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THE CLAIM GAME

Overcoming health insurance reimbursement denials


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Overcoming health insurance reimbursement denials

By Mark Harris

In the United States, health care providers largely rely on health insurance plans to pay for most of each patient's medical treatments and services.

Whether the payer is one of the many private employer-based plans, an individually purchased health plan, or a government program, such as the Medicare, Medicaid, or Veterans Health Administration programs, reimbursement is based on the uncomplicated idea that claims can be submitted for covered services under the patient's defined benefits package.

When an insurance claim is submitted for medical services, both the patient and provider generally expect that the claim will be paid by the insurer. When a claim is for whatever reason unpaid, it can seem bizarre. But even if claim denials are not quite routine, they invariably occur.

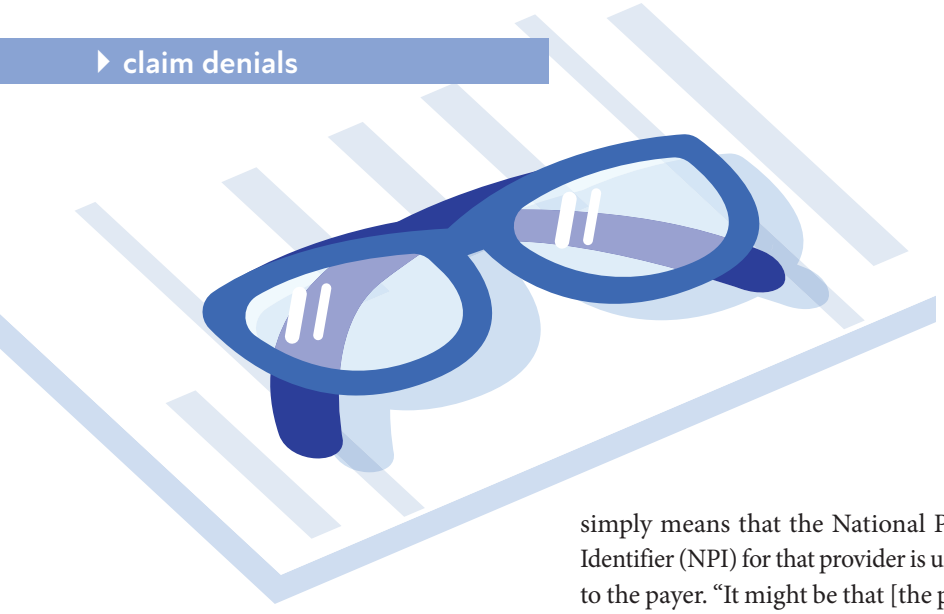
A reported 8.5% of claims from multispecialty practices were denied on first submission, according to 2019 data from the Medical Group Management Association.[1] To put the issue in perspective, the health care industry annually contends with a conservative estimate of at least $11 billion in challenged revenue, a figure that researchers caution in a 2018 *Health Affairs* article could be significantly higher.[2]

The good news is that many denied claims can be successfully challenged. About 63% of denied claims are recoverable.[3] But successfully reprocessing claims is not without its costs. In recent years, health care providers reportedly spent about $118 per claim on administrative recovery costs.[3]

Do not pass go

The reasons insurance companies deny payment for submitted claims can vary from simple inputting errors such as transposing numbers to more complex disputes over "medical necessity" definitions and other coverage eligibility issues. The denials that are due to common errors on the part of the patient or medical practice staff can be remedied with correction, prompt resubmission, and refined office procedure:

Incorrect or incomplete demographic information. "One of the most common reasons for denied claims involves mistakes entering demographic information," says David J. Zetter, PHR, CPC, a senior consultant with Zetter HealthCare in Mechanicsburg, Pennsylvania. "If you do not have the proper insurance ID or proper guarantor, the payer is going to deny the claim. For example, you may have a [male] patient named William Smith. If he calls the practice and says his name is 'Bill Smith,' and the practice registers him as Bill Smith, that can cause a denial. If the patient's insurance is under the spouse's name, and you don't have that information, the claim can fail because the owner of the policy isn't listed. It's this easy for mistakes to occur."



