

CLAIM DENIALS

How to raise your chances of getting paid

Managing rejected claims after the fact is a losing game

4 reasons claims are denied

- 1 The payer includes it in a global package®
- 2 Lack of preauthorization
- 3 Payer assumes the claim is a duplicate
- 4 Registration process involved an error

It's the end of another long day, and your billing manager is in tears. For the third time this month, she is frustrated about the overwhelming amount of work in the billing office. "The staff simply can't keep up!" she exclaims.

She wants to hire another biller. But you have spent considerable time the past few months brushing up on your coding expertise and renegotiating contracts with

your key payers. So why has the billing workload increased so much? Why is your staff overwhelmed?

The problem isn't limited to your practice. All types of medical practices face increased workloads in their billing offices. Quite often, the added work is from a single source—claim denials. If your billing office always seems overwhelmed, check the volume and types of denied claims. Many of the problems are preventable.

The solution to denials is not always to hire more staff. Too often, the billing staff focuses on managing denials *after* they happen, but that's a losing game. Your first line of defense is to fix the problems that cause denials. Then identify strategies to prevent the denials and manage them when they do occur.

1 Don't accept bundling of stand-alone services

Many codes encompass a predetermined period before, during, and after the service you provide. ObGyns are most familiar with the coding for deliveries. For example, a claim for a service coded 59510 includes all routine obstetric care, be it antepartum, postpartum, or the cesarean delivery itself.

If this seems cut and dried, think again. What if the patient returns a week after discharge with a minor infection in the wound site? You'd document your service and bill for an appropriate-level office visit. Despite its merit, that claim might be denied and returned, marked with words such as



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FAST TRACK

Stop trouble before it starts. By being proactive, you can:

- 1 Streamline your staff
- 1 Improve internal processes
- 1 Get paid faster

“inclusive,” “global period,” or “bundled.” Regardless of the exact language, the payer is saying that payment for the service was included in another payment it made.

Train staff to question denials

In many practices, staffers simply accept denials. They write off the charge as a contractual adjustment for that payer, and the money is gone—even though you deserved it! Although many services you provide during a pregnancy can be legitimately included with other procedure codes, this one—and perhaps others you bill—is not one of those bundled services.

Two terms are important: *global period* and *bundling of multiple services*.

Global period is the time (0, 10, or 90 days, for example) during which any services you provide are included in the payment for the service. For obstetric services, that period includes antepartum, delivery, and postpartum care. For gynecologic surgeries, the period varies by the surgery. These periods of time—often called “globals”—are established by the Centers for Medicare and Medicaid Services (CMS) and are published annually in the Resource-based Relative Value Scale.

Bundling means that 1 service is identified as the primary service, and any additional services during the same session are included in the payment. That is, you get paid for the primary service only. CMS publishes a list of primary procedures and the procedures secondary to them in its Correct Coding Initiative, which is updated quarterly. However, many payers establish their own bundling rules.

Note when the global period begins. Let's return to the example of the global obstetric

package. Services rendered during this period are often bundled. Often, even if it is coded appropriately (ie, separately), the first encounter is included in the package payment. ACOG attempted to clarify this situation last October, when it observed, “If a patient presents with signs or symptoms of pregnancy and the patient is there to confirm pregnancy, this visit may be reported with the appropriate level of E/M services code. However, if the OB record is initiated at this visit, then the visit becomes part of the global OB package and is not billed separately.” In fact, the visit becomes part of the global OB package whenever the OB record is started at this time, even if the physician is confirming a pregnancy diagnosed by another source.

Services that are often billed separately but considered inclusive by many payers:

- **annual preventive exams**, which may include a related problem-focused visit and/or related lab tests; and
- **global obstetric packages**, which may include ultrasounds, nonstress tests, and routine Pap smears.

ACTION PLAN

To manage denials for inclusion, require each payer to outline its rules about bundling for the services you commonly bill. For example, ask the payer to list the services included in the global obstetric package, and get it in writing. Then train yourself and your staff on what's included—and what's not.

Have your staff flag denials that can be appealed, and offer to dictate a letter, if necessary, explaining when services you performed were coded and billed appropriately as 2 (or more) distinct services.

FAST TRACK

Have each payer outline its rules about bundling for the services you commonly provide—and get it in writing

2 Make preauthorization top priority

Some payers require preauthorization for specific services. A common example is amniocentesis. Ask your billing staff to alert you to any claim denied for lack of preauthorization, precertification, or refer-

ral approval. Although appeals of these denials after the fact are often unsuccessful, you should usually make the attempt anyway. For example, if your patient did not provide accurate information about

her coverage, you may have unknowingly failed to obtain the necessary authorization or billed the wrong insurance company. Even though it is too late to obtain the authorization after the service is rendered, write an appeal letter for this type of denial. Explain to the payer that the patient failed to disclose the correct insurance coverage; thus, you were not able to follow its rules.

ACTION PLAN

For services you commonly render, make a list of the payers that require authorizations. When the service is ordered, check that list to determine whether preauthorization is necessary. Better yet, summarize those common services and the patient's benefit coverage in the patient's paper or electronic chart. If services are denied, consider appealing the decision.

3 Stop “duplicate billing” denials

Some claims are denied because the payer concludes it is a duplicate. This may happen if you mistakenly send a claim more than once; at other times, the patient actually had similar services performed, but the payer mistakes them for a single service.

For example, a patient presents with a urinary tract infection (UTI) twice in the same week. You appropriately code your level of service for the encounters, which may be code 99213 in both cases, and attach a diagnosis of UTI. The payer may not spot the different date for the second service, and mistakenly assumes the second is a duplicate.

ACTION PLAN

Put your staff on alert for inappropriate denials based on duplication. Appeal these denials for payment and point out in the appeal that the services were rendered and

accurately coded and billed.

Your staff could be a cause of high denial rates. Perhaps they simply resubmit claims without considering the situation, or fail to attach new information to the resubmitted denial to help the payer understand that it is not a duplicate claim. Unfortunately, it is common for unproductive or unknowledgeable staff to simply rebill claims as they work open or denied claims.

Before you rebill a claim, it is important to evaluate the account carefully. Determine the status of an open claim before resubmitting it.

For a denied claim, fix the problem or attach an explanation—instead of making the same mistake twice. If that's the case, you'll just get a denial for a duplicate claim, no payment, and more work to do.

FAST TRACK

Do not resubmit denied claims without adding new information to clarify the circumstances

4 Get the registration right

Many ObGyn practices are plagued by registration-related errors that translate into claim denials. If the registration process is inaccurate, even by a single keystroke, the claim will be denied. Common registration-related denials include: “subscriber not eligible on the date of service” and “subscriber not identified.”

ACTION PLAN

Be a stickler. Track down staffers who make mistakes and show them what they are doing wrong; otherwise, they'll just keep making errors. At each patient encounter, or at least every 3 months, verify insurance and eligibility—with both patient and the payer. Use payers' Web sites to confirm coverage. ■