Medical Billing Denials Are Avoidable: How to Help Prevent the Top 5

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The formal definition of a medical billing denial is, “the refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for healthcare services obtained from a healthcare professional.”¹

As a financial executive for a hospital or health system or their employed practice, you know medical billing denials as constant headaches that negatively affect your organization’s revenue, cash flow and operational efficiency.

Numbers tell the story. The industry benchmark for medical billing denials is 2% for hospitals.² In medical practices, medical billing denial rates range from 5-10%,³ with better performers averaging 4%.⁴ Some organizations even see denial rates on first billing as high as 15-20%!⁵

For those providers, one out of every five medical claims has to be reworked or appealed. Rework costs average $25 per claim,⁶ and success rates vary from 55-98%, depending on the medical denial management team’s capabilities.⁷ When all else fails, write-offs can range from 1-5% of net patient revenue. In an average 300-bed hospital, 1% can mean $2 million to $3 million dollars a year — significant by any standards.⁸

The good news is many medical billing denials can be avoided. Granted, they may never go to zero, but reducing them even by a fraction of a percent can have a substantial impact on your organization’s bottom line. A good approach is to understand the different types of medical billing denials, pinpoint the most common billing problems and take steps to avoid them.

The top 5 medical billing denials

Denials fall into two big buckets: hard and soft. Hard denials cannot be reversed or corrected, and result in lost or written-off revenue. Soft denials are temporary denials with the potential to be paid if the provider corrects the claim or sends additional information. Here are the top five reasons for medical billing denials, according to the 2013 American Medical Association National Health Insurer Report Card.

1. **Missing information**
   Leaving just one required field blank on a claim form can trigger a denial. Demographic and technical errors, which could be a missing modifier, the wrong plan code or no Social Security number, prompt 61% of initial medical billing denials and account for 42% of denial write-offs.⁹
2. **Duplicate claim or service**
Duplicates, which are claims resubmitted for a single encounter on the same date by the same provider for the same beneficiary for the same service item, are among the biggest reasons for Medicare Part B claim denials (up to 32%).

3. **Service already adjudicated**
This error occurs when benefits for a certain service are included in the payment/allowance for another service or procedure that has already been adjudicated.

4. **Not covered by payer**
Medical billing denials for procedures not covered under patients' current benefit plans can be avoided by checking details in the insurance eligibility response or calling the insurer before administering services.

5. **Limit for filing expired**
Most payers require medical claims to be submitted within a certain number of days of service. This includes the time it takes to rework rejections, whether the review was automated (system edits to check for improper coding or other mistakes) or complex (licensed medical professionals determining if the service was covered and was reasonable and necessary). Correcting inpatient medical coding errors, which accounted for 81% of complex claim denials in fourth quarter 2015, can cause delays that push medical billing past the deadline. Workflow practices should alert staff when medical claims approach the time limit.

While working denied medical billing claims after the fact is a critical component of revenue cycle management, relying on this alone can slow cash flow to dangerous levels. A much sounder financial approach is to proactively measure the volume and causes of denied medical billing claims so they can be prevented before they occur.

**How to help prevent medical billing claim denials**
Adding more people to the healthcare claims management team won’t necessarily help reduce or prevent denials unless they know what to focus on. The following should be part of any sound denials management plan:

- **Quantify and categorize denials** by tracking, measuring and reporting trends by doctor, department, procedure and payer. Technology and analytics are essential to reliable business intelligence, but they are well worth the time and investment.

- **Create a task force** to analyze and prioritize denial trends, determine what resources are needed to implement solutions and track and report progress.

- **Improve patient data quality** at registration, which is the source of many errors and, ultimately, denials.

- **Avoid incorrect assumptions and determine the true reasons for denials** by going beyond generic coding explanations and performing root cause analyses.

- **Develop a denials prevention mindset in all parts of the revenue cycle**, including patient accounting, case management, medical records, coding, contracting, compliance and patient access.
• **Optimize claims management software** to help ensure edits are functioning, current and improving your clean claims rate. Your vendor should provide clean claims rate data regularly and tips to improve it customized to your organization.

• **Use automated predictive analytics to flag potential denials** and address them before claims are submitted.

• **Work with payers** to eliminate contract requirements that often lead to denials overturned on appeal. Again, data analytics can help identify trouble spots and support negotiations.

### Efficient and cost-effective denials management

Many hospitals and practices lack the technology and staff capacity to manage denials effectively, especially in light of constantly changing regulations and payer rules.

Outsourcing revenue cycle management to experts like McKesson that have dedicated denials management teams can be a profitable, sustainable alternative. We can help you establish medical billing benchmarks, reduce backlogs, identify root causes of denials and augment your revenue cycle team.

*Learn more about how McKesson’s medical denial management services can help reduce denials and improve compliance your hospital or employed physician practices.*

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**References**

2. "Are You Getting to the True Root Cause of Your Denials?" by Christine Fontaine, HFMA.
7. "4 ways healthcare organizations can reduce claim denials," by Kelly Gooch, Becker’s Hospital CFO, July 26, 2016.
8. Ibid.

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