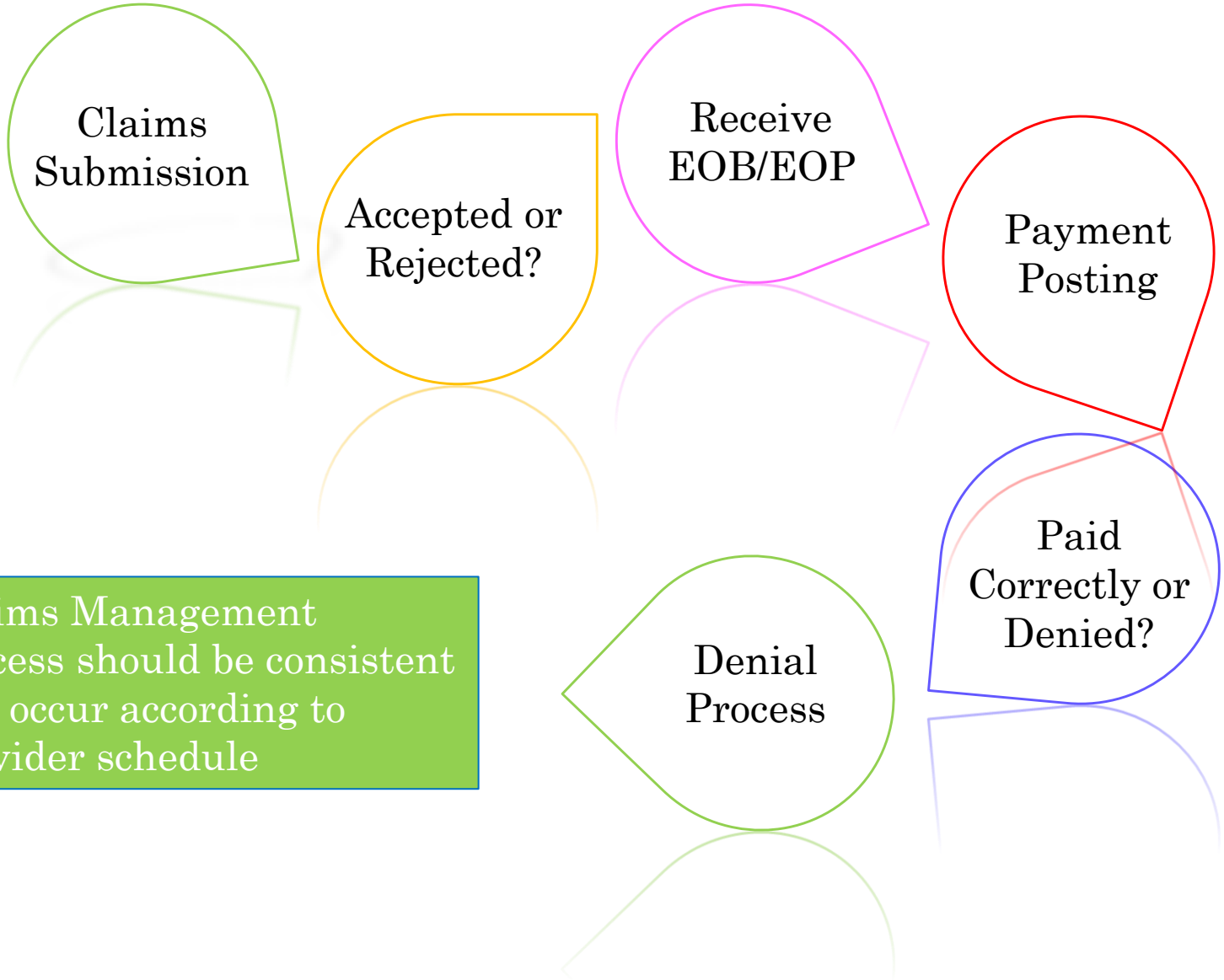
Claims Management Process with Denial



Claims Management process should be consistent and occur according to provider schedule

