Top 7 Reasons for Claims

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Table of Contents

Introduction

An inevitable part of billing is dealing with denials. But denials are one of the most important things to pay attention to because it directly affects your practice revenue.

A common mistake practices make is thinking that simply having a practice management or clearinghouse solution will take care of everything. While electronic systems help automate a huge part of the process and reduce chances of errors and denials compared to filing paper claims, it is important to make sure that you are using the system correctly and know that claims still require some personal attention.

When it comes to denials, we like to think that prevention is better than cure. So in addition to showing you how to spot and prevent a potentially denied claim, we will also show you how to use your clearinghouse and/or practice management solution to its fullest potential.

We will begin this eBook by going through what a denied claim actually means. (Hint: It's not the same as a rejected claim.) Then, we'll show you where to find your denials before diving into the most common reasons for a denied claim.

Understanding and Finding Denials

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Denials vs. Rejections

When it comes to describing an insurance claim status, many people use the term “rejection” and “denial” interchangeably. However, a rejected claim is very different from a denied claim. Let’s take a closer look at the differences between the two and how they are defined.

Rejections

According to The Centers for Medicare & Medicaid Services (CMS), claims that do not meet the basic format or data requirements are **rejected**. This means that these claims do not make it to the payer, and are not considered as received, and therefore will not be processed. As a result, rejected claims need to be fixed and resubmitted.

Denials

On the other hand, **denied** claims are claims that have been received by the payer, but did not result in a reimbursement by the payer. Denied claims cannot be resubmitted since a payment determination has already been made. Instead, denied claims are appealed based on payer-requested modifications, additional documentation, etc. The reason for the denial will appear in your ERA (Electronic Remittance Advice) if you use electronic claim filing or in your EOB (Explanation of Benefits) if you run a paper practice.

Working on rejections are just as important, but in this eBook, we’ll focus on denials.

Finding Your Denials

Before we dive into reasons for a denied claim, you need to know where to find your denials before you can fix them.

If you are a paper practice, you should receive an EOB explaining which claims are fully covered, partially covered, or denied. There is also normally a brief explanation of any claims that were denied.

For those using a clearinghouse or practice management system, if you are set up to receive ERAs, denial reasons can be found on your ERA. But once your receive your ERAs, it is important that you post and reconcile payments to check for full payments. Using the auto-posting feature that most practice management systems provide allows you to enter your ERAs quickly and easily.

If you don't post and reconcile payments in your practice management system regularly, you won't see an accurate number of denials in your system. So don't rely on checking your practice management system for denials unless you know that you're caught up with posting payments.

Top 7 Claim Denial Reasons

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Top 7 Claim Denial Reasons

Now that you know where to find your denied claims, let's take a look at the common reasons for claim denials. Understanding these reasons can help limit the number of denials your practice receives.

We'll give you a breakdown of each reason by explaining what it means, how it happens, and how to fix it. You might be surprised to find out that many of the common denial reasons are easy to prevent.

The top reasons for denied claims covered in this eBook include:

#1 Duplicate Claims
#2 Payer Does Not Cover Service
#3 Late Filing
#4 Bundled Payment
#5 Uninsured Patient
#6 Coverage Termination
#7 Payer Does Not Support Frequency of Services

#1 Duplicate Claims

What It Is:

Duplicate claims are the most common reason for denials. Duplicate claims are two or more submitted claims that include repeated information about patient demographics, provider, date of service, and billing codes.

Why It Happens:

Duplicate claims happen most often when the practice's claim handler finds an unpaid claim in their practice management system and assume that it hasn't been processed. In an attempt to fix the problem, they file it again without researching the original submission.

However, there are many reasons to explain why the claim is unpaid. Processed claims could have gone towards a deductible or could have been denied. Filing the claim again simply creates a duplicate of the claim, and until you correct it, duplicate claims will automatically be denied.

#1 Duplicate Claims

How to Fix It:

Investigate why the claim isn't paid. Was it rejected by the clearinghouse or actually denied? Denial reasons can be found on your EOB or ERA so you can take the proper steps to fix the claim.

When you're ready to resubmit your claim, instead of calling your payer, you can correct a claim electronically by using the resubmission feature most clearinghouses provide.

You will need to refer to the claim you're trying to correct as well as the claim control number (CCN) or internal control number (ICN).

