STUDY ON CLAIMS DELAY AND DENIALS

Internship Training
at
Deloitte Consulting India Pvt. Ltd.

By
Sonam Mittal

Under the guidance of
Dr. Nutan P. Jain

MBA Hospital & Health Management
2013–15

Institute of Health Management Research
Jaipur
2015

Dissertation

on

Study on Claims Delay and Denials
By

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Under the guidance of

Prof Dr. Nutan P Jain

Post Graduate Diploma in Hospital and Health Management

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Institute of Health Management Research
Jaipur

INSTITUTE OF HEALTH
MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

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The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all his future endeavors.

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This is to certify that Ms. **Sonam Mittal** was on a fixed term Internship from **February 09, 2015** to **May 15, 2015**. She has successfully completed her Internship in **Application Management Services**.

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She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish him/her all the best for future endeavors

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Deloitte Consulting India Pvt. Ltd. Bengaluru

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Manager/Team Lead
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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Study on Claims delay and denials** and submitted by **Dr. Sonam Mittal** Enrollment No. **1507** under the supervision of ProfessorNutanPrabha Jain for award of MBA Hospital and Health Management/ MBA Pharmaceutical Management of the university carried out during the period from **Feb 09, 2015** to **May 15, 2015** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

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DISSERTATION

Acknowledgement

The internship was started with a vision to be able to learn about the practical aspects of healthcare delivery system in a detailed manner. I hereby take this opportunity to express my deep sense of gratitude to all those who have been instrumental in the successful completion of my internship. Any accomplishment requires efforts of various individuals and this work is no exception

Firstly, I would like to thank Dr S D Gupta, Director - Institute of Health Management Research, Jaipur, and all the faculties, for the education imparted which has made me the person I am today, and Deloitte India Pvt. Ltd. for believing in my abilities.

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Dr Sonam Mittal
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List of Abbreviations

PCP	Primary Care Physician
HMO	Health Maintenance Organization
PPO	Preferred Provider Organization
POS	Point Of Service
HIPAA	Health Insurance Portability and Accountability Act
HITECT	Health Information Technology for Economic and Clinical Health Act
ARRA	American Recovery and Reimbursement Act
ICD	International Classification of Diseases
WHO	World Health Organization
IPD	Inpatient Department
OPD	Outpatient Department
HIT	Health Information Technology
EMR	Electronic Medical record
EHR	Electronic Health Record
HIP	Health information Privacy
PHR	Personal Health Record
EP	Eligible Professional

1.2 Introduction

About the organization

Deloitte provides industry-leading audit, consulting, tax, and advisory services to many of the world's most admired brands, including 70% of the Fortune 500. Deloitte functions across more than 20 industry sectors with one purpose: to deliver measurable, lasting results. Deloitte helps reinforce public trust in our capital markets, inspire clients to make their most challenging business decisions with confidence, and help lead the way toward a stronger economy and a healthy society. Deloitte has more than 210,000 professionals at member firms delivering services in more than 150 countries and territories. Revenues for fiscal year 2014 were US$34.2 billion.

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US Healthcare Overview –

The healthcare industry comprises of providers of diagnostic, preventive, remedial, and therapeutic services such as doctors, nurses, hospitals and other private, public, and voluntary organizations. It also includes medical equipment and pharmaceutical manufacturers and health insurance firms. It is one of the world's largest and fastest growing industries.

Health Insurance Portability and Accountability Act (HIPAA) –

The act was passed in 1996. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

The Health Information Technology for Economic and Clinical Health Act which was passed as a part of the ARRA Act (American Recovery and Reinvestment Act) focuses on adoption and meaningful use of EHR (Electronic Health Records).

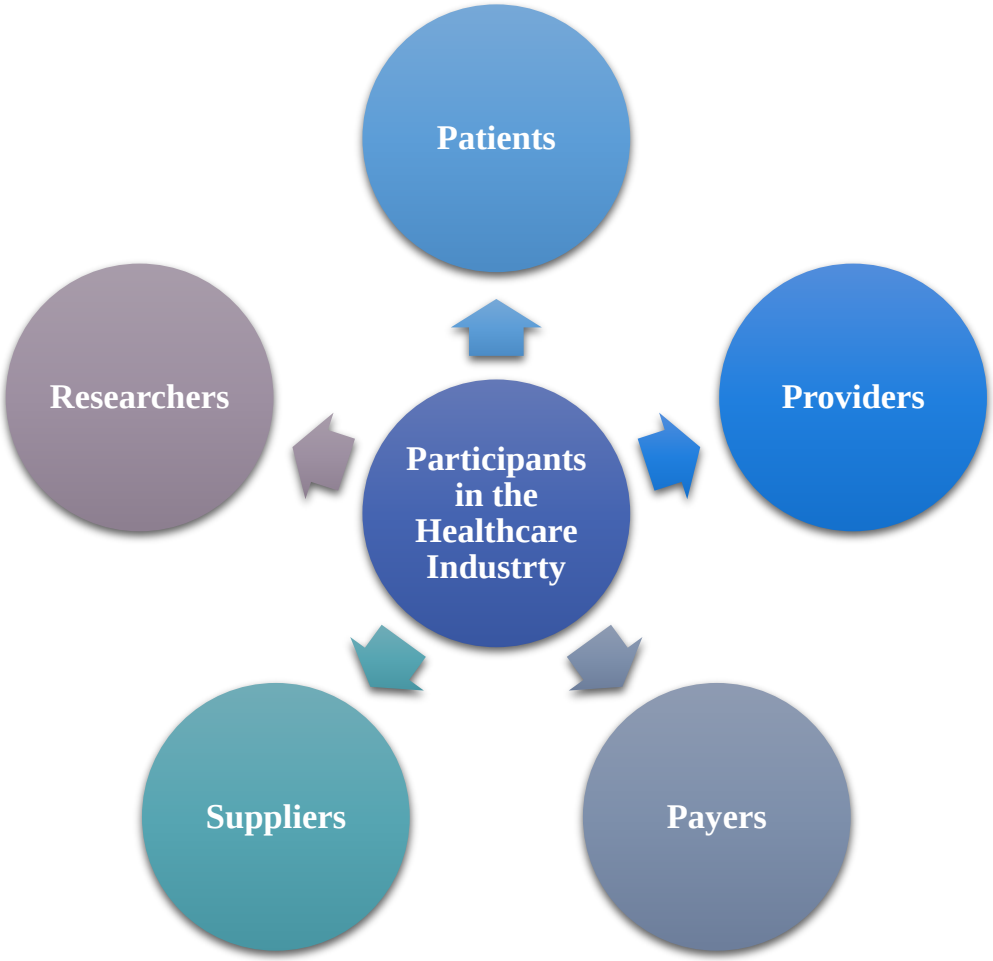
International Classification of Diseases (ICD) –

The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records. The International Classification of Diseases is published by

the World Health Organization (WHO) and used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support in health care. The ICD-10 code set is a new code set that replaces ICD-9. ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2014.

Participants in the Healthcare Industry –

Figure 1 – Participants in the Healthcare Industry



1. **Patients -** A patient is any recipient of health care services. The patient is most often ill or injured and in need of treatment by a physician, physician assistantor other health care provider.
2. **Providers –** Providers are licensed by the government to provide services, supplies and healthcare to the patients. Providers can be doctors, nurses, hospitals, nursing homes etc.
3. **Payers –** Payers are contracted with a patient to pay for healthcare services. These can either be private organizations or government agencies. If neither has contracted with a patient then the patient himself becomes the payer.
4. **Suppliers –** Suppliers are organizations that sell healthcare products to providers.
5. **Researchers –** Researchers investigate new ways to diagnose or treat illness. They lead to technological advances.

Reimbursement System –

Reimbursement is the method by which the providers charge and receive payments. Generally the patients pay a small amount called co-payment/co-insurance/deductibles. The major amount of the payment is done by the payers like insurance companies and government insurance schemes.

1. **Co-payment –** A small fixed amount a patient directly pays a provider for specific services.
2. **Co-insurance –** A fixed percentage a patient pays for services after the deductibles have been paid.
3. **Deductible –** A fixed amount per contractual period that a patient pays before the health insurance will begin to pay.

Providers –

Providers are of two types –

1. **Individual Providers –** These are again of two types –

A. **Primary Care Physicians (PCP) –** They are trained in general medicine and treat routine problems. Some insurance plans require seeing the PCP first before seeing the specialist.

B. **Specialty Care Physician (Specialist) –** They have more advanced medical training and practice in a specific field.

2. **Facility Providers –**

A. **Hospitals -** A hospital is a health care institution providing patient treatment with specialized staff and equipment.

B. **Ambulatory Surgery Center –** These are free standing facilities. They operate exclusively to provide surgical services to patients who don't need hospitalization. They may or may not be affiliated to hospitals.

