Avoiding Admitting Related Denials

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Becky Cloud-Glaab
Director, PFS & HIM

UC Irvine Health

UC Irvine Health

- UC Irvine Health is an Academic Facility located in Orange, CA
- Public Hospital
  - Acute Care/Tertiary (level 1 trauma center)
  - Acute Rehabilitation
  - Psychiatric
  - Onsite and Offsite Clinics
  - 2 Federally Qualified Health Centers (FQHC)

UC Irvine Health

- 3B in Revenue
- Rated among the nation's best hospitals by U.S. News & World Report
  Greater than 40 points of entry
- Largest Payer Mix
  - Managed Care
  - Medi-Cal and Indigent
  - Medicare

What is a Denial

- **Denial** is probably one of the best know defense mechanisms, used often to describe situations in which people seem unable to face reality or admit an obvious truth
- **Denial** is an outright refusal to admit or recognize that something has occurred or is currently occurring
- **Denial** is an insurance companies refusal to pay a claim
- **Rejection** differs from a denial and is never processed by the payer
  - Rejection can occur at the clearinghouse or the payer, with the claim never making it into the payer's system

Denials

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Top 5 Denial Reasons

- According to an article in Healthcare Finance News in July 2013, 3 of the Top 5 Claim Denial Reasons are related to admitting

  - **Claim lacks information.** Human error impacts most hospitals but nowhere is this more prevalent than in claims processing. Basic information, such as a person's date of birth, or spelling of a name, are common mistakes.

  - **Eligibility.** One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and hospital were unaware.

  - **Claim not covered by insurer.** Another claim denial that can be avoided with verification is when procedures are not covered by an insurer.

Overview

❖ Types of Admitting Denials

- No Authorization, Partial Authorization, Procedure Not Authorized, Authorized as different patient status, inpatient vs outpatient
- Unable to Identify Patient/Subscriber
- Not Eligible
- Non Covered Service
- Covered by Medical Group/Covered by Health Plan
- Name Mismatch
- Patient is Covered by a Managed Care Health Plan
- NPI is not Authorized for Services (SAR)
- Patient may have other insurance (TPL)

Authorizations

- A large “majority of insurance denials for imaging exams were due to prior authorizations,” according to a new report by the nonprofit Patient Advocate Foundation, August 2012.
  - The report points to prior authorization programs as the culprit for 81% of the insurance denials for imaging procedures, which stated reasons such as “not medically necessary,” “benefit exclusion” and “necessary prior authorization needed to be obtained.”

Authorizations

- No Authorizations, Partial Authorization, Procedure not Authorized and services authorized as outpatient vs inpatient is one of the easiest preventable denials

  - Call for authorization on every procedure; Even PPO plans require authorization
  - If a payer states that an authorization is not required, ask for a fax or email confirming the conversation
  - Document the name and telephone number of the representative providing authorization
  - Make note if call if being recorded by the payer if hospital does not record calls

Authorizations

- If a patient is on COBRA, be sure to validate the authorization from the COBRA department
- If the payer notes that the patient is out of network, determine if there will be a reduced benefit (payment)
- If out of network services is part of a “continuity of care” issue, assist the patient in requesting a reconsideration for the “continuity of care” treatment/services

✓ Obtaining authorization for services results in excellent customer service

Unable to Identify Patient/Subscriber

- Unable to identify patient/subscriber is another common admitting denial which is avoidable
  - Obtain a copy of the patient's photo identification card
  - Obtain a copy of the patient's insurance card
  - Key the name of the patient and the subscriber exactly as it appears on the insurance card
  - Be careful to obtain the correct name of the employer from who the subscriber is employed

✓ Obtaining the correct information at the time service eliminates delays in payment

Patient Not Eligible

- Eligibility denials are received for a few reasons, and can differ slightly by payer

  - Always verify eligibility prior to/or at the time of service
  - If a patient is pre-admitted and insurance eligibility was obtained prior to the month of service, re-verify eligibility in the month of service
  - Medi-Cal inpatient accounts should be re-verified the 1st and 15th of the month for longer stays; pay special attention to aid codes
  - Avoid pulling insurance information forward from a prior service
  - ✓ Verifying Eligibility each time a patient is seen, guarantees coverage for a patient's service

Non Covered Services

- Payers have become more creative when denying a claim

  - The payer is contracted with the facility, but will not cover outpatient procedures at a hospital setting
  - Know the Medi-Cal aid codes, and what is considered an emergent condition
  - Become familiar with the hospital's payer contracts and covered services
  - Experimental Procedures are sometimes covered; get the doctor involved

  ✓Medical Necessity prevents denials for non-covered services

Health Plan vs Medical Group Coverage

- In today's world of Health Plans contracting with hospitals and Medical Groups, knowing where to send a claim, is more difficult than ever
  - Know your Division of Financial Responsibility (DOFR) with Health Plans and Medical Groups
    - Does the DOFR split services for a single visit?
    - Does the DOFR designate place of service?
    - Does the DOFR identify types of services?

