Denial Management and How To Interpret An EOB

Presented by

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- Learn how to read and interpret an Explanation of Benefits (EOB)
- Review relevant legislation
- Discuss definition and types of claim denials
- Identify reasons for claim denials
- Discuss processes for handling claim denials
- Learn how to effectively communicate with various payers
- Learn how to effectively communicate with coding staff and Patient Administration Directorate (PAD)
- Learn ways to track and manage claim denials and appeals

- Definition and Purpose:

  – An EOB or Remittance Advice (RA) is a document issued by the payer stating the status of the claim; whether it is paid, suspended (pending), rejected, or denied.

  – The purpose is to provide detailed payment information relative to the claim and, if applicable, to describe why the total original charges have not been paid in full.

Sample EOB

EXPLANATION OF BENEFITS

This is **NOT** a bill.

	Group Number:	1234567
	Member:	IMA MEMBER
	Member's ID:	123456789-01
	Claim Number:	8000000001
	Provider:	SMITH, ROBERT
	Payment Reference ID:	20041220112345678

September 6, 2011

Service/ product description	Dates you received service/product (m/d/y to m/d/y)	Charges billed by provider	Provider's fee adjustment (*)	Your copay (C), deductible (D) or amount not covered (**)	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
OFFICE VISIT	06/01/11 06/01/11	75.00	12.00 PDC	15.00 C	48.00	100%			48.00	15.00
LAB	06/01/11 06/01/11	89.12	15.36 PDC	50.00 D	23.76	100%			23.76	50.00
X-RAY	06/01/11 06/01/11	100.00	20.00 PDC		80.00	80%	16.00		64.00	16.00
SURGERY	06/01/11 06/01/11	50.00		50.00 575	0	0%			0.00	50.00
Totals		$314.12	$47.36	$115.00	$151.76		$16.00		$135.76	$131.00

Your 2010/Plan Year Medical Deductible satisfied so far: $100.00
Your 2010/Plan Year Family Medical deductible satisfied so far: $300.00
Amount you're responsible for: $131.00

FUNDING ACCOUNT SUMMARY

Amount paid on this claim: $ 0.00

Your remaining family balance: $ 0.00

For more information relating to your funding account, please see your benefit booklet or visit us on the web at: www.premera.com

Message Codes:
PDC AGREEMENT DISCOUNT
575 THIS PROCEDURE IS CONSIDERED COSMETIC. YOUR PLAN DOESN'T COVER COSMETIC SERVICES.

Benefit Booklet Information:
575 Your plan does not cover any services or supplies furnished in connection with the following conditions, services or supplies: Services or supplies not medically necessary, even if ordered by a court of law, for treatment of a disease, injury, illness or pregnancy.

Other plan provisions may apply. Please consult your benefit booklet for full plan information.

If you have any questions about your EOB call Customer Service at 800-722-1471, Monday through Friday, between 8:00 a.m. and 5:00 p.m., Pacific Time.
Para obtener ayuda en español, llámenos al número de teléfono que se indica arriba. Sa pagtamo ng tulong sa Tagalog, tawagan kami sa nasa itaas na numero ng telepono.
如果想用中文獲取幫助，請撥打上面的電話號碼聯繫我們。Diné k'ehji yáltiʼigíi shikaʼadoolwol nínizingo dii béésh bee haneʼé bichʼįʼ hodiilnih.
Our TDD/TTY number for the hearing-impaired is 800-842-5357.

LIFEWISE
HEALTH PLAN OF OREGON

1) **Service/product description** – services the patient received from the provider

2) **Dates of service** – when the patient received services

3) **Charges** – amount billed to the patient and healthcare plan

4) **Provider fee adjustment** – difference between charges billed by the provider and the amount the provider has agreed to accept as full payment

5) **Copay** – the amount the patient pays the provider for a visit/service

 Deductible – the amount the patient pays toward covered services each year before the third party payer starts paying for services

 Amount not covered – the amount of services/products not covered by the plan

6) **Total amount eligible for benefits** – charges billed by the provider minus the provider fee adjustment minus patient copay, deductible, or amount not covered

7) **%** – percentage level of benefits for covered services/products

8) **Coinsurance** – what the patient must pay the health plan after the health plan pays the covered percentage

9) **Adjustment** – A change that relates to how a claim is paid differently from the original billing

10) **Total paid by health plan** – total amount eligible for benefits minus coinsurance amount

11) **Patient responsibility** – what the patient must pay of the billed charges after the plan benefits have paid

12) **General Information** – patient and provider information including group #, member name, member ID, claim #, provider name, and payment reference ID

13) **Message Codes** – a set of three characters that indicate reasons as to why the total charges were not paid in full

- Title 10, United States Code, Section 1095
  - Authorizes the government to collect reasonable charges from third party payers for health care provided to beneficiaries.