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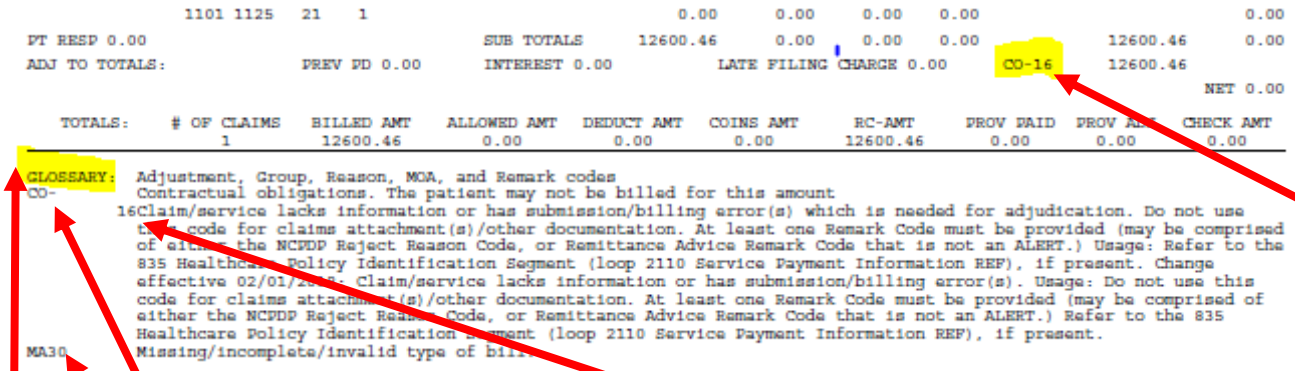
How to Read a Remittance Advice

The remittance advice, Explanation of Benefits (EOB), Explanation of Payments (EOP) is the source for all of your denials data.



1101 1125 21 1 0.00 0.00 0.00 0.00 0.00

PT RESP 0.00 SUB TOTALS 12600.46 0.00 0.00 0.00 12600.46 0.00

ADJ TO TOTALS: PREV PD 0.00 INTEREST 0.00 LATE FILING CHARGE 0.00 CO-16 12600.46

NET 0.00

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	RC-AMT	PROV PAID	PROV ADJ	CHECK AMT
	1	12600.46	0.00	0.00	0.00	12600.46	0.00	0.00	0.00

GLOSSARY: Adjustment, Group, Reason, MOA, and Remark codes

CO- Contractual obligations. The patient may not be billed for this amount

16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Change effective 02/01/2018: Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

MA30 Missing/incomplete/invalid type of bill

Line items claims detail

Listing of definitions

Claims Adjustment Group Code

Remittance Advice Reason Code (RARC)

Claims Adjustment Reason Code (CARC)