Outdated insurance information. Another easy mistake a patient might make is providing an old insurance card during front-desk registration. "A patient could have their old insurance card in their wallet with the new card, but the cards are not dated and [are] from the same payer, so it's hard to tell them apart," says Zetter, who is also the current president of the National Society of Certified Healthcare Business Consultants. "But maybe the new card has a different group ID number. If so, this can lead to a claim denial. The demographic information, which can include a name, ID number, birthdate—all this essential information—has got to be character-by-character validated and verified. This is the biggest problem with denials."

Missing or invalid codes according to ninth or 10th revisions of *International Classification of Diseases* (i.e., *ICD-9, ICD-10*) or *Current Procedural Terminology* (*CPT*) guidelines. "The provider or billing staff really need to know the proper rules for submitting claims for a procedure," cautions Zetter. "For instance, you may have a procedure that requires certain diagnosis codes to justify medical necessity. These could require the use of specific modifiers. You can submit a claim that has a procedure code in addition to an E/M [evaluation and management] code for an office visit, but if you don't append a modifier appropriately, you're going to get a denial."

Claim submitted by an uncredentialed provider. Even though "uncredentialed provider" sounds like a major issue, the term simply means that the National Provider Identifier (NPI) for that provider is unknown to the payer. "It might be that [the provider is] in the process of being credentialed, but they haven't received an effective date yet," says Zetter. "When the NPI for that provider is then processed, the claim logic in the system doesn't recognize that NPI."

Prior authorization missteps. In some cases, denials can also occur if the provider failed to request a required prior authorization for a procedure,[1] or the provider used inaccurate or incomplete information with the request.

Play by the rules

When a claim is denied, billing staff should be familiar with the insurer's system for explaining the reason for the denial. This is communicated on the explanation of benefits (EOB) or on the electronic remittance advice (ERA):

- The EOB describes the health plan's covered costs for medical care or products.[4]
- The ERA describes how a claim is being paid with an explanation of any adjusted claim charges.[5]

The latter may be based on contract agreements, secondary payers, benefit coverage, and expected co-pays or coinsurance.[5]

"The billing staff or billing company has to understand how to read the denial codes," says Zetter. "Unfortunately, sometimes those denial codes are not as exact as they could be. For instance, [a code] might say the provider is out of network. You have a contract, the provider is credentialed, and yet it's still saying, 'Out of network.' Obviously, somebody will need to figure out what happened with that provider not [being] in-network. The issue then is less about the claim and more about the credentialing and contracting."

For staff, working efficiently with insurance claims is all about accuracy and verification, says Kathryn I. Moghadas, RN, CPC, a health care consultant at Associated Healthcare Advisors in Winter Springs, Florida. "You don't have to have a PhD in claims processing to do your job well, but you do need to pay attention to the minute coverage details for each patient who comes through the door. What exactly are they covered for? In my opinion, the No. 1 issue with each patient visit is the verification of current insurance status on the day of service. You always want to verify coverage promptly, not after the patient walks out the door."

Similar advice comes from Joy E. Krumdiack, CMA (AAMA), a now-retired medical practice manager for an internal medicine practice in Washington state. In Krumdiack's experience, patients should always be asked to provide copies of their insurance cards before the initial visit, when completing patient information forms.

"We would go online or [call patients] to confirm that they had the coverage and that we had the right information," says Krumdiack. "If the patient waited until the day of the visit to provide this information, we would have to do it then. But you always want to make sure you have accurately verified their current coverage status in a timely way."

