

Digging for the Gold in Healthcare Billing

By **Melania “Lani” Antonio, CPC**
Revenue Cycle Improvement Specialist
Derry, Nolan & Associates, LLC

So many issues contribute to the soaring volume of claim denials. And those claims denials affect medical organization revenue opportunities adversely. While it is common knowledge among those of us in the industry that medical insurance billing complexity is increasing exponentially, not so common is the knowledge of root cause and how to proactively correct and improve denial patterns.

Where does the denial begin? Perhaps issues are technical – incorrect data parameters in the system. Or perhaps the technical issues simply compound the human equation – rapidly changing regulations are difficult to keep up with, sheer transaction volume can overwhelm staff – billing staff who already spend non value added time on researching duplicate claims or touching a claim multiple times as part of re-work. The bottom line is immediately impacted with increased labor costs combined with decreased cash flow.

The Center for Medicare and Medicaid Services (CMS) notes that one common reason for claim denials is not meeting Medical Necessity requirements. Another respected source, Noridian Medicare Bulletin, provides a “Top Ten” for responsible claim denial

errors. Unlike Letterman’s “Top Ten” this list is far from laughable.

1. Records indicate the performing physician, supplier or practitioner is a member of a group practice; however, the individual and group NPI/PINs were not entered accurately.
2. Patient cannot be identified as our insured.
3. Payment denied due to procedure code/modifier was invalid on the date of service or claim submission.
4. NPI/UPIN of the ordering, referring or performing physician is missing or invalid.
5. Procedure code is inconsistent with the modifier used, or a required modifier is missing.
6. Did not complete or enter accurately the CLIA number.
7. The procedure code/bill type is inconsistent with the place of service.
8. Referring, ordering, supervising provider’s name and/or UPIN/NPI are missing or incomplete.
9. Item 11 not completed.
10. Missing, incomplete or invalid information on where the services were furnished.

So where’s the gold? The revenue that medical organizations need to survive? A map is usually pretty

helpful when looking for buried treasure. Healthcare billing just needs that map, the one that can find hidden revenue opportunities. Identify the root of the problem when you examine the overall revenue cycle. Based on the most common errors, we put together a matrix to help identify affected processes, probable root causes, and possible resolution activities. The matrix on page 2, developed by Derry, Nolan & Associates, LLC, helps identify the processes that are affected, probable root causes, and some action items for resolving the issues.

Set your organization up to win. Train, test and audit staff and providers routinely so any deficiencies leading to denials are identified and resolved quickly. Render the “gold” tangible with revenue your organization deserves because it proactively addresses workflow problems, infrastructure issues and training gaps.

Melania “Lani” Antonio, CPC is a Revenue Cycle Improvement Specialist with the consulting firm Derry, Nolan & Associates, LLC. (www.derrynolan.com) The company is a healthcare consulting firm that specializes in business improvement strategies for large and small private physician groups, hospitals, and integrated health systems. Ms. Antonio can be reached at lani@derrynolan.com.

Matrix of Coding Errors, Workflows Affected, Probable Causes and Action Required for Resolution

Denial	Billing Workflows That May be Affected	Probable Root Cause	Action Required
1. Records indicate the performing physician, supplier or practitioner is a member of a group practice; however, the individual and group NPI/PINs were not entered accurately.	<ul style="list-style-type: none"> Internal billing parameter setups Clearinghouse 	<ul style="list-style-type: none"> Provider numbers may not be linked to the appropriate fields on the claim forms 	<ul style="list-style-type: none"> Review system parameter setups and make appropriate change
2. Patient cannot be identified as our insured.	<ul style="list-style-type: none"> Scheduling Registration Check-in Billing 	<ul style="list-style-type: none"> Data entry inaccuracies and/or missing verification of insurance coverage 	<ul style="list-style-type: none"> Review each step of the workflow and hold staff accountable for accurate information, which may require additional education and training
3. Payment denied due to procedure code/modifier was invalid on the date of service or claim submission.	<ul style="list-style-type: none"> Provider reporting 	<ul style="list-style-type: none"> Inaccuracies of reporting the codes in the Electronic Medical Record or on the charge slip/Superbill 	<ul style="list-style-type: none"> Verify the codes that were denied Determine the appropriateness of reporting the code, i.e. modifier 26/Technical Component Verify the place of service (POS) Education/training and templates
5. Procedure code is inconsistent with the modifier used, or a required modifier is missing.	<ul style="list-style-type: none"> Charge slip/Superbill Electronic Medical Record (EMR) system setups ChargeMaster setups Interface setups Internal billing system setups 	<ul style="list-style-type: none"> Inaccuracies of codes on forms and system setups 	<ul style="list-style-type: none"> TIP: Global codes cannot be billed with place of service (22) hospital outpatient
7. The procedure code/bill type is inconsistent with the place of service.	<ul style="list-style-type: none"> Charge entry Charges via interface Billing 	<ul style="list-style-type: none"> Data entry inaccuracies and/or reporting of codes 	
4. NPI/UPIN of the ordering, referring or performing physician is missing or invalid.	<ul style="list-style-type: none"> Scheduling Registration Check-in Charge slip/Superbill Charge entry EMR Charges via interface Internal billing system setups Clearinghouse 	<ul style="list-style-type: none"> Missing or inaccurate setup of providers 	<ul style="list-style-type: none"> Review system setup and make appropriate changes Review workflow steps to determine the root cause of the errors TIP: Referring provider is required when billing diagnostic services, such as lab, radiology, etc.
8. Referring, ordering, supervising provider's name and/or UPIN/ NPI are missing or incomplete.			
6. Did not complete or enter accurately the CLIA number.	<ul style="list-style-type: none"> Internal billing parameter setup Clearinghouse Billing 	<ul style="list-style-type: none"> CLIA numbers may be setup inaccurately 	<ul style="list-style-type: none"> Review parameter setup and make appropriate changes
9. Item 11 not completed.		<ul style="list-style-type: none"> Claim system setup for line item 11 is blank when "NONE" should be reported 	
10. Missing, incomplete or invalid information on where the services were furnished.	<ul style="list-style-type: none"> Provider reporting Charge slip/Superbill Charge entry EMR Charges via interface Internal billing system setups Clearinghouse 	<ul style="list-style-type: none"> Inaccuracies of reporting POS and the facility where services were performed 	
Medical Necessity Claim Denials			
	<ul style="list-style-type: none"> Provider reporting 	<ul style="list-style-type: none"> Coverage limitations apply 	<ul style="list-style-type: none"> Verify the CPT and diagnosis codes that were denied Review Local and/or National Coverage Determinations Review provider documentation on the appropriateness of reporting the codes

Source: Derry, Nolan & Associates. For more information see www.derrynolan.com or contact Melania "Lani" Antonio, CPC at lanid@derrynolan.com.