#2 Payer Does Not Cover Service

What It Is:

The service that you provided isn't fully covered by the insurance plan your patient has.

Why It Happens:

A list of covered services can be found in the written agreement between you and the insurance company. Not checking the guidelines of that agreement or eligibility for the service to be provided ahead of time can result in performing a service that is uncovered by the insurance, leading to a denied claim.

Tip: For those practicing in Texas, a common mistake that many practices that accept Blue Cross Blue Shield (BCBS) make is not knowing that corneal topography isn't covered by BCBS, though it is a very common test that practices run frequently.

#2 Payer Does Not Cover Service

How to Fix It:

Review the payer guidelines for the treatment you are going to provide to see if it meets your patient's health plan's coverage criteria. To be fully sure about the services covered, you should use an automated real-time eligibility system usually provided by clearinghouses and practice management systems.

When you have this type of denial, you have two options on how to deal with it: bill the patient or write off the claim.

Billing the patient is an unpopular option because nobody likes an unexpected bill and it might mean losing your patient. It could also result in a bad online review that could tarnish your businesses reputation. So before you bill your patient, think about whether it's worth upsetting them.

To prevent either from happening, it's important to read your payer specific guidelines and pull eligibility benefits before the appointment so you can inform your patient of their financial responsibility if the service is not covered by their plan.

#3 Late Filing

What It Is:

Another important detail to read in your contract with your insurance payer is the claim submission deadline. Every payer has a firm deadline for accepting and processing claims. Every payer's deadline varies and can range between 90 days to a year from providing the service. If you miss this deadline, your claim will be denied.

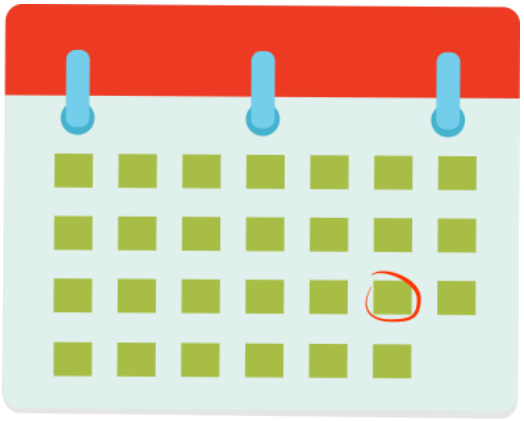
Why It Happens:

We are all human and it's normal to occasionally forget tasks and miss deadlines. But sometimes, the denial reason could appear as "late" even if you remembered to file before the deadline. That's because even if you file a claim before the deadline, there is still the risk of it being rejected.

Tip: Generally, Blue Cross Blue Shield and Medicare allow you to submit a claim within a year of performing the service, while Aetna and United Healthcare will only accept claims if they are submitted within 90 days of the service.

#3 Late Filing

How to Fix It:



It's important to check for rejected claims frequently, so you can follow up to fix and submit it before the deadline.

While you should always submit your claims as soon as possible, knowing your timely filing guidelines will help you prioritize claims that should be worked on first when you have piled up claims. It is also important to remember that your payer should receive the claim before the deadline.

#4 Bundled Payment

What It Is:

Sometimes, payments get bundled into another procedure and you do not receive payment for the services you performed.

Why It Happens:

Office visits associated with surgical procedures are prone to this kind of denial. A common example to explain how this happens would be filing a claim for cataract surgery or punctal plug surgery.

Typically, an ophthalmologist performs the surgery, while an optometrist provides the post-op care. If the ophthalmologist's office did not state that they completed only one of the services, not both, both payments will be bundled in one payment to the ophthalmologist.

How to Fix It:

If appropriate, consider correcting the claim using a CCI (correct coding initiative). The modifier will show that it is a separate service to bypass the rule to ensure that you're paid for your services.

#5 Uninsured Patient

What It Is:

When the patient can't be identified as being insured, it doesn't always mean that they do not have coverage. It is usually due to data entry errors or incorrect coverage information.

Why It Happens:

Data entry errors refer to a staff member in your practice entering the wrong policy number or wrong demographic information.

Incorrect coverage information, on the other hand, usually happens when the patient did not provide complete information to the insurance company when they were setting up their plan. This happens frequently when patients don't update their insurance company of the change of their last names from their maiden names.

Tip: Many patients don't realize that Medicare is an insurance plan. Simply note that when a patient says that they have no coverage, make sure to ask if they have a Medicare plan.

