Managing CPT Code Rejects: Updating Processes and IT Helps Cope with Growing Claims Work

by **John R. Thomas**

Each year healthcare adds programs, initiatives, and regulations to improve transparency and create efficiency. Unfortunately, many, if not all, add further complication, leading to higher CPT rejects. To effectively control the increasing time pressure of identifying, measuring, and repairing CPT codes, healthcare providers must update their billing processes and technologies and leverage reporting tools to manage the added burden.

HIPAA, the Physician Quality Reporting Initiative (PQRI), and the National Provider Identifier (NPI) are all relatively recent additions to our lexicon of healthcare terms. HIPAA has the high expectation of establishing a single legal claim format. Unfortunately, with more than 1,500 HIPAA-compliant claim formats available, efficiency remains elusive.

The cost of implementing these programs has increased healthcare costs significantly by generating a new, faster form of CPT code denial called the reject. CPT rejects are pre-adjudicated errors that require a provider to fix the transaction to seek payment or adjudication. The amount of work and time spent diagnosing and resolving claims production problems has gradually increased due to the increase in claim reject reasons.

Claim Reject 101

Each CPT within a claim is a unique economic event requiring measurement at the CPT code level versus the claim level. Generally, there are two types of claim rejects: format and content.

Format rejects are technical rejects generally at the batch level for a specific payer. In other words, the failure of a standardized claims process has given rise to format denials (e.g., “What goes in box 19 for the electronic format for XYZ Insurance Company?”). These format rejects are technical claim filing issues requiring knowledge of the electronic claims production process as well as various eligible formats of the practice management system setup.

Content rejects are data elements that need to be completed and can be identified at the clearinghouse or payer level. Unfortunately, it is difficult to determine at which level they occur within the practice management system.

For example, a report showing all CPT codes with a claim date will have both CPT codes that have been accepted by the payer and those with content format that have passed the clearinghouse but have not been received or accepted by the payer. A claim date analysis is a critical report, but unfortunately, many of the rejects that must be identified do not have a claim date and are therefore difficult to find in the practice management system.

Identification and Resolution

A few years ago, many healthcare providers could manage the revenue cycle process by employing generalists. However, claim rejects resulting from NPI and the adverse impact of many states’ recent clean claims legislation have moved forward in the revenue cycle process, exacerbating timely filing as practice management systems and many clearinghouse products cannot readily identify these issues. This increase in claim rejects and the technical issues related to these claim files have given rise to a new specialty within the billing office: claims production.

Today, these billing organizations are being transformed from generalist organizations into specialist organizations called central billing organizations (CBOs). Improving CBOs helps better manage the increasing complexity that causes high volumes of rejects.

Medical providers must increase the segmentation of the various portions of their revenue cycle to manage through the increasingly complex and technical segments. Arranging the CBO into clearly defined segments will provide measurable functions within the revenue cycle and improve the efficiency of managing claims. Suggested functional segments and their core responsibilities are broken down below:

- **Claims production** entails electronic as well as paper production cycles of primary, secondary, and patient statements.
- The **insurance A/R analyst** plays a fundamental role in the A/R process. This individual must understand the logic of prioritizing the credit balances to work the credit balance lines in the most efficient and effective method. Insurance analysis is a distinct skill set separate from self-pay analysis.
- The **patient services function** encompasses processing self-pay accounts for payment including call center functions and tracking the self-pay balance through the payment function.
- **Payment services** is best described as the payment posting, imaging, indexing, and reconciliation to the bank deposit file on a daily basis.
- The **technical services segment** involves application hosting (i.e., IT infrastructure), connectivity, security, and disaster recovery.

Claim Reporting Tools

To help identify and capture the information necessary to address all claim reject issues, providers can develop the following essential reports:

- **Past due claims report** includes all CPT codes with no claim date greater than five days from the date of service. Each provider may alter the date difference to reflect coding delays. However, the longer the delay, the more time is wasted if repairs are needed to get acceptance.
- **No response report** identifies all CPT codes that have not been denied or paid (greater than $20 for copayments) within 45 days of the date of service. The number of these CPT codes will be a key indicator of the claims production process.
- **Payer reject reports** capture CPT rejects by the payer for a specific reason. Many clearinghouses pass these reports to the provider. However, they might be in code that requires some investigation on the meaning. These reports are usually worked on a daily basis. These reports should be posted into the practice management system by reason in order to resolve these rejects in bulk. Working these reports independently does not allow for tracking or compliance until the no-response report is produced, thus creating a greater time constraint to correct issues.
- **Past filing deadline report** includes a subset of a basic denial report identifying the claims and their payers who have CPT codes that are not accepted for payment due to timely filing guidelines. If more than 0.25 percent of all CPT codes charged for a period receive this denial code, a claims production or verification of benefits issue likely exists. Additionally, reviewing payer concentrations will determine the nature of the claim or payer issue within the process.

Tips to Efficiently Managing Claim Rejects

In addition to segmenting the CBO, healthcare providers must master the essential components of processing claims. By following the tips below, they can effectively leverage technology and resources to manage increasing claim rejects:

- **Separate claims production** from A/R follow-up. The increasing complexity and number of claim rejects requires that claims production serve its own discreet function.
- **Reconcile production analytics** on a daily basis. First, reconcile outbound claims to the clearinghouse and then send the outbound claims to the payer.
- **Work the exception report** daily. To process and refile a claim, it is essential to understand what claims are accepted and why other claims are rejected (i.e., systematic problem, payer failure, or claim failure).
- **Monitor outbound claims**. Outbound claims do not have claim dates and therefore must be pulled through additional reports. If outbound claims are not referenced through other reports, they will be lost and not processed to the full extent.

These tips will help create an effective CBO. The most important tip is dividing the claims production role from A/R follow-up. This role is essential to the success of the organization's CBO and demands a discreet function to properly manage increasing

claim rejects.

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Creating a Revenue Integrity Department

by Donna D. Wilson, RHIA, CCS

What is revenue integrity? As I researched this question, I came across an article from SITA, specialists in air transport communication and IT solutions. It said, "Over the last thirty years, a large number of airlines have invested heavily in traditional revenue management solutions while ignoring the possibly greater return on investment offered by revenue integrity solutions. Revenue leakage—the gap between the revenue that airlines book and the amount that they eventually receive—was a significant problem. What exactly is revenue integrity? It is ensuring that passengers travel within the conditions applied to their ticket. This is achieved by eliminating reservations that either create unnecessary additional costs or reduce the saleable space available to other passengers. A simpler definition is ensuring that the correct passengers travel on the correct flight at the correct fare. SITA's White Paper on revenue integrity examines the benefits to be gained from developing a revenue integrity program and puts the case for applying a consistent approach."

After reading this, I couldn't help but think that revenue integrity is a department for an HIM/coding professional! With our background in coding, documentation, billing, and compliance, we are the absolute "best fit" for this necessary role. Chief financial officers across the country are investing in this role due to many initiatives: Sarbanes-Oxley, recovery audit contractors (RACs), MS-DRGs, etc. This article will describe how one revenue integrity department was created.

Read more.

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CodeWrite offers practical news for coding, reimbursement, and healthcare compliance. Each issue also features "ICD-10 Checkpoint," which compares ICD-9-CM codes to ICD-10-CM codes for a specific diagnosis. Additionally, readers find a timely coding challenge for discussion, upcoming events, and a coding-related crossword puzzle or word search.

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