- Title 32, Code of Federal Regulations, Part 220
  - Implements 10 U.S.C. 1095 and specifies:
    - Statutory obligation of third party payers to pay; no assignment of benefits required
    - Certain payers excluded from Third Party Collection Program
    - Applicable charges
    - Rights and obligations of beneficiaries
    - Special rules for Medicare supplemental plans, automobile insurance, and workers' compensation programs
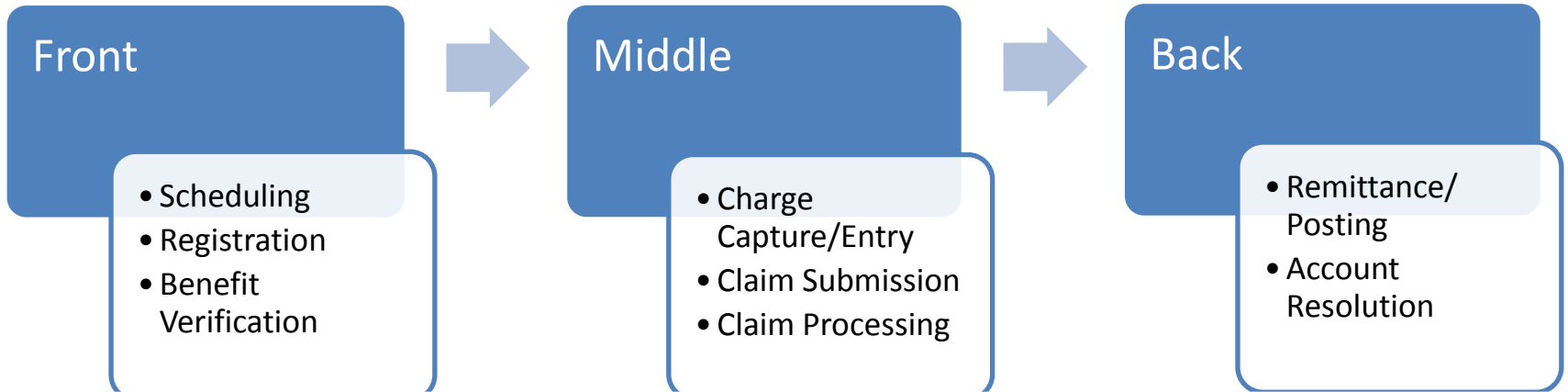
- Health care industry does not have one universal definition of a claim denial:

  - "Any intentional reduction of payment resulting from the failure to provide medically necessary services in an appropriate setting, failure to follow the payers' technical guidelines, or failure to consistently document for the services provided." (HFMA)

  - "A claim line item or service line item that results in no payment including rejected claims."*

*Denial Management: Key Tools and Strategies For Prevention and Recovery, Pam Waymack

- Why Is Denial Management So Difficult?
  - Complexity of third-party denials
  - Denial information provided by third-party payers is not standardized
  - Perceived inability to capture the denial data
  - Constantly changing information
  - Requires coordination throughout the revenue cycle
  - Challenging appeals process

Front →

- Scheduling
- Registration
- Benefit Verification

Member Not Eligible

Coverage Termed

Non-Covered Charges

Out-of-Network Provider

Member Cannot Be Identified

Middle →

- Charge Capture/Entry
- Claim Submission
- Claim Processing

Missing/Incorrect Modifiers

Not Medically Necessary

Missing Claim Information

Additional Clinical Information Required

Back

- Remittance/ Posting
- Account Resolution

Duplicate Claims

Previously Paid Claim

Additional Claims Information Required

Incorrect Denials

- Non-participating provider

- Medicare EOB required

- Incorrect dates of service

- Termination of coverage

- Failure to obtain pre-authorization

- Non-covered benefit

- Untimely filing

- Out-of-network provider utilized

- Procedure or service not medically necessary

- Additional Information Needed

- Coding Errors

Hard Denials
(Appeal Necessary)

- Timely filing
- Not financially responsible
- No pre-authorization

Soft Denials
(Additional Information)

- Missing/inaccurate information
- Charge/coding issues
- Secondary payment pending receipt of primary EOB
- Pending receipt of itemized bill

Clinical

- Medical Necessity
- Delay in Discharge/Procedure
- Alternate Setting
- LOS exceeds Authorization

Administrative

- Failure to pre-certify care
- Lack of clinical information
- Lack of benefit
- Exclusion denials

- Challenges in understanding denials
  - Variance in denial reason codes by payer
  - Denial reason does not necessarily identify the real issue
  - Inconsistently applied codes even with same payer
  - Missing denial codes
  - Denial codes that don't fit the reason the claim was denied

- Always best to call the payer for explanation. Some payers offer live online assistance through chat windows on their website.