When a claim denial occurs due to a registration mistake or other error, this can be the perfect moment for staff education, says Moghadas, author of *Medical Practice Policies and Procedures* and a past president of the National Society of Certified Healthcare Business Consultants. "We have an incredible opportunity at that point to train staff," she says. "Of course, you will need to do some forensics on that denial and where it broke down. Often, it's going to be when the patient first arrives, and someone

fails to verify the coverage. The manager can then say, 'Well, here's an opportunity to learn from our mistakes. We saw 30 patients that day, but one patient got by whom we didn't verify. This is the result of the action that we failed to do, and this is what we need to do now.' "

Such teachable moments are not about being punitive, says Moghadas. "Unfortunately, if the billing person is the only one to know there is a denial, the front-desk staff will never find out that they made a mistake. What happens then? They [never] have a chance to change their actions. The focus should always be on how we can learn from our mistakes."

I spy

Inaccurate recording of demographic information can go beyond an individual's mistakes. "Sometimes we have to look at staffing issues," says Moghadas. "For example, did we have adequate staffing at 11 a.m. on Tuesday to see and process patients? Are staff being distracted by other concerns? If so, what can we do to mitigate that? You might also have to ask, 'Is it a matter of lack of staff knowledge or skill? Or is it a lack of care?' You have to identify whatever the issue is, and then you address it."

Indeed, whether the concern is a specific denied claim or a larger pattern of denials, the key is to always assess the source of the problem. "You have to determine the root cause of denied claims," says Zetter. Accordingly, Zetter recommends medical practices periodically conduct a revenue cycle assessment for the entire practice. This assessment entails validating the operation of the practice's financial systems and processes, including staff education and training in registration, billing, and claims operations.

"The revenue cycle begins the day the practice initially communicates with the patient or [when the patient] is scheduled and referred by a referring provider. In order to prevent denials, you really have to look at the whole picture to determine what is causing the denials. If you take phone calls to register patients, for example, then you'll want to look at [phone procedures] and see what mistakes are being made there. You should look at charge entry, billing, payment posting, denial management, claims submission. … You should even look at [the practice's] financial policies. [To what extent is the *patient* responsible for making] sure they're giving the proper insurance card? Are you checking insurance cards on every visit? Why not verify that everything is being done correctly?"

As part of the assessment, Zetter suggests considering whether some claim denials are also just being overlooked. "Denials are the most thankless and difficult job because most people don't have the time to follow up on these issues," he notes. "Are there denials being missed? Are people sticking them in a drawer? This can happen. Sometimes, they just get set aside. Then you only have so much time to resubmit that claim denial before it's not going to get paid." Notably, remembering to submit claims in a timely manner, within the allowed filing deadlines, is necessary for both initial claims and all resubmissions.[1]

In essence, a revenue cycle assessment is about verifying that a medical practice has an efficient, accurate system in place for finances that assigned staff are familiar with and competent in using. "The revenue process should be detailed and documented in your policies and procedures," concludes Zetter. "This way, if anyone doesn't know what they're doing, you can show them an office document that tells them line by line what the process entails."

Rematch!

In addition to creating and using an efficient system for claim submission, staff must also have knowledge of the appeals process for claim denials to help patients navigate the process when necessary. Under the Patient Protection and Affordable Care Act (ACA), patients have the legal right to request an internal review to appeal a denied claim. If that request is denied, patients are legally allowed to ask for an independent, external review. This right applies to health plans created after March 23, 2010.[6] For plans purchased after July 1, 2011, insurance companies are required to inform patients of why their claim was denied and of their right to an appeal.[6]

Additionally, health plans are required to notify their members within 30 days when a claim is denied for medical services members have already received. If the claim involves a prior authorization request for treatment, the deadline to deny the claim is 15 days. For urgent care cases, a 72-hour deadline is imposed.[7]

While claim resubmissions are often preventable by staff, formal appeals may be unavoidable. A formal appeal of a denied claim can involve disputes over any number of issues related to the insurer[7]:

- A specific benefit is not offered under the patient's health plan.
- The claim was for services from a provider or facility not in the plan's approved network.