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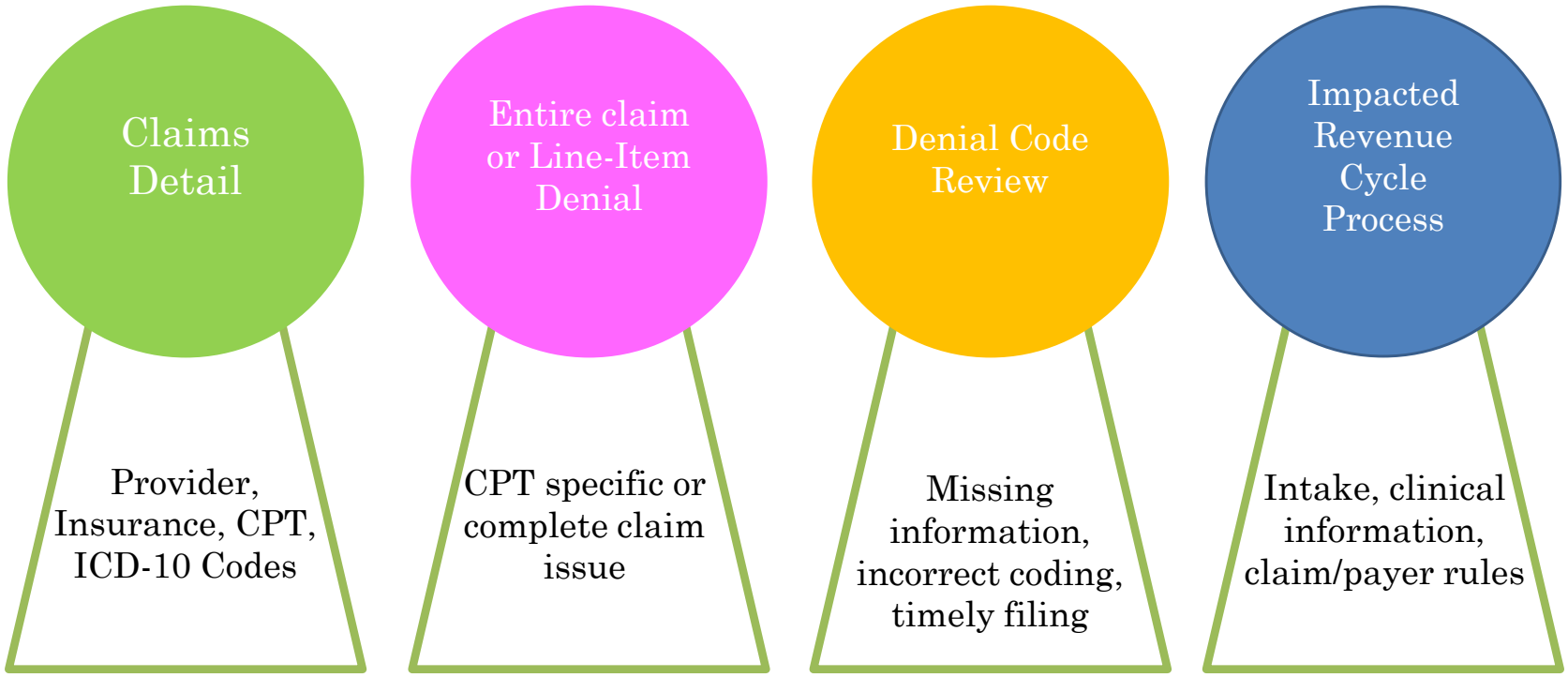
Keys to Fixing Claims

Figuring out what needs to be done requires creating a routine for claims review. Mastering this process will take practice and repetition and in some cases trial and error.



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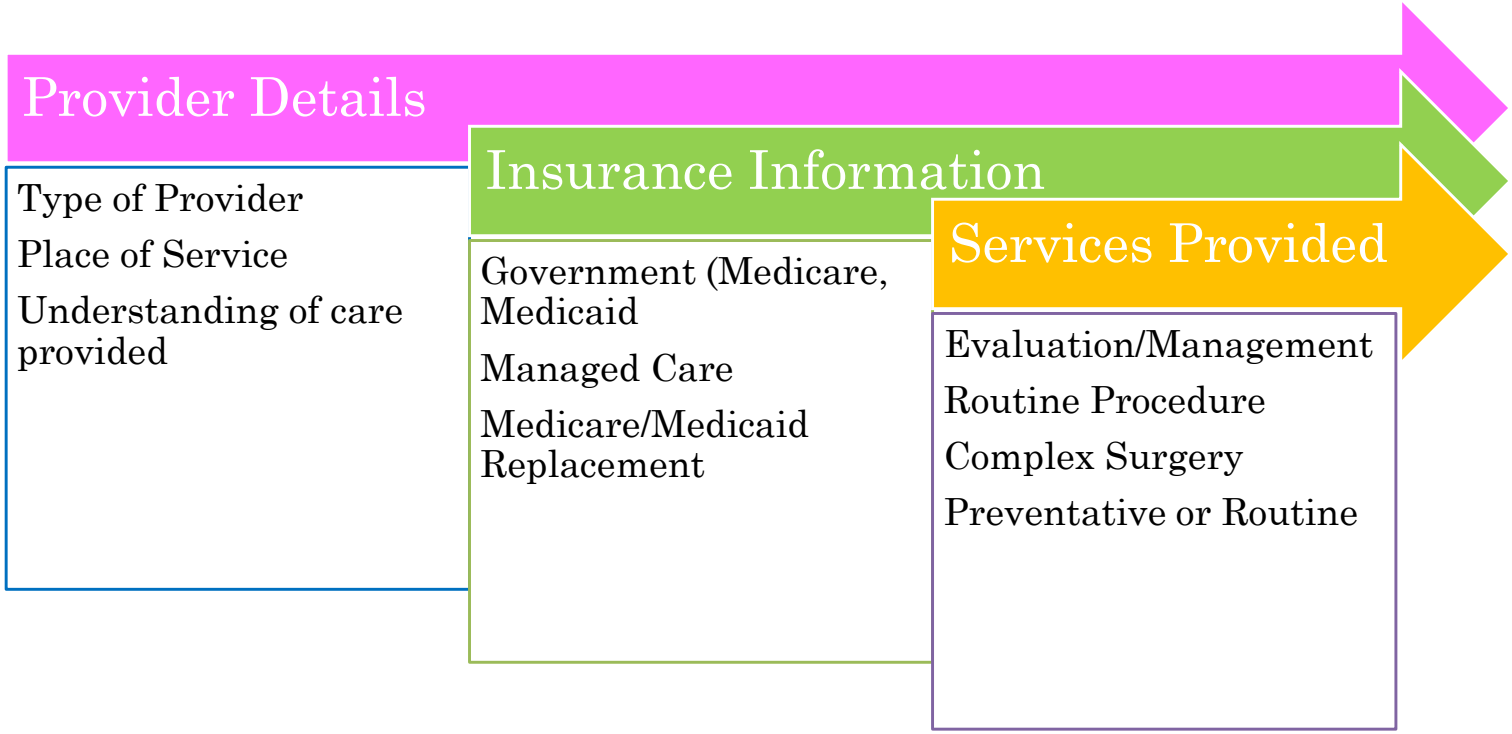
Claims Detail