C. **Skilled Nursing Facility –** they provide long term, inpatient, and skilled nursing care at a lesser intensity as compared to hospitals. There is at least one physician on staff or on call. They provide 4 basic services –

   i. Personal care

   ii. Residential services

   iii. Medical care

   iv. Nursing and rehab services

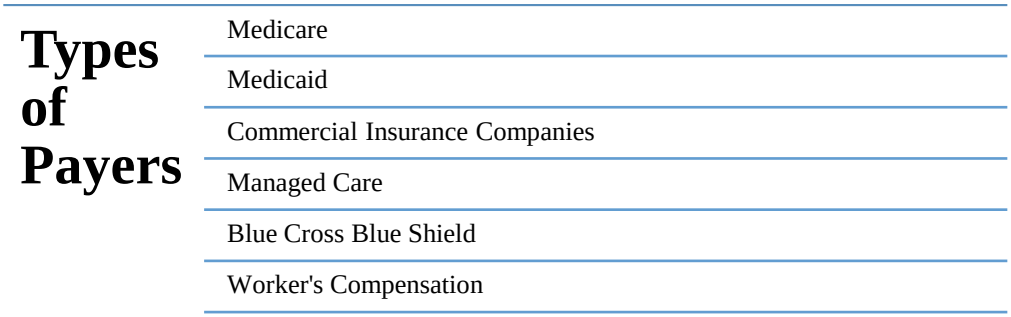
D. **Home Health –** They provide medical or non-medical services at home according to the treatment plan. They look after disabled, chronic and terminally ill patients.

E. **Hospice –** these provide supportive care to terminally ill patients. They provide counselling, pain relief and symptom management.

Payers –

Payers are third party organizations. They pay for most of an enrollee's healthcare through direct payment to the enrollee's provider.

Figure 2 – Types of Payers



- **Medicare -** Medicare is a national social insurance program, administered by the U.S. federal government since 1966, that guarantees access to health insurance for Americans aged 65 and older and younger people with disabilities as well as people with end stage renal disease.
- **Medicaid -** Medicaid in the United States is a social health care program for families and individuals with low income and resources. Medicaid recipients are enrolled in a private health plan, which receives a fixed monthly premium from the state. This insurance covers –

- ✓ Low income families and children
- ✓ Disabled, blind and aged
- ✓ Certain low income pregnant women and children

- **Commercial Insurance –**

  - ✓ **Commercial Insurance Companies –** These are private for profit companies. They are financed by premiums and offer other insurances also.
  - ✓ **Commercial Insurance Plan –** Here the company pays a large portion of the amount and the rest is paid by the patient. Individual as well as group plans can be purchased.

- **Managed Care –**

    - ✓ **Health Maintenance Organization (HMO) –** In a HMO, the patient first sees the PCP, who then refers him to a specialist if required. The co-payment is very less in HMO, but the patients are restricted to go only to a HMO hospital.
    - ✓ **Preferred Provider Organization (PPO) –** In a PPO, the patient can choose the physician and the hospital he wants to go to. It is the most expensive insurance as the co-payment is very high.
    - ✓ **Point Of Service (POS) –** In POS, the patient can choose from a network or non-network provider at a different fee.

- **Blue Cross Blue Shield –** It is the 1st private health insurance company. It is a not for profit organization and is located in every state of US.
- **Worker's Compensation –** This insurance is for employees who have been injured while at their job. They receive a percentage of their wages. The funding for this insurance is done by employer's tax and the employees are not charged a premium.

Claims -

Health insurance or mediclaim is a contract between the health insurance company and the insured individual, wherein the health insurance company agrees to pay the insured individual hospitalization expenses to the extent of an agreed sum assured.

Medical billing is the process of submitting and following up on mediclaims or health insurance with health insurance companies in order to receive payment for services rendered by a healthcare provider. It is an interaction between a health care provider and the insurance company (payer). The entirety of this interaction is known as the billing cycle also referred to as Revenue Cycle Management. The insurance company (payer) processes the claims usually by medical claims examiners or medical claims adjusters. For higher dollar amount claims, the insurance company has medical directors review the claims and evaluate their validity for payment using rubrics (procedure) for patient eligibility, provider credentials, and medical necessity. Approved claims are reimbursed for a certain percentage of the billed services. These rates are pre-negotiated between the health care provider and the insurance company. Approved claims once paid by the payer are considered as Closed claims. Claims which have been accepted by the payer but still has not been paid are referred to as Delayed claims. Failed claims or the claims for which the payer have rejected to pay are called Denied claims. Denial of claim is the refusal of an

insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional and a notice is sent to the provider. Most commonly, denied or rejected claims are returned to providers in the form of Explanation of Benefits (EOB) or Electronic Remittance Advice.

Upon receiving the denial message the provider deciphers the message, reconciles it with the original claim, makes required corrections and resubmits the claim. This exchange of claims and denials may be repeated multiple times until a claim is paid in full, or the provider relents and accepts an incomplete reimbursement.

1.3 Process flow of Claims Processing

Figure 3: Process flow at Provider's end

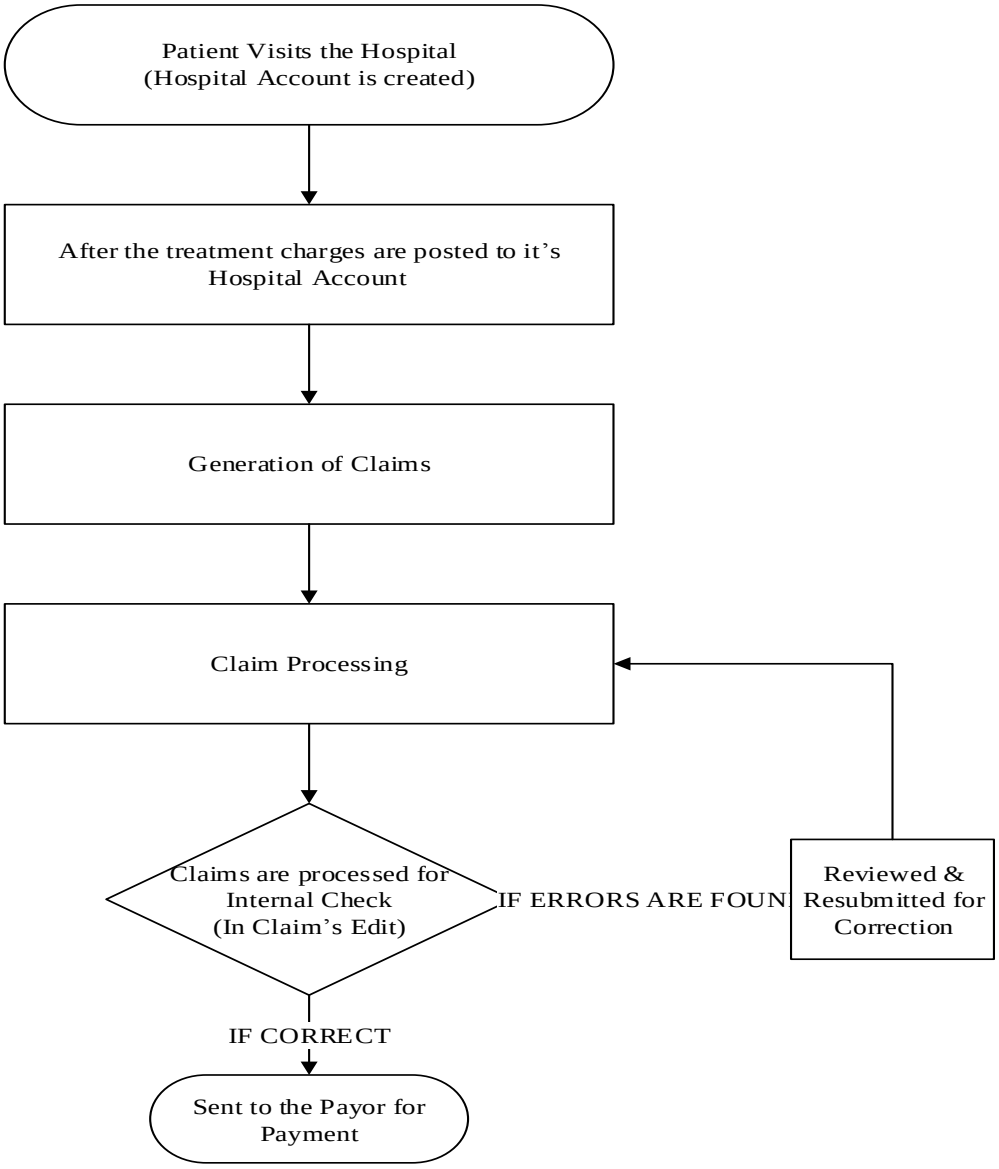
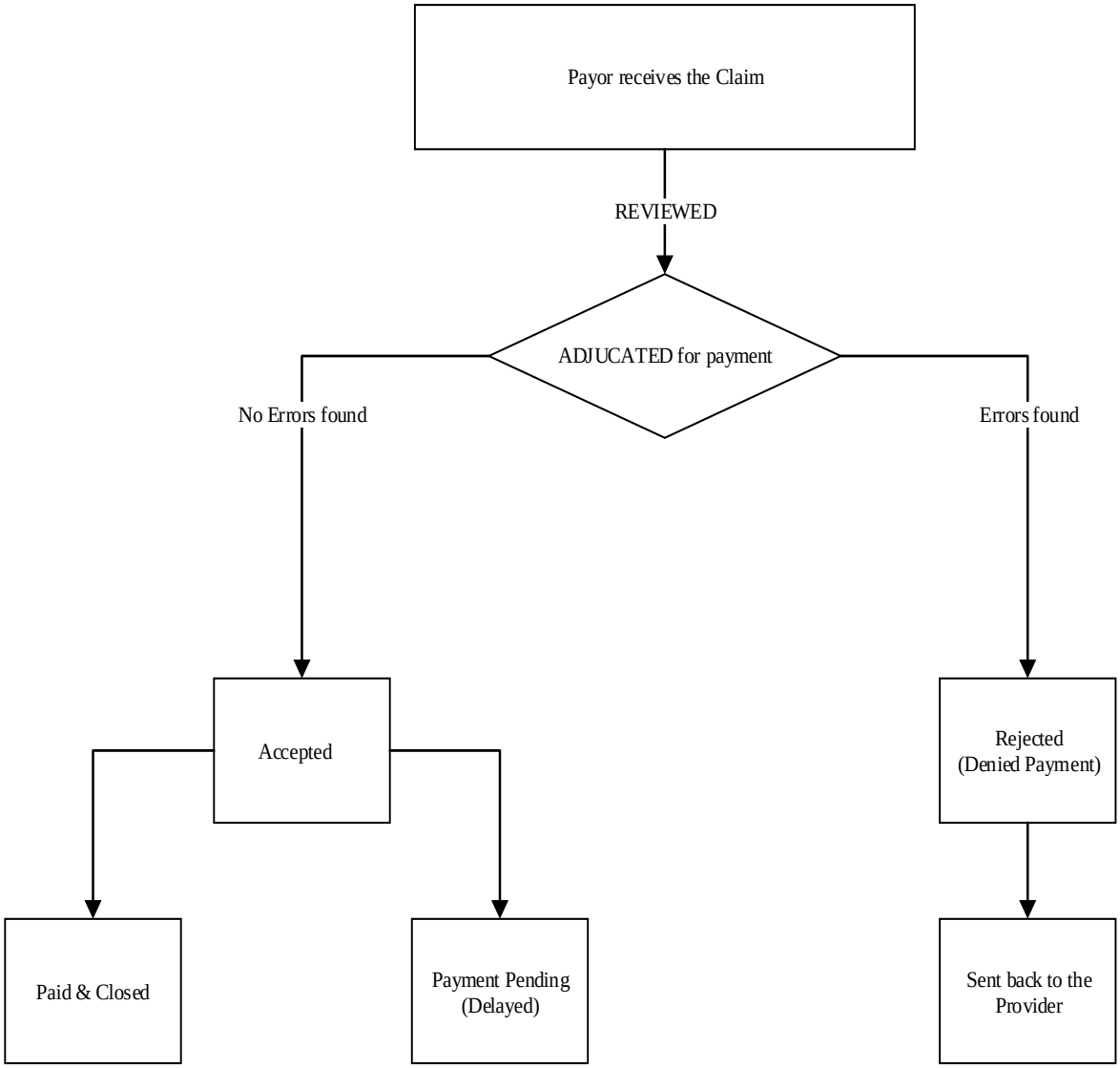