Losing hands

Despite staff doing everything correctly, denials for health insurance reimbursements can still happen due to many common reasons[12]:

- No prior authorization
- Incorrect demographic information, procedural codes, or diagnosis codes
- Unmet medical necessity requirement(s)
- Noncovered procedure
- Payer processing error(s)
- Out-of-network provider
- Duplicate claims
- Coordination of benefits–related issue(s)
- Bundling
- Uninsured patient

"The most important advice I have is to **BE ACCURATE** *when you are initially inputting insurance claims. Be accurate with descriptions; chart notes—everything that communicates what your office is charging for. You have those* CPT *and* ICD-10 *codebooks for a reason. Back up your chart notes with proper codes, and usually, your claims will sail right through."*

—Joy E. Krumdiack, CMA (AAMA)

- The insurer determined that a treatment or service fails to meet "medical necessity" criteria.
- The insurer maintains that the beneficiary is no longer enrolled or eligible to be enrolled in the health plan.
- The insurer rescinded the individual's contract because the individual allegedly enrolled in the plan using false or incomplete personal information.

Generally, a formal appeal of a denied claim must be filed within six months of the denial notice. Notably, insurance companies in all states are required to provide an independent external review process for some types of claim denials. For example, an external review might be used for a denial in which medical judgment is disputed by the patient or provider or when the insurer has determined a treatment is not covered on the grounds of it being experimental or investigational.[7]

When filing appeals, many experts advise providers to act promptly, adhere to the insurance carrier's filing requirements, and follow up regularly on their appeals. "You should have some type of regular communication [with] the carrier," says Moghadas. "I suggest following up on [each] appeal every two weeks. You should also follow the appeals guidelines that are written by the carrier. Basically, you want to familiarize yourself with the carrier's process and provide the documentation they request. You want to summarize your appeal with the important data, using the correct coding and terminology. Use your *ICD* codes; use your *CPT* codes; use your date of service. If the insurer asks for additional explanations or chart notes, you should provide those. Be succinct … [, but] do not cut corners."

To make life easier, many medical practices have sample appeals letters (templates) on file, which can be customized as needed for specific denied claims. These can be found in many office procedural manuals or elsewhere. For example, members of the American Medical Association (AMA) can access sample appeal letters for denied claims from the organization's website. The sample letters address claims denied for reasons involving authorization and eligibility, prior authorization, and referral requirements.[8]

Additionally, patients can also be referred to groups such as the Patient Advocate Foundation, which provides sample claims appeal letters and other resources to assist with insurance denials and appeals.[9]

Battle 'ships

Admittedly, appealing a denied claim can appear to be something of an uphill battle. But because a majority of claims are potentially recoverable, appealing a claim denial is a manageable challenge for those who learn the process and are willing to follow through until every appeal option is explored.

Yet even a manageable challenge remains just that—a challenge. "Insurance companies always have the upper hand, because they hold the contract over the provider's head," acknowledges Mary Covington, president of Denials Management, a Salt Lake City–based advocacy group that assists patients and providers with filing appeals for denied claims.

As a long-time industry expert, Covington says insurance companies have become more aggressive in pursuing ways to deny claims. "Unfortunately, I find [that] the payers right now are in more of an adversarial role than they've ever been, denying more, paying less," she reports. "The insurance companies are banking on the fact that the insured patients are not going to be savvy enough to understand how to go after the money that's been denied."

In fact, insurance claim denials among health systems may be as high as 1 in 10, according to a 2019 report.[10] A couple factors may be driving the notable denial rate[10]:

- **Automated reviews; automated denials.** Software algorithms used by payers can now quickly identify potential reasons for denying claims, such as downgrades of diagnosis-related groups (DRGs) and medical necessity issues.
- **Complicated criteria.** Insurers are also using increasingly complicated criteria for claim submissions and medical necessity requirements. This includes adding more technical or minor medical necessity criteria that represent fine-print obstacles to getting claims paid.

What is an EOB?