#5 Uninsured Patient

How to Fix It:

Incorrect coverage information is the patient's responsibility. There's not much you can do here, but to explain to the patient that they aren't actually insured and need to get in contact with their insurance plan.

Correcting data entry errors is your responsibility, but it is a problem that's easy to nip in the bud. When the patient comes in for their appointment, make sure you double check for the following items:

- Name
- Date of Birth
- Responsible Party
- Vision Insurance – policy and policy numbers
- Medical Insurance – policy and policy numbers

Pulling patient benefits is also a good way to ensure that you're seeing the right patient and you have the most updated information about their plan coverage because you'll identify the missing information prior to the visit.

#5 Uninsured Patient

How to Fix It:

On top of checking for this basic information, there are also a couple of entities to be aware of like sister insurance companies and Medicare Advantage Care.

- **Sister companies:** Big insurance companies often acquire smaller insurance companies. When this happens, it provides patients with a wider network of providers, and new insurance cards may be handed out to patients.

  However, insurance companies usually retain their independent, existing contract prior to the acquisition with providers like you. Therefore, in most cases, you should be filing your claims to the individual payers. Every contract is different, but you should be aware of the main insurance company to file your claim to, instead of just looking at the logo on the patient's insurance cards.

- **Medicare Advantage Care:** Similar to the sister companies, just because a patient has a Medicare card, it doesn't mean that you should file the claims to Medicare. A lot of times, Medicare claims are processed by other insurance companies. It's important to know which one to file to.

#6 Coverage Termination

What It Is:

Insurance coverage termination can be a result of the patient getting a new policy or dropping the plan. In this section, we're specifically talking about coverage termination due to a late or non-payment on insurance premiums paid on a monthly basis.

Why It Happens:

If you were diligent about pulling their eligibility and still received a denied claim, it could be because you checked the eligibility information a little too early.

A policy might be active in July, but if the appointment is scheduled for August, and the patient missed their insurance payment that month, you will receive a denied claim because the patient is not covered by insurance during the time of the appointment.

Tip: Always check for eligibility ahead of time! But note plans that are paid as a monthly premium and check for eligibility only when it's close to the appointment scheduled.

#6 Coverage Termination

How to Fix It:

Being aware of the types of insurance that are paid through a monthly premium will help you determine the right time to check for eligibility. Take Medicaid as an example. The insurance plan becomes active at the beginning of the month when the plan renews. So checking for eligibility at the beginning of the month of the appointment for a patient with Medicaid is essential. While it's good to check for eligibility information ahead of time, make sure you note plans like Medicaid, and check them only when it's closer to the appointment, so you're positive that the eligibility information is accurate for the proposed date of service.

If you own an independent practice, you could make it a policy to not see Medicaid patients for the first 5 days of the month depending on how busy your practice is. If you know when your busy months are, implement the policy to avoid seeing Medicaid patients at the beginning of the month to make sure that you have enough time to check for eligibility before seeing them.

It is within your legal rights to limit patient appointments based on their insurance. But to avoid complaints from patients who might view this as "discriminatory" to their insurance plan, simply ask for their insurance plan before providing them with appointment availabilities.

#7 Payer Does Not Support Frequency of Services

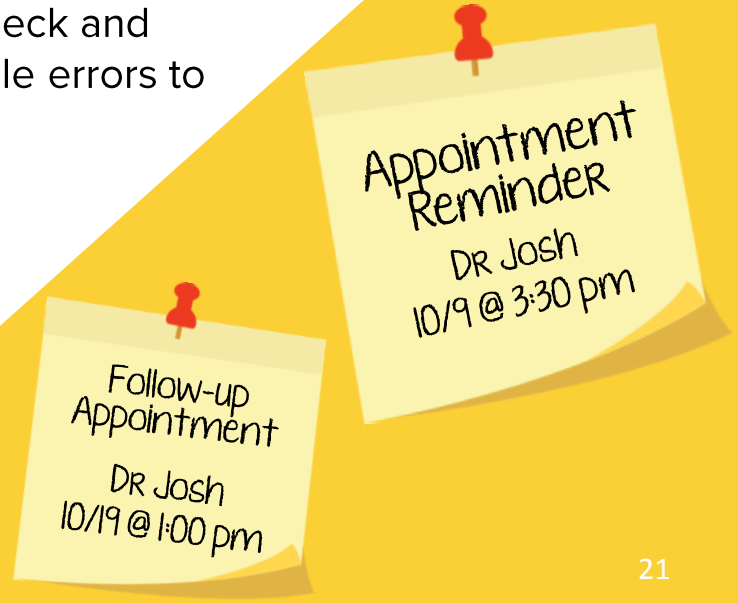
What It Is:

Your claim might be denied because the service you billed is a service not deemed as a "medical necessity" by the payer.

