A consistent and healthy cash flow is the lifeblood of a thriving medical practice, so any upward trend in payer denials can have a direct and a significant negative impact on its bottom line. For many practices, maintaining an acceptable revenue level while also minimizing denials remains an ongoing struggle in today’s challenging world.

“The rate of denials has sharply increased and insurance companies have [become] more bold [in denying] services,” says Dominic Gaziano, a board-certified internal medicine physician in Chicago, Ill. “The process to dispute claims wastes a lot of time and is deliberately complicated and stacked against the provider. [Billing should] not be this complicated.”

According to the American Academy of Family Physicians (AAFP), the average practice has a claim denial rate between 5% and 10%, with rates of less than 5% indicative of the most efficient revenue cycles.

The costs associated with denied claims can be substantial. “The administrative burden of correcting denied claims is a frustrating one,” says Susan Whitney, certified professional coding instructor at Medical Group Management Association (MGMA). “[Depending] on the volume and provider specialty, a study by MGMA found the cost to rework a denied claim is at least approximately $25. More alarming is that as many as 50 percent to 65 percent of claims are never reworked.”

For many practices, costs may edge higher. A 2014 survey by RAC monitor, a website detailing news and information on third-party contract auditors which has found that more than half of respondents had denials resolution expenses of $30 per claim, while 38 percent experienced costs of $40 or more. If a practice has only 30 denied claims per month, the annual cost to rework may quickly surpass $9,000. Moreover, these expenses do not consider the impact on a practice’s cash flow. “When a claim is denied, there is no money coming into the practice except from patient co-payments or private pay patients,” says Maria Ward, director of HIM Practice Excellence at the American Health Information Management Association (AHIMA). Since the majority of a practice’s gross charges are generated from billing to commercial and governmental payers — more than 94 percent according to a 2014 MGMA Cost Survey — the result could be detrimental.

“High claim denials will significantly restrict the inflow of funds. An average practice could lose anywhere from $30,000 to $80,000 each year [due to] denied claims,” says Ward. Gaziano estimates a loss of $20,000 annually in revenues in addition to the staffing expenses associated with resolution.

Failure to properly address denials can lead to additional unintended consequences, such as worsening relationships with patients. “Patients do not like to receive bills months past their visits, because [a practice] didn’t comply in a timely fashion,” says Michelle Kemling, billing administrator at Minars Dermatology Skin and Laser Center in Hollywood, Fla. A 2015 study by technology company NextGen Healthcare, found that billing issues accounted for 35 percent of incoming patient calls, which can place an even greater burden on staff (manpower) and negatively impact the patient-provider relationship if billing concerns aren’t handled to patients’ satisfaction.

Excessive denials can lead to strained payer relations as well. Practices may blame payers for billing issues and the resulting loss of revenue,
WHY ARE YOU BEING DENIED?
While denial rates can vary between practices and specialty types, the most common denial reasons can generally be grouped into six key areas:

Lack of specificity. This payer denial can occur when practices fail to code to the highest level of specificity. The transition to ICD-10 has resulted in a massive expansion of available procedure and diagnosis codes, from roughly 3,800 to 72,000 and from 14,000 to 70,000 respectively.

A code may require up to seven characters as well as the inclusion of both alpha and numeric placeholders, which can increase the potential for coding errors.

“With the advent of ICD-10-CM, the specificity of the diagnosis is required and the chart or super-bill does not indicate that,” says Maxine Lewis, certified professional coder, audit, and member of the National Society of Certified Healthcare Business Consultants (NSCHBC). “Billers and office staff do not take the time to research a more specific code.” Failure to include other required claim information, such as a subscriber number or the incident date related to an injury or accident, can prompt similar denials. One mistake is all it takes!

Inaccurate claim information. Payers may also deny claims when the information provided, especially demographic data, doesn’t match their records or is otherwise deemed inaccurate.

A 2015 Revenue Cycle Benchmarking Survey by The Advisory Board, a global healthcare research and consulting firm, found that 61 percent of initial claim denials and 42 percent of denial write-offs are due to missing or incorrect demographic information or technical errors.

Demographic discrepancies can occur at any point up to the filing of the claim as the patient’s personal health information passes through the hands of several practice employees.

For example, front-desk staff may enter a patient’s name or date of birth incorrectly. Entering a shortened first name as opposed to the legal name on file with the payer or transposing a few digits in the date of birth may cause the claim to be denied.

Another potential denial can occur when the Healthcare Common Procedure Coding System (HCPCS) codes are missing or invalid. When durable medical goods or supplies are used during a visit, perhaps for the administration of chemotherapy or vaccinations, then Level II HCPCS codes should be used. Since each payer may have specific rules surrounding HCPCS billing, it is important for practices to know how the requirements may vary in order to avoid denials.