An explanation of benefits (EOB) is an overview of the total charges, including how much the patient and the health plan must pay. Patients might need to be reminded that an EOB is not a bill but a breakdown of what the health plan covers.[13]

Each insurance company has its version of an EOB, but generally, an EOB will list the services provided to the patient as well as the amounts of the following[13]:

- Provider's charges
- Services covered and not covered by the patient's plan
- What has been or will be paid to the provider by the insurance company
- What the patient is responsible for paying

As Covington observes, insurance is not a topic most consumers learn in school. Indeed, health care beneficiaries are often unfamiliar with their plan policies and rules and do not always make the effort to challenge denials of coverage. In the context of industry practices, billing staff—who are properly trained in how to submit claims; how to identify and correct demographic, coding, and other errors; and how to file necessary appeals on denials—can play a vital role in improving reimbursement results for patients and providers.

For cases in which a formal appeal is advisable, Covington recommends first determining what evidence is needed to support the claim. "Each claim is denied for a different reason. For example, a claim

Ready, set, go!

A critical step to achieving prompt processing of claims is filing claims correctly and completely. Insurance companies reject claims containing incomplete, invalid, or incorrect member ID numbers. Next, send the claim to the correct address or, if possible, file the claim electronically.[11]

Always keep documentation of when the claim was submitted. File the claim using whatever method will best record when the insurance company received the claim. Keep records of telephone conversations and all written correspondence with the insurance company regarding the claim's status.[11]

If the insurance company denies and returns a claim because of mistakes, correct the mistakes immediately, and resubmit the claim to meet any filing deadline specified in the contract or the patient's plan document.[11]

Most importantly, post the claim payment to the account as soon as it is received.[11]

may be denied because it doesn't meet the criteria of medical necessity or the definition of a covered facility. Whatever the reason, each denial has its own process. You have to know what evidence you need to gather in order to file an appeal. Of course, we always try to fill our appeals basket with lots of evidence."

Covington also cautions providers: do not assume policy information given by insurers is always accurate. "There are a lot of people in the insurance world who aren't always well versed in what a policy says," she explains. "For example, we might call an insurance company and be told, 'The claim is in process.' Well, it's been in process now for 95 days. How much longer is it going to be 'in process'? What does the insurance policy say? It says if they have a clean claim, they're supposed to process it within 30 days, according to the holder's policy. It's at that point that we might say, 'We're done; we're filing a complaint.' "

Notably, some states, such as California, have established medical provider complaint lines, under the authority of the state department of insurance. "Get to know the provider complaint mechanism in [your respective] state," advises Covington. "You can go to them directly if you don't think you've been paid appropriately or if you think an insurance company has denied a service that's covered. This can be a helpful resource."

If a claim appeal has been filed, Covington recommends exploring every option for a successful resolution of the claim. "I have a sign in my office that says, 'Never give up.' … Since we know that almost 70% of denied claims are payable, you never want to give up on a valid claim. If it's valid, it's valid. You just have to figure out what you can do to get it resolved. That's our message."

Up your game

Furthermore, the unique challenges many health care providers are now facing because of the COVID-19 pandemic present claim approval challenges as well. In addition to the public health risks posed by the pandemic, many patients have also experienced job losses and changes in their health plan status.

While some insurers have waived copays and other costs related to COVID-19 testing and care, the health care system remains under stress with much uncertainty and complexity. "Unfortunately, one of the chief causes of denials right now is lack of coverage," reports Moghadas. "If a patient has failed to update their current employment status [with their health care provider's administration team] for whatever reason, you might be seeing more denials.

"There is a new normal [developing], and we don't fully know what is going to happen," concludes Moghadas. "But as professionals, our foremost job is to recognize that we are providing a service to patients with all different types of vulnerable conditions. What we can do now is continue to rely on [and improve] our established standards in training, staffing, and communication to maintain quality care for patients."

More than ever, providers, medical office managers, and staff must work together on behalf of patients to maintain fair and efficient claims processing and reimbursement practices. ✦

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