Figure 4: Process Control at Payer's end



1.4 Problem Statement

Health care organizations face heavy losses every year as a result of claim rejections and denials, and this in the long run affects the productivity and sustainability of the medical practice to a bad extent.

1.5 Rationale of the Study

Claim denials can be a major source of frustration for physicians and their practice managers, and can have a real impact on cash flow and the financial performance of a practice. Sometimes, the denial stems simply from the fact that the claim had some kind of error. In 2012, the American Medical Association reported that an average of 9.5% of health claims processed by private health insurers contained errors. Knowing the major areas of these errors can help reduce the number of claim denials, thereby lowering the turnaround time of the claim payments.

1.6 Research Questions

- What is the turnaround time of claims payment?
- How much does claim denials account as a percentage of claim delay?
- What are the areas and reasons for claim denials?
- How can the denials affect the revenue cycle management of the provider?

1.7 Objectives

1. To determine the turnaround time of claims payment
2. To find the percentage of claims denied by the Payer
3. To find the reasons of claim denials
4. To determine the impact of denials on revenue cycle of the provider.

1.8 Review of Literature

According to a study "Hospital Denial Management, Insource, Outsource or Both?"(Holly Pelalia, Human Arc, 2013), roughly 67% of all denials are appealable, suggesting hospitals should be setting their expectations a bit higher. It also estimates that among U.S. health care providers, gross charges denied by payers have grown to an alarming 15% - 20% of the nominal billing value of all claims submitted, according to recent estimates. It is estimated that around 90% of all denials are preventable, so the provider's objective should be to analyze the root causes of its denials/audits, understand how to avoid them, and reduce future denials to a minimum.

"Driving the Denials Management Initiative, a Renewed Focus" (The Advisory Board Company, Washington, D.C.-based, global health care research, technology and consulting firm, web conference, July 28, 2009), encapsulated that denials cost health care organizations about 3% of their net revenue stream. It also said that out of all the claims denied, 67% of it were recoverable. According to them the denials can be reduced by custom denial mapping, departmental tracking and root cause analysis of the denials.

According to the American Medical Association (AMA, National Health Insurer Report Card, 2012), the claim management process is far from efficient and quite error-prone. It found that 19.3%—almost one in five—of medical claims processed by the nation's largest commercial health insurers is inaccurate. The report found a 2% rise in claims processing errors over last year's findings, which added "an estimated $1.5 billion in unnecessary administrative costs to the health system," according to the AMA. The doctors' group

estimates that if all health insurers were able to eliminate all claim payment errors, the health care system would save $17 billion a year.

As per the study “Denial Management: Field Tested techniques that get claims paid (Elizabeth Woodcock, American College of Medical Practice Executives, 2014),denied claims represent unpaid services — and lost or delayed revenue to your practice. Importantly, they also signify an avoidable cost to the medical practice. Employees’ time spent managing and — ideally — resolving denials saps significant resources from the medical practice’s business office.

1.9 Methodology

Study design:

This is a Cross sectional Analytical study on Quantitative data pertaining to claims of the patients generated in a XYZ hospital.

Study time line

The study was conducted over a duration of 2 months.

Study area:

The study was conducted in Deloitte Consulting India Private Limited.

Study population:

Data on claims generated in a particular US based Healthcare Facility over a period of one month.

Sampling:

Sampling procedure used was Accidental non probability sampling with a sample size of 171 claims from 13 payers.

Data collection:

- Technique: Data is collected through desk research.
- Data type: Primary Data on the claims sent to the 13 payers by the XYZ hospital(US based Healthcare Facility) over a period of one month

1.10 Statistical Treatment

Data collected was cross checked for any incomplete or partial filling. Using Microsoft Excel, collected data was then be de-identified, coded, tabulated and organized for the required analysis.

1.11 Ethical Considerations

- Permission and Approval from the organisation is obtained before accessing and using the data.
- Data collected for claims payment contained information pertaining to the patients hence confidentiality of the data obtained will be maintained.
- Name of the insurance companies (Payers) included in the study are de-identified because of PII and PHI regulations followed by Deloitte.