Past timely filing limits. When practices do not submit the initial claim, corrected claim, or appeal within a specific timeframe, a timely filing denial can result. “Timely filing of claims is, you would think, one of the easiest denials to avoid,” says Ward. “However, with so many payers and many of them having different filing timelines, it is very easy for a deadline to be missed.”

According to Medical Economics’ 2017 Payer Scorecard survey, the average practice is contracted with 13 payers and nearly one-quarter are contracted with more than 20.

To avoid these unnecessary denials, Ward suggests creating a list of each payer’s filing deadlines that can be used for frequent reference.

Another way this denial can transpire is when there are changes in patients’ insurance coverage or coordination of benefits in addition to sometimes not even having a valid referral.

In cases like this, if it is not caught in time the practice needs to bill the patient for active insurance which now takes a longer process when no one responds and sometimes leads to the account going into a collections agency and never seeing that money for the practice.

Practices may run into timely filing issues when they neglect to verify coverage prior to claim submission, and as a result, incorrectly file with the wrong primary payer. “Patients change insurances and forget to tell the practice of their new coverage,” says Lewis. “It is only [after the denial that] the practice realizes the coverage has been terminated and the practice must contact the patient for the new insurance.”

If denials aren’t reviewed regularly and then resubmitted prior to the filing deadline, the practice may have to write off the remaining balance. Lewis says that determining the primary payer when there is a working spouse can cause confusion for practices and hinder their ability to file the claim on time. “In the case of a married couple, [determining] which insurance is primary, especially when the payer may be Medicare, also [poses] a problem,” she says.

Service not included. Depending on the patient’s insurance plan, there may be restrictions on the type of procedures or treatments that are covered. Services such as fertility treatments and cosmetic procedures are frequently non-covered services, while other service or treatments may be covered but are limited in scope. “There are some services that can be provided with a limited number of
services,” says Lewis. “For example, the insurer will only pay for five visits for [a specific] CPT and the sixth visit will not be paid.”

**Payer needs more information.** In some instances, payers may deny a claim and request additional information, such as the patient’s EHR, before adjudication can be completed. The remittance advice may not detail the specific information or data that is needed, so practice staff may need to contact the payer directly to determine the appropriate follow up.

**Claim is illegible.** Payers may receive claims that are illegible, and therefore, unable to be processed without submission of a corrected claim. “Manual claim forms that are handwritten or even printed out on an inkjet printer can cause smudging of the ink,” says Ward. “Printed claims can also be illegible if the printer run out of ink or toner, leading to incomplete characters or blank fields on the form.”

**FINDING THE RIGHT BILLING PARTNER**

Before partnering with a third-party billing service, it is important for practices to thoroughly screen all contenders. While each practice may use slightly different criteria when weighing their options, the majority express similar preferences. According to a 2014 Black Book survey, 99 percent of physicians favor billing services that provide a U.S.-based account manager to serve as the point of contact for staff as well as a U.S.-based call center to handle patient calls.

In addition, Ward offers these tips. “It is always important [to] check the references of third-party billing services,” she says. “Get proof of their typical turnaround time on claims, find out what their denial rate is on initial claims, and determine how successful they are on appeals.”

Lewis suggests practices ask the following questions:

- Who is doing the coding and data entry? Are the coders certified?
- Which specialties does the service have experience in?
- What is the collection policy?
- Can meaningful reports be produced in a timely fashion?
- Are the files HIPAA-compliant and password-encrypted?
- How often are the ICD-10-CM or CPT files updated?
- Are the claims being paid properly according to the appropriate fee schedule?
- How often are statements sent and what follow-up is performed?
- Is credentialing offered?

**AVOID COMMON DENIALS THROUGH STAFF TRAINING**

With many practices plagued by persistent and even increasing numbers of payer denials, prevention is key. According to Advisory Board, 90 percent of denials are preventable if the root cause is identified and corrected. Since human error can represent a significant portion of these denials, staff training can provide an opportunity to catch potential issues well before the claim is filed.

“Insurance companies have their own proprietary rules for claims processing and payment and it takes a savvy staff to understand all of the multiple payer ‘player’ rules,” says Whitney. “A financially healthy practice is one that relies not only on the [coders] or billers, but the entire team of staff and providers to produce a clean claim and keep the revenue flowing with minimal denials and interruptions.” Therefore, each staff member — from coders to billers to physicians — must understand the unique role they play in an efficient claims process along with their role when a claim is denied.

While it may seem that the claims process starts with coders, it actually begins with the physician’s documentation. “To be paid properly, the documentation must reflect not only the service, but all of the necessary information to correctly bill the service performed,” says Lewis. Next, coders review the physician’s notes with the goal of coding to the highest level of specificity based on the clinical documentation available.

The coders must be able to avoid under- or up-coding claims, either of which can trigger costly and time-consuming audits, appeals, and claim rework. Lastly, billers verify the transfer of data into the claim fields and finalize the claim before submission. “Billers must be aware of unbundling, correct coding, and [ensure] that all demographic information is updated and correct,” says Lewis. If any piece of the process fails, then a denial can occur.