✓Knowing your DOFR will eliminate delays in payment

Health Plan vs Medical Group Coverage

- Consider Creating payer plan codes that clearly identify where a claim should be directed or consider converting existing plan codes to more descriptive plan codes
  - Identify Payer
  - Identify type of plan (HMO, PPO, POS, Senior HMO, Workers Comp, Government)
  - Identify Medical Group
  - UCI will be converting from 3 digit plan codes to 4 digit plan codes; Blue Cross will convert from B20 to BX1N (Blue Cross, HMO, HPN)

Common Denials

❖ Other avoidable common denials are identified below

- Name Mismatch
  - Usually a Medicare related denial; ensure the name is keyed exactly as seen on the Medicare insurance card
- Patient is Covered by a Managed Care Health Plan
  - Commonly seen when verifying Medicare or Medi-Cal coverage; must read the results carefully
- NPI is not Authorized for Services
  - A common CCS denial, where the physician NPI, doesn't match the attending; Must ensure the NPI listed on the SAR is at least one of the NPI's listed in the physician fields

Common Denials

❖ Continuing with other avoidable common denials

- Patient is incarcerated
  - Commonly seen with Medicare; Medicare has been retracting payments due to the SSA records not matching the incarcerated records; Must contact SSA with the patient to get the issue resolved

- Patient is Covered by a Third Party Liability
  - Commonly seen with Medicare; must complete the MSP screening form with any accident details to allow correct billing

- Injury is the result of a work related accident
  - Thoroughly screen the patient and obtain accident details; If case has settled, obtain date of settlement

Avoid the Denial

- Categorize the Pre-Bill Edits by Area of Responsibility
- Map the Remit Denial Codes by Area of Responsibility
- Track & Trend Admitting Related Denials
- Meet with Admitting to Review Errors
- Identify Retraining Opportunities
- Send out Global Notification to all Scheduling and Admitting Areas (RegLine)
- QA Admissions/Registrations

How to Avoid the Admitting Related Denial

- Communicate
- Communicate
- Communicate

- When Admitting/Registration/Scheduling identifies a potential issue with a patient's insurance, notify PFS immediately and be specific!

- When PFS identifies a potential issue, receives a denial or rejection for a specific patient, notify admitting/registration/scheduling and be specific!

