



White Paper

Top Practices To Prevent Claim Denials



Overview

The proper meaning of medical billing denial is, “the refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for healthcare services obtained from a healthcare professional.

As an employee of the practice, you know medical billing denials as constant headaches that negatively affect the practice’s revenue, cash flow, and operational efficiency.

Numbers tell the story. Over 200 million claims are denied every year and on average 15% of claims require rework.

Fortunately, there are many medical billing denials that can be avoided. Granted, they may never go to zero, but reducing them even by a fraction of a percent can have a substantial impact on your practice’s bottom line.

A decent methodology is to comprehend the different types of medical billing denials, pinpoint the most common billing issue and take considerable steps to avoid them.



Top 4 medical billing denials

Denials fall largely into two buckets: hard & soft. Hard denials cannot be reversed or rectified, and result in lost or written-off revenue.

Soft denials are temporary denials with the potential to be paid if the provider rectifies the claim or sends additional information.



Missing information

Leaving simply one required field blank on a claim form can trigger a denial. Demographic and technical errors, which could be a missing modifier, some wrong plan code, or no Social Security number, prompt 61% of initial medical billing denials and account for 42% of denial write-offs.

Duplicate claim or service

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Not covered by payer

Medical billing denials for procedures not covered under patients' current benefit plans can be avoided by checking details in the insurance eligibility response or calling the insurer prior to overseeing administrations.

The limit for filing expired

In medical billing, a timely filing limit is a timeframe within which a claim must be submitted to a payer. Different payers will have different timely filing limits; some payers allow 90 days for a claim to be filed, while others will allow as much as a year.

Payers set their timely filing limit with respect to the date of service rendered. If a claim is received after the predefined date, the carrier will then deny the claim with no patient responsibility. Correcting inpatient medical coding errors can cause delays that push medical billing past the deadline.

So the bottom line is, rather than working on the denied claims, it is always better to have a much sounder financial approach that can proactively measure the volume and reasons for denied medical billing claims so they can be avoided before they occur.

How to avoid medical billing claims denials?

Adding more people to the medical billing claims management team won't necessarily help reduce or prevent denials unless they know what to focus on.

The following can be a part of your medical billing denials management plan:

- Quantify and categorize denials by tracking, measuring, and reporting trends by the provider, procedure, and payer. Technology and analytics are vital to reliable business intelligence, but they are well worth the time and investment.
- Build a task force to analyze and prioritize denial trends, determine what resources are needed to implement solutions, and track and report progress.
- Further improve patient data quality at registration, which is the wellspring of many errors and, eventually, denials.
- Avoid incorrect assumptions and discover the true reasons for denials by going beyond generic coding explanations and performing root cause analyses.
- Optimize claims management software to help ensure edits are functioning, current, and improve your clean claims rate. Make sure your vendor should provide clean claims rate data regularly and tips to improve it customized to your organization analyses.
- Make use of automated predictive analytics to flag potential denials and address them before claims are submitted.
- Work with payers to eliminate contract requirements that often lead to denials overturned on appeal. Above all, data analytics can help identify trouble spots and support negotiations.



Outsource for efficient & cost-effective denials management

Many practices are lacking the technology and staff capacity to manage denials effectively, especially in light of constantly changing regulations and payer rules. Outsourcing revenue cycle management to experts like Capline that have highly-dedicated denials management teams can be a profitable, sustainable alternative.

We are well-known when it comes to revenue cycle management services, we can help you establish medical billing benchmarks, reduce backlogs, identify root causes of denials and augment your revenue cycle team.



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