Why It Happens:

This could happen simply because you did not check for eligibility and did not follow the coverage limit. But, if you made sure to check and still received a denial, the error could be in the claim. Possible errors to check include:

- Linking wrong codes
- Non-specific diagnosis
- Needs of the patient is in excess of benefits the plan offers the policy holder

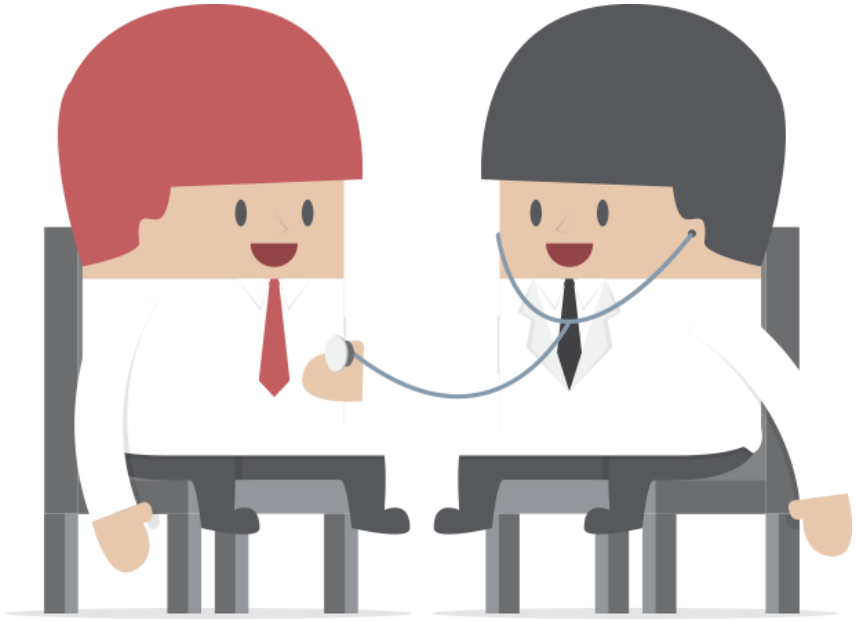


#7 Payer Does Not Support Frequency of Services

How to Fix It:

Sometimes your patient's insurance just doesn't support the frequency of services even though you think it's important for them to come in for several follow-up visits. This one is tricky, but our best advice to you is to use your own experience and knowledge to do the right thing.

Don't let the payers determine what's important for your specific patient. If you think that the patient should be coming in more often than what's covered, you should obtain an Advance Beneficiary Notice (ABN) and explain why it's important that they come in for another appointment before billing.



Conclusion

Now that we've covered the most common reasons for denials, and more importantly, how to fix them, we hope that you'll use this eBook to reduce the number of denied claims in your practice!

Some denial reasons will require more attention from you such as double checking patient's information or being more aware of your contract with your insurance payers. But the most common reasons for denied claims covered in this eBook are easily preventable when you know what to look out for and have a robust practice management and clearinghouse solution to help you through the process.

A lot of practices become frustrated when dealing with denials, but at the end of the day, properly dealing with denied claims is a must as they directly affect your practice's bottom line.

VisionWeb's Claim Management Solution

VisionWeb brings every aspect of insurance claim filing together in one complete, online solution. It's affordable for any practice and will help improve claim acceptance and expedite reimbursements.

Enjoy these features when you use our clearinghouse solution:

- Thousands of payers in one location
- Patient eligibility verification
- Claim submission and tracking
- Detailed reporting and analytics
- 24/7 availability
- Claim uploading from PM systems
- Free electronic remittance advice (ERA)
- Training and customer support

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VisionWeb provides software and technology services to streamline and simplify the eyecare industry. Through our online ophthalmic product ordering and electronic claim filing solutions, our technology helps eyecare practices, laboratories, manufacturers, and payers drive out inefficiency, increase customer satisfaction, and improve their bottom line.

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