5 STEPS to Prevent and Manage Denials
Table of Contents

STEP 1
Calculate Your Denial Rate
04

STEP 2
Identify Top Denial Reasons
05

STEP 3
Implement Eligibility Verification
06

STEP 4
Improve Coding
07

STEP 5
Follow Up on Denials
08
The Medical Group Management Association (MGMA) has found that better-performing medical practices average just 4% in claims denials in their medical billing. And yet, time and time again, practice and billing managers say they struggle with denials.

According to medical billing and practice management expert Elizabeth Woodcock, it can cost as much as $15 per denial to follow up. This explains why only 35% of practices appeal denied claims.

Woodcock says a medical billing staff person should be able to follow up on about 50 items a day. So it is doable. Your practice can manage denied claims—and, according to Woodcock, for a lower cost.

But can you reduce the percentage of denied claims at your practice and avoid many denials altogether? Yes! Any practice can reach that 4% (or less) threshold because there are many ways to prevent and reduce denials before they happen.

This guide provides five simple ways to prevent denials before they happen and quickly follow up and resolve denials afterwards.
Step 1: Calculate Your Denial Rate

The first step is to figure out what your denial rate is with one of these formulas:

\[ \frac{A}{B} = C \]

- **A**: total claims filed
- **B**: total claims with at least one line item denied
- **C**: percentage denied

or

\[ \frac{A}{B} = C \]

- **A**: total line items (CPT® codes) billed
- **B**: total line items (CPT® codes) denied
- **C**: percentage denied

Once you know your percentage of denied claims you can set a realistic goal for reducing that rate.
Step 2: Identify Top Denial Reasons

Start by running a report that shows your top 10 to 20 denial reasons. Most likely this will include issues like incomplete insurance information (or other missing information), claims that lack enough specificity, claims not filed on time, and eligibility problems.

As you identify each issue, work on a plan to address that problem and reduce the impact on your practice.

Using software that also provides alerts when claims are denied or when a response has not been received for claims within a specified period of time can help your staff take quick action on problem items.

For example, if eligibility is a common problem:

1. Work with front desk staff on a step-by-step process to ensure that they gather and double check patient information on the phone and in person at each visit.

2. Have billing staff review the charges and look for specific items that are often missing to ensure the information is there and accurate.

3. Use a billing system that provides claim scrubbing before submission to the clearinghouse and a clearinghouse that provides claim scrubbing when claims are received. This will often catch things that humans can miss.
Step 3: Implement Eligibility Verification

By far, the most frequent type of denials in medical billing are those that are related to registration. These denials center on the patient’s eligibility for insurance coverage—or, in the case of a denied claim, the lack thereof. If the patient isn’t eligible for the services you render, you can (and, perhaps, should) bill the patient.

Keep in mind, however, that to ensure you can collect from patients you need a very thorough collections process. Once a patient leaves the practice, your chance of collecting the full amount drops dramatically.

Thus, before you transfer the invoice to the patient, check all other sources of registration information you can access - such as the hospital’s registration system - and verify every character on the card that you captured at the point of service.

Since some, if not most, registration denials end up as patient bad debt, it pays to make pre-visit eligibility verification an integral part of the registration process. Download your schedule of all patients with upcoming appointments into an automated eligibility system or perform real-time eligibility verification, available through most practice management systems.

Performing eligibility verification a day or two prior to the patient’s appointment allows time to contact ineligible patients about an alternate insurance. For those patients who no longer carry insurance, you can communicate with them and state your expectations about payment arrangements.
Step 4: Improve Coding

The second most common cause of denials is inaccurate coding. Physicians make mistakes. The coding process is complicated, and it is easy to enter the wrong diagnosis code. It is also easy to miss a modifier or under- or over-code a visit. Use mistakes as an opportunity to educate the provider about what happened so they don’t make the same mistake again.

If you’ve never conducted a coding audit, now may be the time. You can use the information to identify and correct ongoing mistakes and also use this data to help prepare for ICD-10.

Coding problems are often more common in the first part of the year when most changes to reimbursement occur. However, ICD-10 will also bring many changes, and preparing sooner rather than later will be to your benefit!

Coding accuracy can be greatly improved with an EHR, and even more so with an integrated practice management system. The EHR will help the provider document more comprehensively and code more accurately. The practice management system will scrub the claim for errors or issues before it is submitted.

According to research conducted by UBM, using an EHR in the average family practice can increase coding accuracy by 3.5% and charges by 5%.
Step 5: Follow Up on Denials

Elizabeth Woodcock offers a process to follow up on claims that are denied. The majority of denied claims (75%) can be resolved without an appeal. This process is for what she calls “hard” denials where the claim is denied because of a mistake or inconsistency in the claim—not an issue like coinsurance being due.

Her approach is simple: if there is a mistake, correct it and resend. If action is needed, investigate. Your investigation may include the following:

1. Reviewing insurance card (both sides)
2. Consulting the payer membership database
3. Contacting the patient directly
4. Looking at supporting documents:
   a. EOB/ERA
   b. Office notes and operative reports
   c. Proof of filing date(s)
   d. CPT® Manual
   e. Provider manual
   f. Payer reimbursement guidelines and policies

Be sure to use reminders or ticklers so that work on denials is done in a timely fashion. Otherwise, you could miss your window to resend the claim.

75% of denied claims can be resolved without an appeal.
Woodcock recommends setting up a protocol to ensure denials are managed and write-offs don’t happen automatically.

1. Denials should be worked within 3-7 days.
2. Follow the individual payer’s process so you don’t get another denial for a duplicate claim.
3. Protocol for write-offs requires the manager to sign off and is a written policy.

In the event that you do need to make an appeal, follow these steps:

1. Put it in writing. Maintain a library of appeal letters so you don’t have to recreate the wheel each time. Make sure it includes all research and backup along with the claim, patient, and details of service information. Be professional and state the facts.
2. Use authoritative sources such as medical literature, specialty society information, national and local Medicare coverage determinations, CPT® manual, and the payer’s website and policy manual.
3. Request a peer review by an expert in your specialty.
4. Carbon copy the state insurance commissioner and medical director. A list of insurance commissioners is available at: [www.naic.org/state_web_map.htm](http://www.naic.org/state_web_map.htm).
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