# How to avoid denied claims

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**Disclosures**
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Unless your practice is cash-only, reimbursements from your patients' health insurance companies are necessary to ensure its survival. Although the reimbursement process appears straightforward (provide a service, submit a claim, and receive a payment), it is actually quite complex, and, if not properly managed, a claim can be denied at any stage of the process.[1] In its 2013 National Health Insurer Report Card, the American Medical Association reported that major payers returned 11% to 29% of claim lines with $0 for payment.[1,2] This often is the case because patients are responsible for the balance, but it also occurs as the result of claim edits (up to 7%) and other denials (up to 5%).[1,2]

Claims can be denied for various reasons, including[1]:

- missed filing deadlines
- billing for non-covered services
- discrepancies between diagnostic codes, procedures codes, modifiers, and clinician documentation
- missing pre-authorization documentation or a signed Advanced Beneficiary Notice of Non-Coverage.

## Strategies for avoiding denials

A psychiatric practice requires a practical system to prevent the occurrence of denials, starting from the point of referral. Working through denials is more costly and time-consuming than preventing them from occurring in the first place. For every 15 denials prevented each month, your practice can save approximately $4,500 per year in costs associated with correcting those claims; by preventing denials, the practice also receives reimbursement sooner.[1] You can be guaranteed to leave significant amounts of money on the table if you are not able to prevent or reduce denials.

The following methods can be used to help reduce the likelihood of having a claim denied.[1,3]

**Obtain the patient's health insurance information** at first contact and confirm his or her coverage benefits, deductibles, copay requirements, and exclusions before scheduling the first appointment. Verify this information at each of the patient's subsequent visits to reduce the chances of having a claim denied due to invalid subscriber information. Also, keep in mind that Medicaid eligibility can change daily.

**Employ a digital record system**, such as electronic medical records, to track authorizations.

**Know the filing deadlines for each of your payers.** If you miss a deadline, there is no recourse.

**Check each claim** for accurate coding, diagnosis, and payment (eg, copay, co-insurance,

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and/or deductible, depending on the health insurance plan) taken before the claim is submitted. If your practice size permits, assign a staff member to confirm this information and keep track of deadlines for submissions, resubmissions, and appeals of denied claims. Using a single gatekeeper can help decrease the chances that a denial will "slip through the cracks."

**Confirm that diagnostic codes, procedures codes, and modifiers are justified by the clinician's documentation.** Have a medical coder compare notes with the clinician to determine if any critical information needed to justify the codes used has been omitted.

**Implement an electronic system that can automatically identify any changes and updates** to the Centers for Medicare and Medicaid Services (CMS) regulations and guidance, International Classification of Diseases (ICD) versions and codes, and Current Procedural Terminology (CPT) codes and guidelines. To help reduce denied claims, educate all staff (schedulers, coders, billers, nursing staff, and other clinicians) frequently about these changes, and provide regular feedback to those involved in correcting denials.

**Have a coder review your clinical notes to make sure they contain the information needed to justify the codes used**


**References**

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