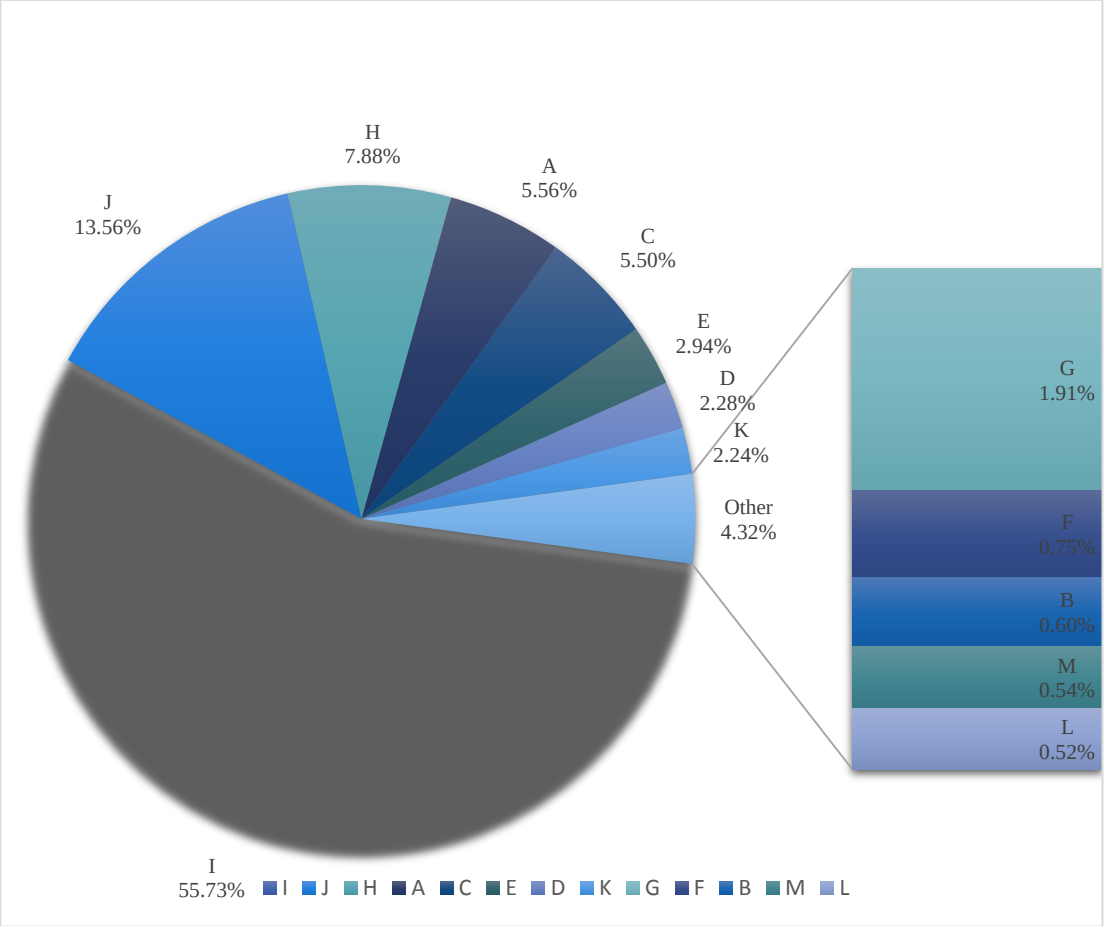
1.12 Result

1.12.1 Proportion of claims of each insurance company:

Every insurance company (Payer) have different proportion of the claims submitted by the hospital. The payer with the highest proportion is Payer I accounting for 55.73% of all the

claims submitted by the hospital over a period of one month, indicating that this is the most preferred insurance company for the medical insurance by the patients.

Figure 5: Proportion of claims sent to each payer



1.12.2 Calculation of turn-around time

The turn-around time of each payer was different from the other, because the system of payment of claims varies from payer to payer. Each payer had their own specific guidelines and set of conditions for payment of the claims. The turn-around time was minimum for Payer H, showing that Payer H takes only 20 days on an average to make the payment of the claims sent to them by the hospital. Whereas Payer L took an average of 48days, which

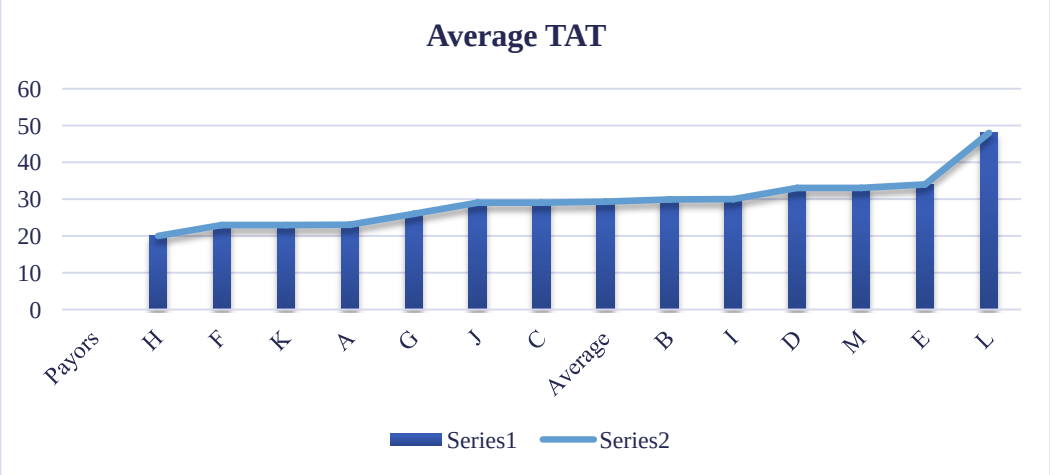
is maximum time for the payment of the claims. The average turn-around time for the payment of claims over a period of one month by all payers comes out to be 29. 3 days.

Table 1: Turn-around time of each payer

Payers	Total claims	Total claims (%)	TAT
A	1016	5.56%	23.03
B	109	0.60%	29.94
C	1005	5.50%	29.03
D	417	2.28%	33
E	537	2.94%	34
F	137	0.75%	23
G	350	1.91%	26
H	1442	7.88%	20
I	10192	55.73%	30
J	2479	13.56%	29
K	410	2.24%	23
L	96	0.52%	48
M	98	0.54%	33
	18288		29.30

With the average turn-around time of 29.30 days, payers which make the payment on within the average turn-around time are H, F, A, G, J and C. The payers who are above this average are payer B, I, D, M, E and L.

Figure 6: Average turn-around time



1.12.4 Proportion of claims paid and not paid

Of all the claims sent by the hospital to the payers, 77% were paid. For individual payers the proportion of claims not paid and paid is high for payer B and M, indicating that these two payers have higher number no. of not paid claims than the paid claims.

Figure 7: Proportion of claims paid and not paid

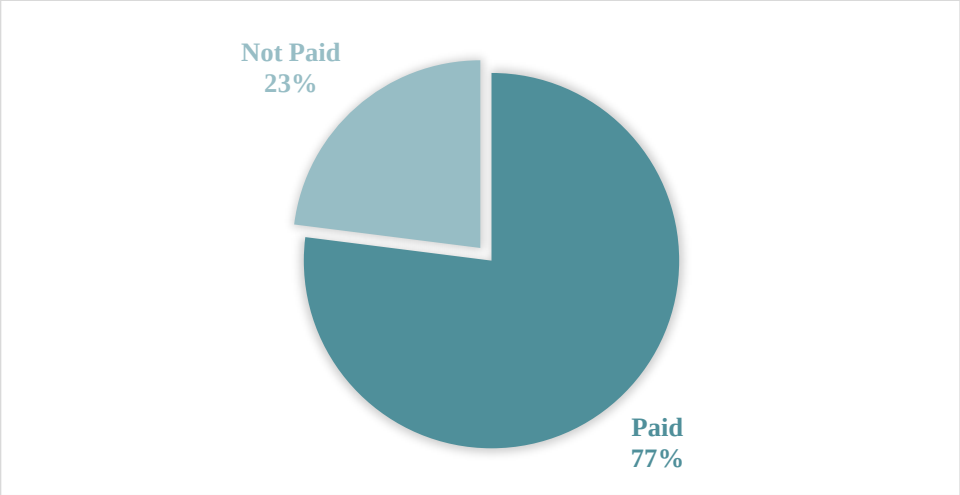
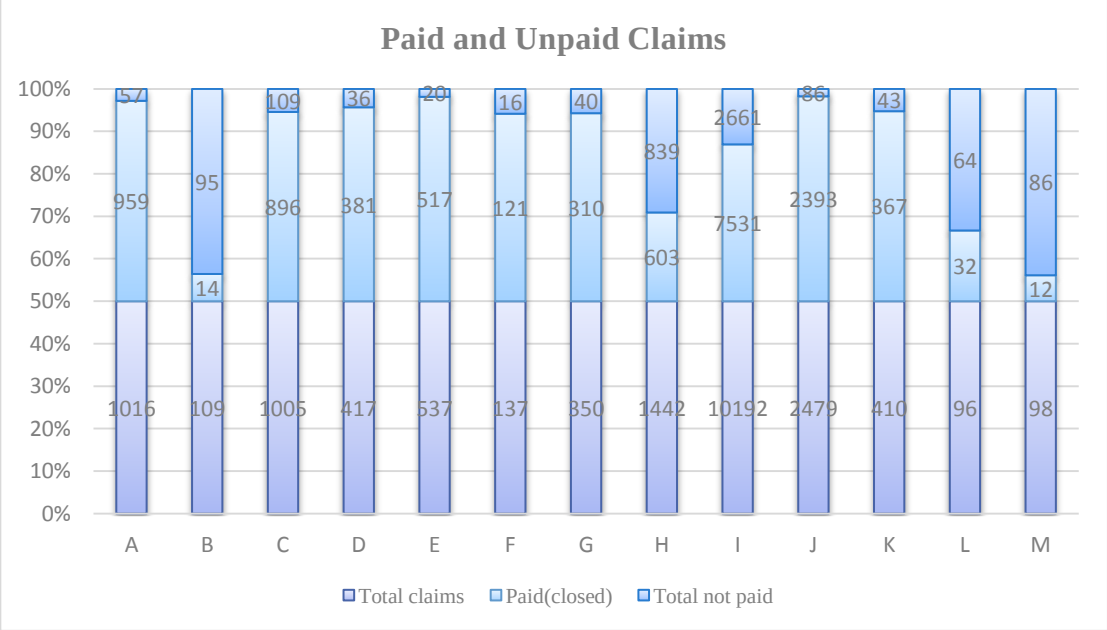