When denials do happen, each staff member must know how to respond. While simple demographic errors may be handled by the front desk, other issues may require other expertise. “A medical necessity issue may need to involve the provider to assist with the appeal,” says Whitney. “The revenue cycle really depends on the entire team. If any part of the team has a ‘not my job’ mentality, it will be a stick in the spoke of success in revenue cycle management.”

To ensure staff is clear on the claim filing process and on the same page, a standardized billing and coding policy should be created. In order to keep up with payer changes though, Lewis encourages practices to review the policy regularly — at least once per quarter — and update both the policy and staff each time.
payers release additional guidelines or alerts.

This type of ongoing staff training is imperative, but may be customized to each practice. For Kemling, payer updates are communicated to the practice’s billing team and clerical staff during weekly training and coaching sessions. Other practices may find that the training services offered by a consultant are the most effective solution to address their unique needs.

Regardless of the chosen training method, a practice’s staff should have a plan in place to closely track each denial, so that claims can be reworked as timely as possible. While each practice may determine their own guidelines for when or if a claim should be corrected and resubmitted, many take a more encompassing approach. “Insurance companies find creative ways to deny services,” says Gaziano. “My biller disputes all of them [and] I encourage doctors to dispute this every time it happens.”

**AVOID COMMON DENIALS THROUGH TECH**

Technology and third-party software can provide yet another way to reduce payer denials. New billing programs have a built-in ‘scrubber’ that can pinpoint errors before the claim is released to the clearinghouse. “The pre-billing ‘scrubber’ is a wonderful tool to prevent denials. Much of the software comes with standard edits from the National Correct Coding Initiative (NCCI) and/or basic medical necessity edits,” says Ward. Errors related to incorrect subscriber numbers, dates of birth, names, zip codes, and gender can quickly be corrected and save crucial time in the revenue cycle.

Other denials, such as illegible claims, can be eliminated completely when a practice shifts from manually submitted paper claims to an electronic filing system. Moreover, connecting revenue cycle management and EHR technologies can prevent claim denials due to insufficient clinical information. “For best automation and system-flow efficiencies in a practice, [it’s] ideal when systems ‘talk to one another,’” says Whitney. “Most claims are processed without the need for medical records, but it is nice to be able to quickly capture and send electronic information [housed in] EHRs. Many payers still, however, rely on fax submission and/or snail mail.”

Besides billing software, denials management technology can be instrumental in recapturing lost revenues. With more than 31 percent of healthcare organizations still using a manual denials management process, according to a 2016 RCM Denial Management Study conducted by HIMSS Analytics, moving to an electronic denials management (EDM) system can help streamline the entire process. Claims can be segregated by denial reason and then routed to the appropriate staff who can then perform the necessary follow-up. “Some EDM systems have the ability to flag claims that [are] close to a deadline [too],” says Ward. “The EDM also allows for data analysis to identify the root of the [denials] and [whether it is due to a] pre-billing edit versus post-billing.” The software can even calculate the practice’s overall denials percentage as well as track the total revenue lost per denial.

While care should be taken when selecting third-party software, it is critical that practices seek solutions that grant access to real-time data. “In today’s medical billing world, it is essential to use software [that is] updated on a daily basis or you are left behind,” says Kemling.

The draw of pre-billing software, for example, is founded in the potential to be proactive and identify claims issues prior to filing, and in turn, avoid weeks of waiting for an official payer denial. Software that accepts edits in real-time is important too. “Because most practices bill to [several] payers, [each with] different rules or edits, the pre-billing software needs to have the ability to easily add customized edits to address these differences [or] flag unspecified codes,” says Ward. Without access to current, updated information, practices may be at a distinct disadvantage and hinder their capacity to prevent front-end denials as well as properly address those on the backend.

**CONCLUSION**

Despite implementing the staff training and technology solutions outlined above, many practices may continue to struggle with costly denials. For those practices, partnering with a third-party billing service can prove beneficial in several ways.

“A reputable third-party billing service can be advantageous for a practice that cannot afford a qualified coding professional and billing expert [or if] there is a turnover of coding professionals in a practice,” says Ward. Partnering with a team who is experienced with modern billing technology has become an enticing option for practices of all sizes, perhaps because of the potential cost savings and the ability for the practice to concentrate on more pertinent needs. Up to 90 percent of solo or small practices plan to outsource all of most of their future billing needs while nearly 70 percent of physician groups with 10 or more providers currently outsource at least a portion of billing and collections, according to 2014 and 2015 Black Book surveys. The 2015 survey also indicated that 54 percent of chief financial officers believe that outsourcing revenue cycle management processes results in greater efficiency and improved financial wellness.

From the opportunity to focus solely on clinical care improvements instead of financial issues to the increase in patient satisfaction due to streamlined claims management, practices have much to gain by reducing denial rates.

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