- Early Intervention
  - Respond to denials immediately
  - Focus on effective communication with payer and internal departments
- Safety Net for Appeals
  - Monitor and act upon unresolved denials
  - Follow-up on all levels of appeals process
  - Measure denials and appeal results
  - Trend issues by payer and reason
- Impact of Best Practices
  - Improved cash flow due to an increase in clean claims and a reduction in denials

- Effective and continual communication with payers is essential
  - Develop standards for what information is required
  - Read the EOB carefully
  - Understand payer specific guidelines
  - Call the payer if a denial reason needs clarification
  - Develop individual relationships with payers through calls, e-mail, and scheduled teleconferences

- When speaking with the payer, be sure to ask:
  - What data was missing or inaccurate on the claim which caused the denial?
  - How long you have to resubmit the claim?
  - Does the payer needs any additional documentation sent with the claim?
  - Does the payer require any specific indicators on a claim when it is re-sent to indicate that it is a corrected claim?
  - Where does the information need to be sent?
  - Is there a reference number for this phone call?
  - If payer representative is not helpful, ask to speak with a supervisor

- Accurate coding is necessary for receiving payment
- Build relationships with coders so clean claims can be produced
- Build good relationships with your Patient Administration Directorate (PAD) staff
- Billers and coders need to share and communicate processes so that both parties have some cross training

- Interpret the EOB to ensure that a valid denial reason has been received

- Determine if it needs to be written off or billed to the patient

- Determine if denial can be corrected and resubmitted or if the claim requires an appeal

- Develop a communication plan

- Engage appropriate departments

- Establish goals for follow-up

- Develop your case based on the payer's guidelines

- Monitor corrected or appealed claims

- Denied claims should be pursued aggressively
    - Aggressive does not mean calling every day
    - Scrutinize all denied claims for incorrect information
    - Disputed claims should be communicated to the payer in writing
    - Aggressively appealing denials has been shown to reduce denial rates

- Insurance companies frequently do not pay what they approve
  - They have no incentive to ensure that everything is paid appropriately
  - Track payments for approvals or overturns
    - When a payer accepts an appeals argument and agrees to reverse their decision on a claim denial
  - Develop system for logging all payer approvals and be able to submit documentation of the overturn back to the payer in the case of a dispute

- What About Upheld Denials?
  - Request the payer send supporting documentation
  - For incorrect payments, request a copy of the fee schedule
    - A list of CPT codes and dollar amounts a payer will allow for a particular medical service

- Why track denials?
  - Defines where breakdowns are in the process to identify opportunities for performance improvement
  - Identifies unreasonable payer practices
  - Collaborative effort appeals are easier to handle in the future
  - Identifies areas where denial management efforts have been successful
  - Allows UBO to develop future goals and opportunities for preventing future denials

- Claim denial spreadsheet
  - Payer and type
  - Reason
  - Develop denial categories
  - Status for follow up
  - Identify services and areas that result in the majority of denials
  - Show impact on revenue
  - Evaluate weekly what is being denied
  - Monitor action taken on denials
  - Communicate to leadership

Sample tracking spreadsheet

Consider developing a payer information document

Payer Information Document

Texas Medicaid
(800) 925-9126
Attn: Claims
P.O. Box 200555
Austin, TX 78720-0555

Tammy, Customer Service Representative
999-999-9999
tammy@tmhp.com

Aetna
(888) 632-3862
Attn: Claims
P.O. Box 981106
El Paso, TX 79998-1106

John, Claims Representative
800-888-8988
johndoe@aetna.com

- If paper claims must be filed:
  - Use only original claim forms
  - Make sure claims are printed clearly
  - Avoid folding claims, if possible
  - Avoid using terms such as "re-filed claim" or "second request"
  - Avoid handwritten claims
  - Don't use all UPPERCASE letters
  - Don't use punctuation or decimals on claims
  - Don't send unnecessary attachments
  - Don't use staples, paperclips or post-it notes
  - Don't mark up the claim with highlighters
  - Don't use circles or additional markings
  - Don't attach labels or stickers
  - Don't add notes or instructional assistance

If electronic institutional and professional (837I/837P) claims are sent:

- Identify the correct payer ID for electronic transactions

- Consult 837I/837P EDI companion guide found on payer website

- Use the UBO User Guide and online Data and Billing in Sync training modules to identify information that is required for 837I/837P transactions

  - Available at http://www.tricare.mil/ocfo/mcfs/ubo/policy_guidance/userguide.cfm and http://www.tricare.mil/ocfo/mcfs/ubo/learning_center/Teleconferences.cfm

- Be familiar with claim adjustment reason codes (CARC) available at http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

- Be sure to understand the denial codes on the EOB
- Focus on effective communication with payers
- Develop a strategic plan for managing individual claim denials
- Develop a method for tracking claim denials and appeals
- Make sure claims are "clean" before they are sent
- Contact your Service or NCR MD Program Manager for Service or NCR MD specific guidance

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