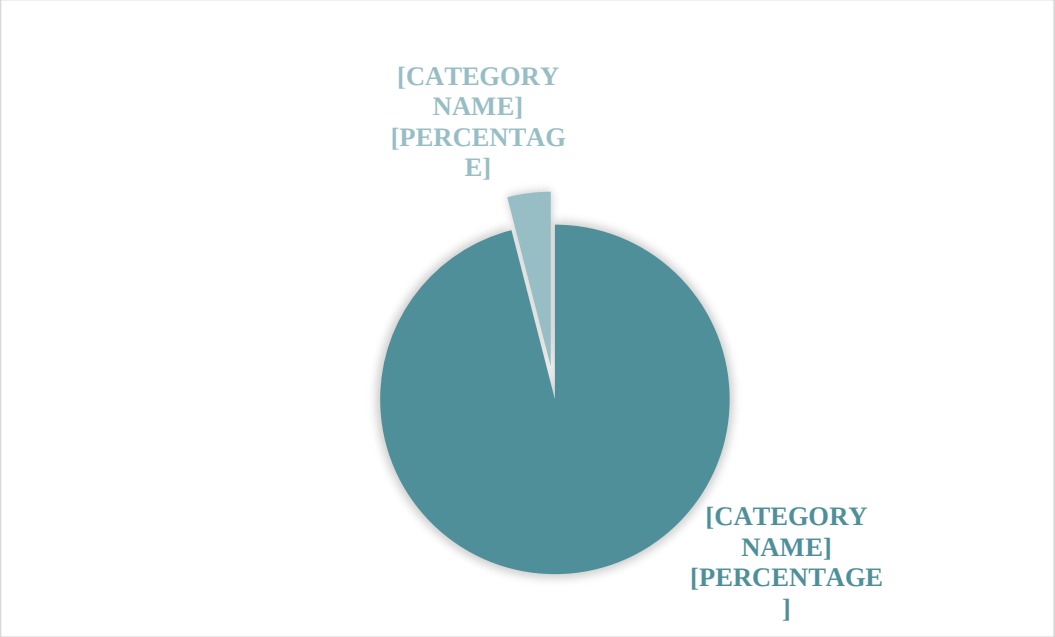
Figure 8: Proportion of Claims paid and not paid for each Payer



1.12.5 Computing claims delayed and denied as a percentage of all not-paid claims.

The claims not paid can be further divided into two categories, one which has been accepted by the payers but the payment has not been made yet, and the other which are rejected by the payers for the payment. Out of all the not paid claims, 4% are rejected and 96% are accepted but waiting for their payment.

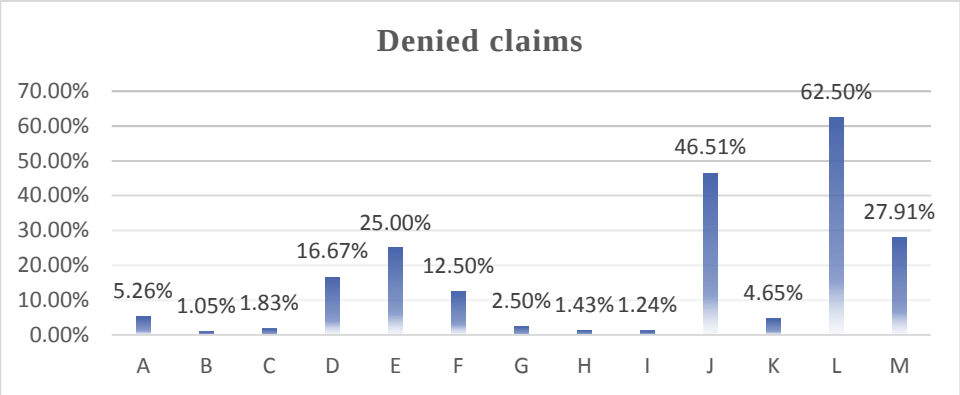
Figure 9: Proportion of claim accepted and rejected



1.12.6 Denial rate for each Payer

Denial rate for each payer is different due to the variations in the process for the claim payment. Payer L have the highest denial rate of 62.50% and payer B have the lowest denial rate of 1.05 %. Denial rate of 5% is still considered to be acceptable and within the limits. Out of 13 payers, only 6 payers have denial rate under 5% rest all are above it, showing that overall denial rate is high.

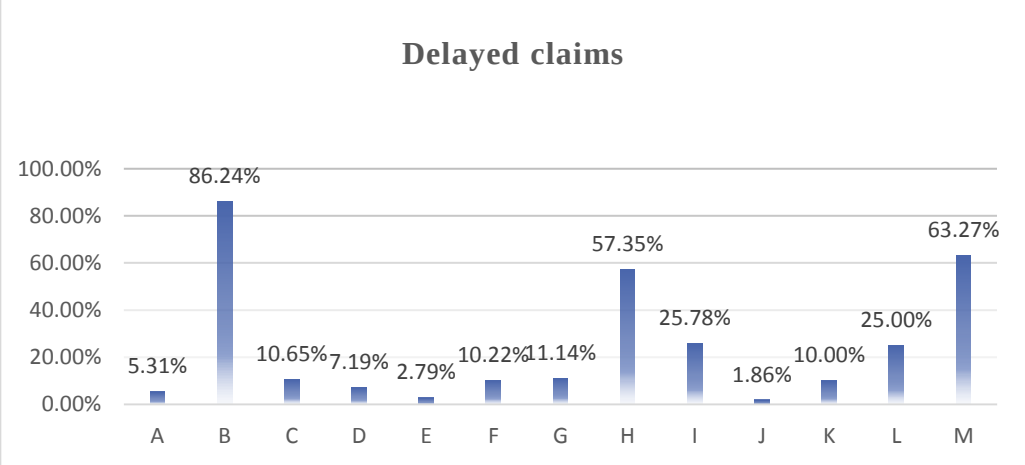
Figure 10: Denial Rate for each Payer



1.12.7 Delay rate for each Payer

The claim verification and other prerequisites for the payment of claim for each payer is different, which contributes to the differences in the Delay rate of the claims by the payers. Payer B has the highest delay rate of 86.24% and payer J have the lowest delay rate of 1.86%. As per the organization's norms, if the payment of the claims is delayed by 10% of the total revenue generated from the payment of the claims submitted to that payer over a period of one month, than it is acceptable, but if it is above 10% than it has be tracked to know the reason for the delay in order to get it paid.

Figure 11: Delay Rate for each Payer



1.12.8 Impact of denials and delays on the revenue cycle management in terms of monetary losses

With the delay and rejections (denied) of the claims payment, the hospital faces loss in terms of the money as well as resources. The total monetary impact to the hospital due to not paid claims for one month is $1,419,973. Out of which $45,629 is due to Denied claims and $1,373,344 is due to delayed claims.