Understanding the encounter begins with looking at the details of the claim regardless if it is institutional or provider claim.



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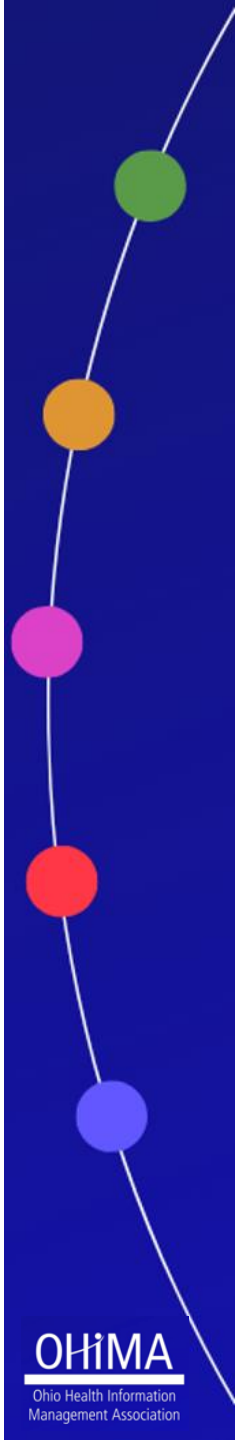
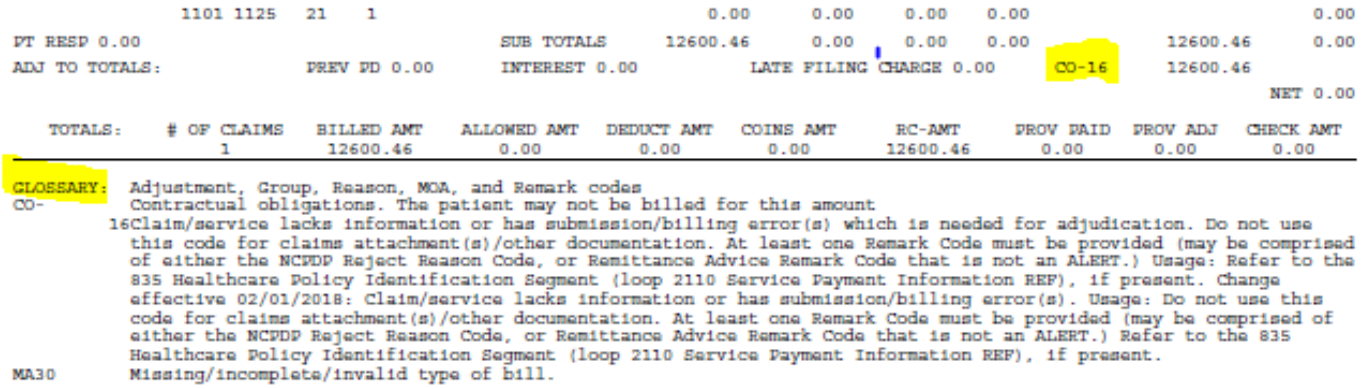
Denial Details