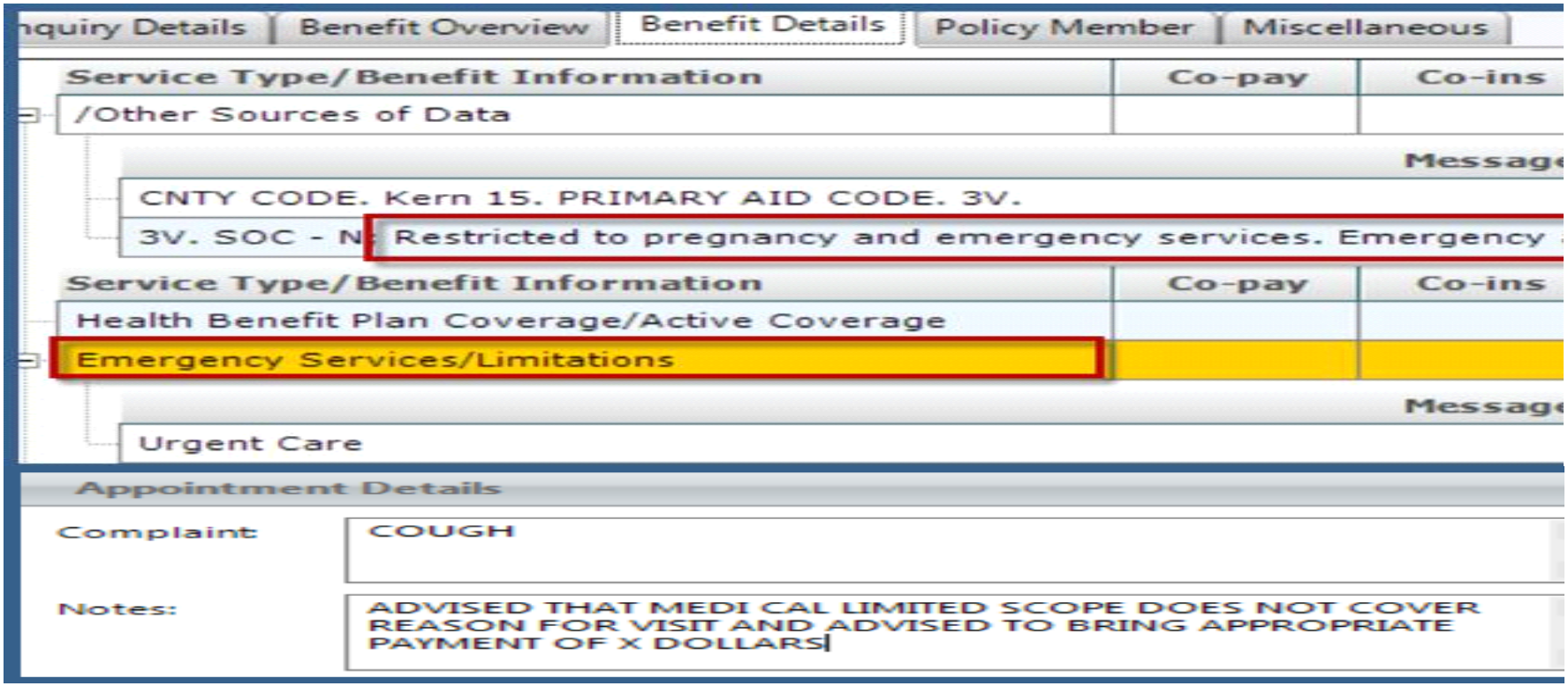
REGLINE

REGLINE

TO: All Staff

RE: Appointments for patients with Medi-cal Limited Scope

Medi-cal Limited scope provides benefits for emergency or pregnancy related services **only**. It is very important to verify eligibility at the time of scheduling outpatient appointments or prior to providing outpatient services. If the patient is determined to have Medi-cal limited scope (see screen shot below) and the service requested is not emergent or the patient is not pregnant, the patient must be registered as self-pay. The patient **MUST** be advised that their medi-cal limited scope does not cover the service and provide them with appropriate payment information and advise that full payment is required at the time services are rendered. Documentation must be placed in the appointment that patient advised that services are not covered and payment information provided.



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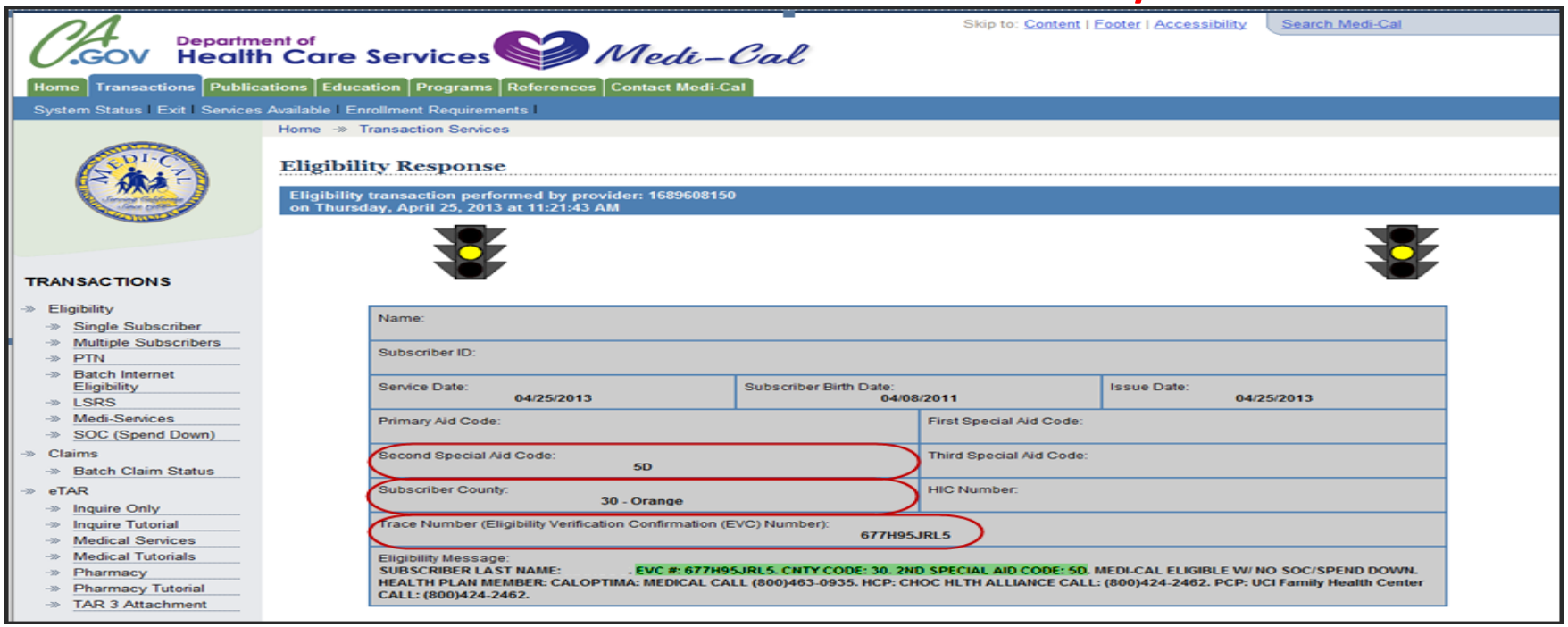
Sample RegLine

REGLINE
To: All Staff
RE: New Requirements for Medi-Cal, CalOptima and CCS Medi-cal plans

It has come to our attention that we cannot bill Medi-Cal, CalOptima and CCS Medi-Cal plans without obtaining the County Code, the Second Special Aid Code and the Eligibility Verification Confirmation Number (EVC). Effective immediately, we are now requiring that these fields be valued at the **VISIT level** on the insurance tab. The new values ***must not be entered at the patient level.***



Have a Great Day!

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