Table 2: Monetary losses due to Denied and Delayed claims

Insurance co.	Denied	Delayed
A	$304.00	$22,211.00
B	$135.00	$4,995.00
C	$15,739.00	$45,156.00
D	$216.00	$15,028.00
E	$1,142.00	$11,317.00
F	$631.00	$4,314.00
G	$67.00	$15,776.00
H	$2,284.00	$368,743.00
I	$4,993.00	$797,790.00
J	$6,086.00	$33,082.00
K	$393.00	$17,651.00
L	$9,878.00	$5,680.00
M	$3,761.00	$32,601.00
Total	$45,629.00	$1,374,344.00

1.13 Discussion

The objective of the study was to find out the turn-around time of the claims payment which will help to find out the delay and denials of the claims by the payers. After finding the denial and delay rate, on discussing with the key stakeholders, it was found important to

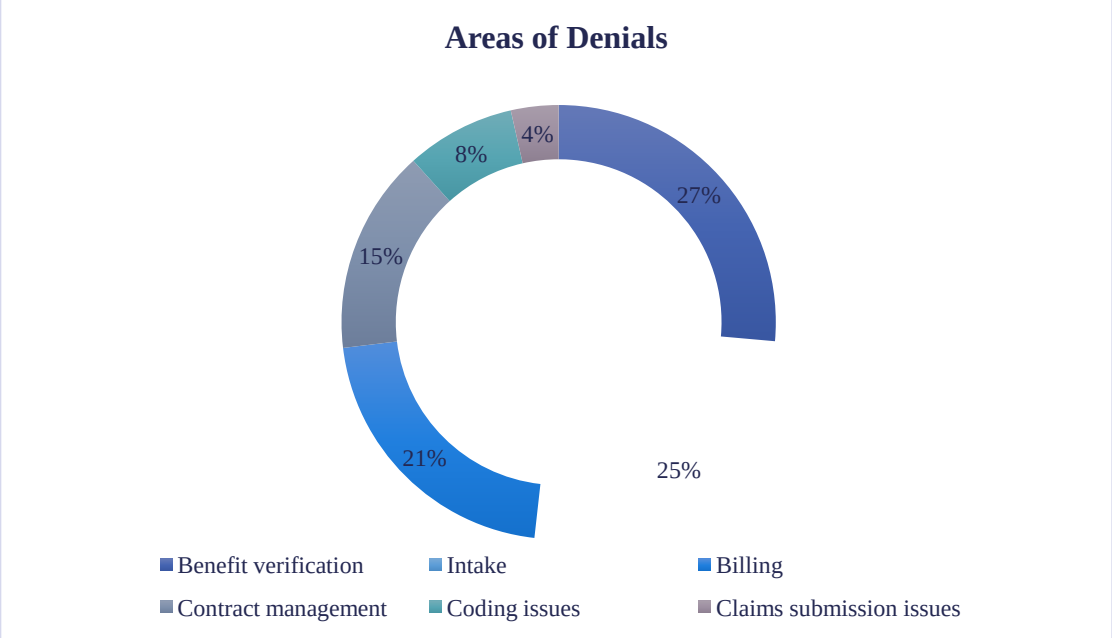
know the areas and the reasons for the claim denials, so that necessary action can be taken accordingly to reduce the higher turn-around time in order to improve the efficiency.

1.13.1 Areas of denials

The denials of claim payment can stem from following four areas:

- Contract management
- Benefit verification
- Billing
- Claims submission issues
- Coding issues
- Intake

Figure 12: Areas of Denials



1.13.2 Reasons for Denials

The areas of denials is further divided into the reasons under these areas which lead to the denials of the claim payment by the payers

Table 3: Areas and Reason for Denials

Reasons for Denials	**Areas of denials**
Plan procedures not followed	Contract management
Bundled/unbundled	Contract management
Plan expired	Contract management
Additional info needed	Intake
Not medically necessary	Intake
Not eligible to provide service	Intake
Incorrectly prescribed	Intake
Liability/work related claim	Intake
Incorrect/incomplete Rx	Intake
Not prescribed by Physician	Intake
Service not provided is documented	Intake
Member not eligible	Benefit verification
Other insurance	Benefit verification
Non-covered charges	Benefit verification
Authorization/referral needed	Benefit verification
Out of network provider	Benefit verification
Patient not identifiable	Benefit verification
Coverage terminated	Benefit verification
Benefit maximum met	Benefit verification
Capped services	Benefit verification
Incorrect coding	Coding issues
Past timely filing	Billing
Billing error	Billing
Previously paid	Billing
Qualifying service missing	Billing
Missing/incorrect claim info	Billing
Claim Sent to Wrong Address/ Unit	Claims submission issues
Insufficient Bill Edits	Claims submission issues

These denial reasons can be further divided into two categories as:

Hard Denials: Those denials which requires appeal for their corrections. These include

- Denied claim for elective service without pre-authorization

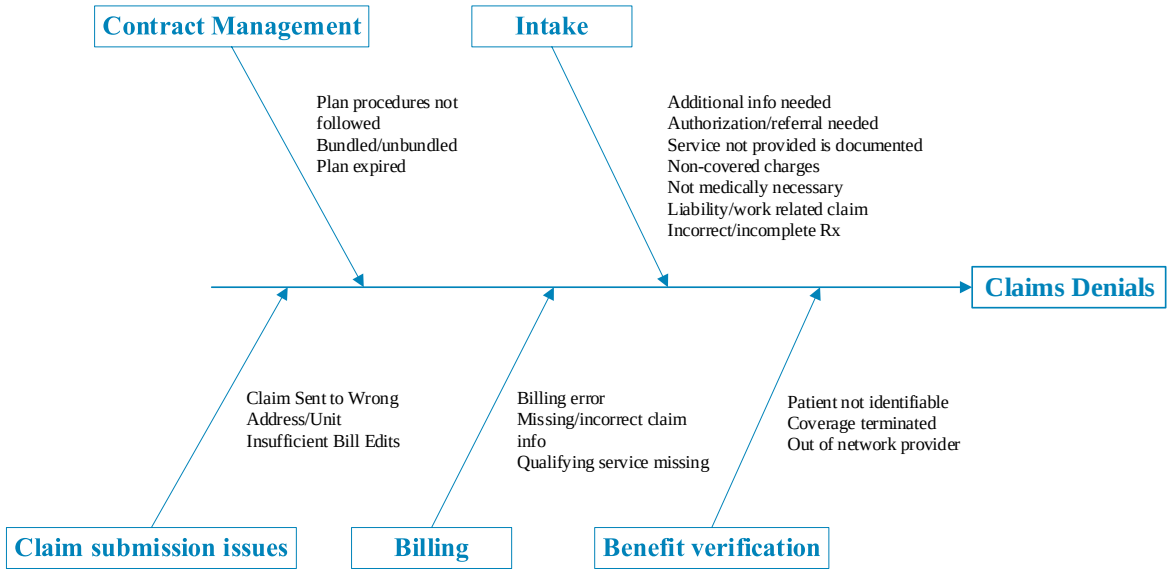
- Denied days, service, or level of care for no concurrent authorization or lack of medical necessity
- Denied due to charge/coding issues
- Denied as not a covered service
- Denied charge/procedure as bundled
- Denied for untimely submission

Soft Denials: Those denials which only requires additional information for correction.

- Denied claim due to missing/inaccurate information
- Denied charges pending receipt of itemized bill
- Denied secondary payment pending receipt of primary EOB

1.13.3 Fish Bone Diagram

Figure 13: Cause effect diagram for claim denials



1.13.4 Pareto analysis for Denials

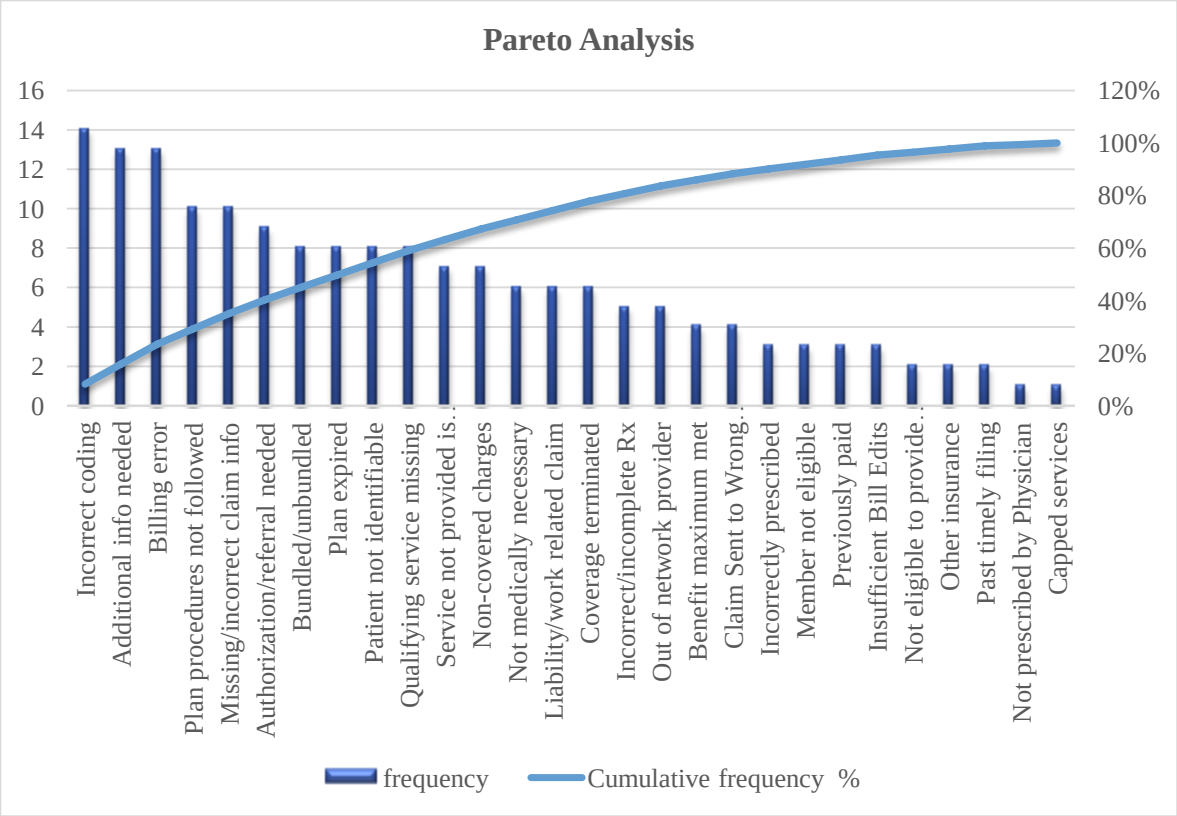
The reasons of denials are varied and have their impact on the denials at different degrees. Pareto Analysis have been done to know which reasons account for most of the denials and which reasons have to be worked on. Pareto analysis showed that the 80% of the denials are due to the following reasons:

These reasons which account for the 80% of denials should be worked first in order to reduce the number of claims denied by the payers.