- Denials will appear on your remittance advice or explanation of benefits in the transaction line of the claim
- Denials are assigned standardized codes by payers down into three major categories
  - Claims Adjustment Group Codes
  - Claims Adjustment Reason Codes (CARC)
  - Remittance Advice Reason Codes (RARC)
- Understanding these codes and what part of the revenue cycle has impacted the denial will help fix and resubmit the claim quickly to avoid potential lost revenue



CARC & RARC Review

Understanding what the denial codes mean will assist with determining what part of the revenue cycle the issue resides. Focusing on these items will help narrow down the solutions or potential errors



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MA30 Missing/incomplete/invalid type of bill.

CARC	Definition	RARC	Definition
CO-16	Contractual Obligation – Claim Lacks Information for Adjudication	MA30	Missing/incomplete / invalid type of bill.

Codes like CO-16 and CO-96 must include RARC to identify which functional area the issue resides

List of all approved codes are can be found at: https://x12.org/codes

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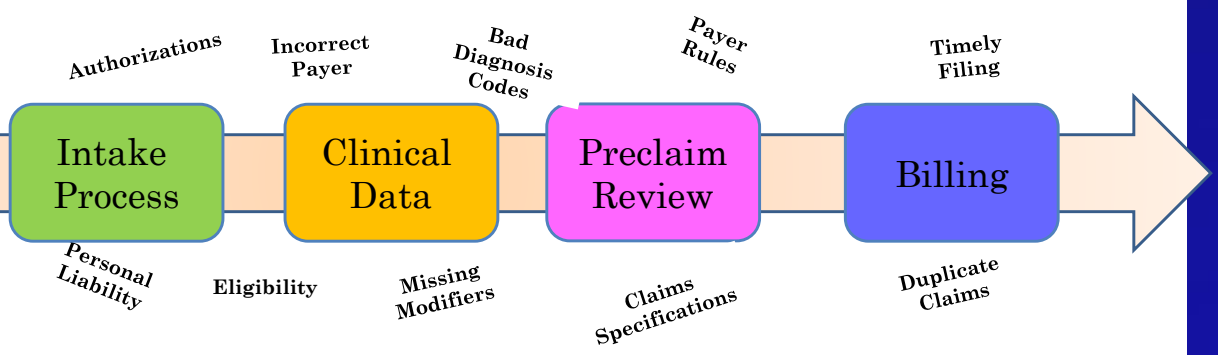
Impacted Revenue Cycle Process

Identify which step within the revenue cycle process is impacted by the denial, this will allow you to home in on the correct fix.

- **Patient Access** (intake Process) – Registration, Authorizations, MSP, ABN completion.
- **Clinical Data** – Incomplete diagnosis codes, Outdated CPT/HCPCS, Missing Modifiers.
- **Pre-claim Review** – Payer rules not correct, Missing claim items, incomplete claims
- **Billing** – potential duplicate submission, missed correspondence or remit posting errors



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Common Denial Codes and Impacted Areas

Patient Access

Denials tied to this portion of the revenue cycle are a result of missed or inaccurate information at the time the patient is registered.

CARC	Definition	Potential Fix
22	This care may be covered by another payer per coordination of benefits.	Review patient insurance or MSP Questionnaire.
31	Patient cannot be identified as our insured.	Check eligibility, subscriber ID, spelling of name.
197	Precertification/authorization/notification/pre-treatment absent.	Review authorization, does the information match the claim

Common Denial Codes and Impacted Areas

Clinical Visit

Denials tied to this area are created when there is incorrect coding, (ICD-10CM or CPT/HCPCS), provider, and documentation.

CARC	Definition	Potential Fix
5	The procedure code/type of bill is inconsistent with the place of service	Review documentation to ensure place of service is correct (ex.-Inpatient visit with Outpatient POS).
11	The diagnosis is inconsistent with the procedure.	Confirm the diagnosis code is valid with the procedure being billed
96	Non-covered charge(s).	Review denied charge codes to make sure they are accurate and can be billed in conjunction with payer rules.
150	Payer deems the information submitted does not support this level of service.	Review medical record for correct coding, (usually E/M level), appeal if necessary.

