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Be Diligent About Denied Claims

Having reliable procedures in place for submitting claims to payers in a timely manner is critical to a medical practice's cash flow. Given that up to 20% of all claims submitted are denied (according to industry experts), it is equally important to have effective procedures for managing denied and underpaid claims.

Costly Either Way

It's understandable that some physicians feel they're between a proverbial rock and a hard place on this issue. Not making an effort to collect on denials means they're missing out on what could be significant revenue. And simply resubmitting denied claims is rarely productive. On the other hand, trying to recoup the lost revenue means that each underpaid or denied claim must be researched and resolved. This kind of robust pursuit will almost certainly add time and create additional expense. However, once an efficient system of follow-up is in place, the result might very well be a net gain.

EOBs Tell the Story

Your billing department is already reviewing insurers' explanation of benefits (EOB) forms as part of your claims management procedure. Ideally, your staff is cross-checking reimbursement amounts with each payer's fee schedule to ensure that your practice is receiving the proper payment. When an EOB shows that a claim has been delayed, underpaid, or denied, it should be marked for immediate follow-up.

Claims Management Procedures

Claims are denied for a variety of reasons, many of which stem from processing errors that occur before claims are even submitted. Late filings, missing Social Security numbers, incorrect coding, and missing supporting documents are just a few examples of in-house errors you can take steps to correct. Eliminating careless errors will decrease the number of denied claims, leaving more time to resolve errors that originate somewhere else in the process. Here are some ideas that may help improve accuracy.

- Create a reference sheet for codes and have it readily available. Be sure to include the most commonly used codes, including ICD-9-CM and CPT codes.
- Be familiar with insurers' procedure reporting requirements.
- Foster good communication between practice physicians and your coding staff.
- Make sure all claims are carefully reviewed before they are submitted. Consider using "scrubbing" software to spot obvious errors.

- Create a system for logging in claims that require some type of follow-up. Include the results from the first submission (i.e., payment denied, delayed, paid in part, etc.), actions required, actions taken, and any pertinent deadlines.

An Appealing Prospect

Simple problems can often be handled with a phone call or visit to the payer's website. More complicated situations may call for an appeal -- or several, in some cases. If you exhaust the appeals process, you can request an external review. In the end, your persistence may pay off, literally.

Your diligence may have other positive results. It might encourage a payer to change the way it handles certain claims, thus reducing future denials. And it will definitely show that your staff is on the ball and doing what it can to eliminate mistakes.

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