1. Incorrect coding
2. Additional info needed
3. Billing error
4. Plan procedures not followed
5. Missing/incorrect claim info
6. Authorization/referral needed
7. Bundled/unbundled
8. Plan expired
9. Patient not identifiable
10. Qualifying service missing
11. Service not provided is documented
12. Non-covered charges
13. Not medically necessary
14. Liability/work related claim
15. Coverage terminated
16. Incorrect/incomplete Rx

17. Out of network provider

Figure 14: Pareto Analysis for Claim Denials



1.14 Conclusion

The study aimed to find out the turn-around time for the payment of claims which will in turn help to find the delay and denial rate for each payer. As is evident from the results and the discussions, the denial rate for payers is high, and hence need a strategic action to manage these denials. On discussion with the key stakeholders, it was concluded that, to manage and control these denials, an effective denial management system must be established and implemented. For this Denial Management system was suggested so as to mitigate these denials and to avoid these denials in future.

Best practice is to trend and track the denials at the time of posting the payments. Denials should be tracked by payer, type of denial, and provider. Staff members must be assigned to work denials on a regular basis, daily for a large medical practice. When trends in the denials are identified, providers and/or staff members should be informed and processes put in place to avoid the denials in the future. By working the denials in a timely manner, processes can be corrected on a timely basis.

Third-party payers have specific instructions for appealing denials. The instructions should be appropriately followed and claims should not be haphazardly re-transmitted, since this can result in duplicate claims. Medical practice staff members that are responsible for denial management should develop a first-name relationship with provider representatives at high-volume payers. Reimbursement generated from successful appeals can be tracked to demonstrate the value of monitoring and working denials.

To prevent denials, specific staff members should be assigned to monitor correspondence, instructions, bulletins, etc., from high volume payers. Information should be shared with the appropriate providers and staff members so claims can be completed and transmitted according to the payers' specifications.

A questionnaire tool has been designed for the staff members, with which we can improve claim processing and payments.

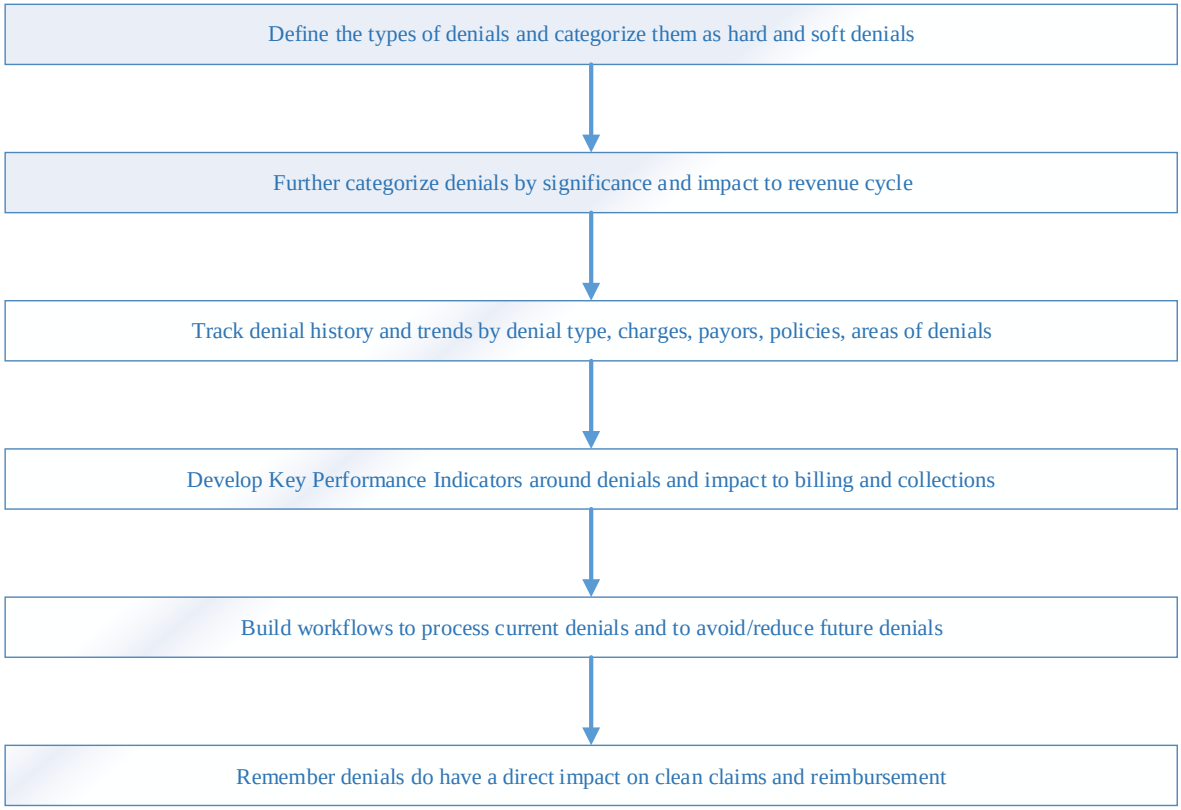
Keys to Prevention

1. Understanding the root cause.

2. If internal, communicating and collaborating internally to update processes that will mitigate denials in the future

3. If external, communicating and collaborating with the payers to update processes

Denial Management



Keys to Denial Management

- Maximize cash flow - Reporting identifies denial causes having the greatest financial impact, thereby accelerating cash flow.
- Identify the root cause of denials - Collecting and interpreting denial patterns to quantify denial causes and their financial impact.
- Support accurate workflow priorities and scheduling for follow up - Collecting information on denial appeals, including status, escalation, correspondence with payers, and the disposition of denial appeals to increase recovery amounts.

- Provide accurate and timely statistics for Management / Clients - Providing management analysis reports and other information to prevent future denials.
- Track, Prioritize & Appeal denials - Generating appeal letters based on federal and state statutes and case citations favoring the medical provider's appeal.
- Avoid out-of-timely filing.
- Analyze the effectiveness of denial resolutions.
- Identify business process improvements to avoid future denials

1.15 Limitations

1. This study is done only for one hospital and data collected was of only one month, and hence cannot be generalized for the complete US Healthcare Market.

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ANNEXURE

Improving Claims Processing and Payment:

A Self-Assessment Tool for Physicians/Providers

A major goal of physicians/providers and plans is to reduce the frustration and unnecessary expense associated with claims that are misfiled, delayed, denied, or not paid in an expedient manner. A variety of factors influence how health insurance claims are processed and the extent to which they are paid promptly and accurately. One of the first steps that a physician/provider can take to improve claims processing and payment is to undergo a self-assessment of his or her practice. The self-assessment can take the form of a diagnostic assessment (i.e., to determine the cause of a problem), or a routine maintenance assessment (i.e., to fine tune claims processing procedures). The purpose of the following set of questions is to assist physicians/providers to better understand the processes used within their own practice to submit and track claims, and to discover opportunities for improving those processes for the purpose of improving payment and accounts receivable.

Electronic claim submission is a quick and efficient way to process claims. Most health plans accept electronic claims from a variety of sources and methods. Contact them directly for more information.

Self-Assessment Questions for Physicians/Providers

Step 1: Start by collecting some basic information about how your practice is currently performing with regard to claims processing and accounts receivable. Ask your billing staff or service to provide answers to the following questions:

A) How many claims did your practice submit in a recent 30 day period?

(1) Paper Claims

(2) Electronic Claims

B) Of the number of claims submitted in those 30 days, approximately what percent were denied? %

C) For claims denied, what were the most frequent reasons stated by the payer for the denial?

(1)

(2)

(3)

D) Of the number of claims submitted in that 30 day period, approximately what percent were delayed (i.e., not paid within 30 days of the claim submission date)? %

E) For claims that were delayed, what were the most frequent reasons stated by the payer for the delay in payment?