Common Denial Codes and Impacted Areas

Pre-Billing Review

Denials originating from here have to do with the set up of the practice management system as it related to payer and payer rules (Ex.- Informational modifiers, incorrect payments, bundling, etc.)

CARC	Definition	Potential Fix
50	These are non-covered services because this is not deemed a medical necessity' by the payer	Review payer guidelines to determine if there are codes that are not covered
181	Procedure code was invalid on the date of service	Confirm the CPT/HCPCS codes have correct start and end dates, recode or appeal with proof
207	National Provider identifier - Invalid format	Review set up of bill to ensure NPI is correct or missing payer rules
256	Service not payable per managed care contract	Review payer contract to confirm these services are billable

Common Denial Codes and Impacted Areas

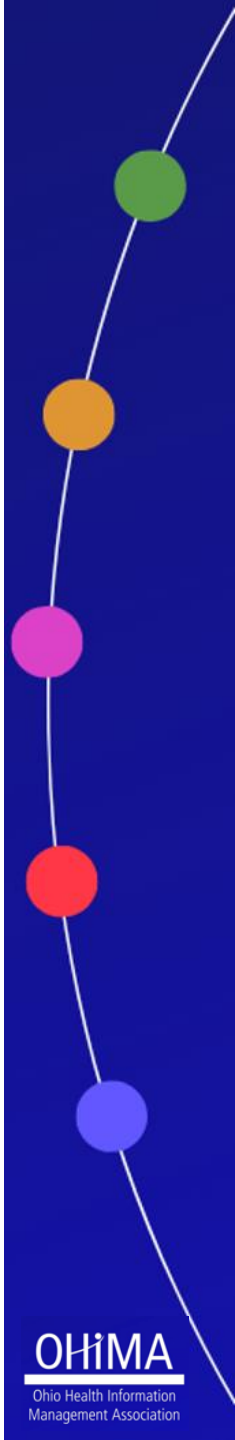
Billing

Billing process errors are common and are easily corrected as most are based on a missed procedure and staff must follow up on these quickly to avoid lost revenue.

CARC	Definition	Potential Fix
18	Exact duplicate claim/service	Confirm the claim has not already been submitted by this provider or another one (ex.- 2 Hospitalist code and bill for an admission)
23	The impact of prior payer(s) adjudication including payments and/or adjustments	Normally occurs when the secondary information does not match what was submitted, review claim and payment information
29	The time limit for filing has expired	Review to see if a claim was submitted within payer timeframe or if the original denial was incorrect
276	Services denied by the prior payer(s) are not covered by this payer	If primary payer says charges are to be contractually written off, secondary will not pay. Confirm primary paid appropriately.

Review

- Denials and rejections occur when the payer has received the claim and either refuses to pay or process the claim.
- It can come from any process that occurs with in the Revenue Cycle.
- Create a process to review all details of the claim to help identify why the payer has not paid the claim.
- The payer will utilize Claims Adjustment Reason Codes (CARC) and Remittance Advice Reason Codes (RARC) to explain the reason for the denial.
- A solid denials management process will minimize potential revenue leaks and eliminate bad debt write-offs.



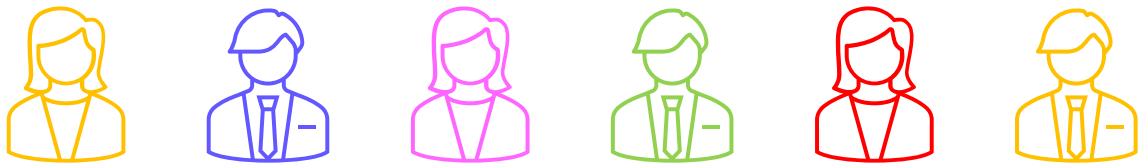
Careers

Billing Process

- Billing Specialist
- Revenue Cycle Manager
- Director of Revenue Cycle

Data Analytics

- Chargemaster Analyst
- Revenue Integrity Analyst
- Revenue Integrity Specialist
- Chief Date Officer



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THANK YOU FOR JOINING!

Kenneth Voll, RHIT

ktv1994@gmail.com

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