(1)

(2)

(3)

F) Does the percentage of denied or delayed claim payments vary between paper claims and electronic claims? ❑ Yes ❑ No

Step 2: Use the following checklist to collect additional information about specific practices and policies used by your billing staff or billing service. Your answers to the following questions should provide you with a number of specific suggestions and ideas for improving your billing practice and accounts receivable.

1. Does the billing staff or service track the percent of claims that are denied on the first submission? ❑ YES ❑ NO

If No, make tracking the percent of claim denials a part of your routine billing practice. By doing so, you and your billing staff will be able to notice and respond to increases in claim denials that may be indicative of a systematic or isolated problems.

2. Do you know the most frequent reasons for claim denials in your practice (as stated by payers)? ❑ YES ❑ NO

If No, begin collecting and noting the most frequent reasons for claim denials. The leading causes of claim denials are related to submission of duplicate claims and issues of eligibility. A variety of the tips contained in this document are directed at reducing claims denied as "duplicates" and those that are denied due to ineligibility.

3. Do you have claims that have been denied because they were submitted to the wrong payer? ❑ YES ❑ NO

If Yes, consider your responses to the following questions.

4. Does the office staff make a copy of each new patient's insurance card?

❑ YES ❑ NO

If No, require the office staff to make a copy of each patient's insurance card, as well as their spouse's or other parent's insurance card if they have secondary coverage.

5. Does the office staff ask every patient at every visit about changes in their insurance information? ❑ YES ❑ NO

If No, require office staff to ask every patient at every visit about changes in insurance information. If there are changes in insurance information, be sure to make a copy of the patient's new insurance card and replace the old information with the new. Keep accurate

records of all insurance information (current and previous) for use in claim follow-up, appeals, disputes or COB issues.

6. Do you have claims that are denied due to ineligibility? ❑ YES ❑ NO

If Yes, consider your response to the following question.

7. Does the office staff routinely check patient eligibility before or during the office visit? ❑ YES ❑ NO

If No, establish a routine office procedure to check eligibility prior to the visit or at the time the patient is in the office. Most health plans allow physicians/providers to check eligibility in a number of ways, including traditional telephone contact, interactive voice response technology, and on-line.

8. Do you have claims denied or delayed due to coordination of benefits (COB) issues? ❑ YES ❑ NO

If Yes, consider your responses to the following questions.

9. Does the office staff ask each patient about secondary or other coverage?

❑ YES ❑ NO

If No, make it a routine practice to ask patients about whether they have secondary or other insurance coverage. Gathering this information and using it when billing the insurance carriers can reduce the number of claims that are delayed pending coordination of benefits (COB).

10. When checking eligibility via "live" telephone contact, does the office staff ask the payer to verify that they are the primary carrier? ❑ YES ❑ NO

If No, use this opportunity to ask the payer to verify whether they are the primary or secondary carrier. In some instances, if the payer is secondary they may be able to tell you which payer is primary.

11. When benefits are being coordinated between two payers, does the billing staff always send the EOB from the primary payer when submitting a claim to the secondary or other payer? ❑ YES ❑ NO

If No, establish a routine office procedure to ensure that when claims are sent to the secondary or other payer, they routinely include a copy of the Explanation of Benefits (EOB) from the primary payer. Failure to attach the EOB from the primary payer is likely to result in a claim that is delayed or denied due to Coordination of Benefits (COB).

12. Do you have Medicare claims that are denied or delayed? ❑ YES ❑ NO

If Yes, consider your responses to the following questions.

13. Does the office staff ask each new patient age 65 and older to provide a copy of their Medicare card? ❑ YES ❑ NO

If No, establish a routine office procedure to ask all patients for a copy of their Medicare card if they are 65 or older, or when they turn 65. Federal laws determine when Medicare is the primary payer. Remember that it is possible for a patient to have only Medicare Part A or Part B, or to be ineligible for Medicare despite being 65 or older. It is also important to know if Medicare eligible patients also have group health insurance. Be sure to update your records with the information provided from patients and documented on the Medicare card.

14. If Medicare is the primary payer, does the billing staff check to see if Medicare "crosses over" with the secondary or other payer before sending a bill to the secondary payer? ❑ YES ❑ NO

If No, remind billing staff that many health plans pay Medicare to send them claims that are their responsibility as a secondary payer. This is called a "cross over". The billing staff should determine whether the patient's claim will be "crossed over". If so, submitting a claim directly to the secondary payer will result in a denial due to duplicate claim.

15. Do you have claims that are denied as duplicates? ❑ YES ❑ NO

If Yes, consider your response to the following questions.

16. Does the billing staff or service use a suggested minimum rebilling cycle of at least 30 days? ❑ YES ❑ NO

If No, use a minimum rebilling cycle of at least 30 days to allow time for the original claim to move through the payer's cycle. Resubmitting a claim in a lesser amount of time uses unnecessary resources and is likely to result in a denial for duplicate claim.

17. Does the billing staff or service reconcile claim denials and claim payments at least every 10 days?❑ YES ❑ NO

If No, require your billing staff to reconcile claim denials and claim payments at least every 10 days. This includes regularly working through electronic error and rejection reports. This practice will help avoid common mistakes such as rebilling a denied claim or billing the patient's portion to the insurance carrier.

18. When a claim requires follow-up by billing staff or a third party, is contacting the payer the first step in the follow-up process (as opposed to automatically resubmitting the claim)?❑ YES ❑ NO

If No, encourage billing staff to telephone payers or use on-line tools when additional information is needed regarding a claim that is unpaid or incorrectly paid. You will reduce the number of duplicate claim denials by not automatically rebilling all outstanding claims.

19. Does the practice have an official policy about collecting the patient's co-payment at the time of service? ❑ YES ❑ NO

If No, establish a routine office procedure to collect the patient's co-payment at the time of service. This practice improves accounts receivable by allowing your billing staff to achieve zero balances as soon as insurance payments are received, and eliminates the need to send additional bills to patients.

20. Is there a practice or billing service policy about small balance write-offs? ❑ YES ❑ NO

If No, consider establishing a policy about small balance write-off so that the billing staff can handle such accounts quickly and efficiently. This will have a positive overall effect on accounts receivable.

21. Do you have claims that are denied due to missing or inaccurate information supplied on the claim form? ❑ YES ❑ NO

If Yes, consider your response to the following question.

22. Does the billing staff or service double-check every claim to be sure that it is filled out completely and accurately? ❑ YES ❑ NO

If No, establish a routine office procedure whereby the billing staff double checks every claim prior to sending it to the payer. Common billing errors include providing incorrect or incomplete patient information (i.e., member number, policy number, full name of subscriber), and incorrect or incomplete service information (i.e., date of service, diagnosis code(s), CPT code(s) and modifiers).

23. Do you have appeals or corrected claims that are denied as duplicates? ❑ YES ❑ NO

If Yes, consider your response to the following question.

24. Does the billing staff or service know about the special requirements that each health plan or payer may have regarding submission of claims appeals or corrections?

❑ YES ❑ NO

If No, remind billing staff that many plans and payers have specific requirements for submitting appeals or corrections. Some plans and payers require that appeals be submitted on a specific form and not include a copy of the original claim. Unless the plan directs you otherwise, do not stamp a claim as "Second Request" or "Appeal" because such claims will generally be treated as new claims and denied as duplicates. In addition, be sure that the appeal or correction is submitted to the correct address, as many plans and payers request that appeals be submitted to an address or P.O. Box that is different from the one used for original claims.

25. Do you feel you have claims that were paid incorrectly because separate services were bundled? ❑ YES ❑ NO

If Yes, be sure appropriate modifiers were on the original claim, or submit a corrected claim if they were omitted. For appeals of bundling problems, include documentation of separate services.

26. Do you feel you have claims that were paid incorrectly because services were not paid at the appropriate level? ❑ YES ❑ NO

If Yes, confirm whether the medical record documentation supports the level of service coded. If it does, submit an appeal with appropriate documentation.

27. Is there a practice or billing service policy about bad debt collection? ❑ YES ❑ NO

If No, consider establishing a policy about bad debt collection so that the billing staff can handle such debts quickly and efficiently. This will have a positive overall effect on accounts receivable.

Step 3: Now that you have successfully completed the self-assessment, use your enhanced understanding of the claims processes used within your own practice to refine those processes for the purpose of improving claims payment and accounts receivable. Please retain this self-assessment tool and refer to it in the future to diagnose or prevent problems related to claims processing and payment.

A committee representing health plans and health care physicians/providers prepared this document. Organizations that participated in the development of this document include American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American Academy of Dermatology Association, Bethesda Healthcare System, Piedmont Hospital, Group Health Incorporated, and Health Alliance Plan. America's Health Insurance Plans and the Healthcare Financial Management Association convened the committee.