Challenges in the Appeal Department:

What's in YOUR Denials Queue Today? **No, really.** ***How do you know?***

APPEAL ACADEMY

SAVING HEALTHCARE...
ONE APPEAL AT A TIME

"Every battle is won

BEFORE

it is fought."

Sun Tzu

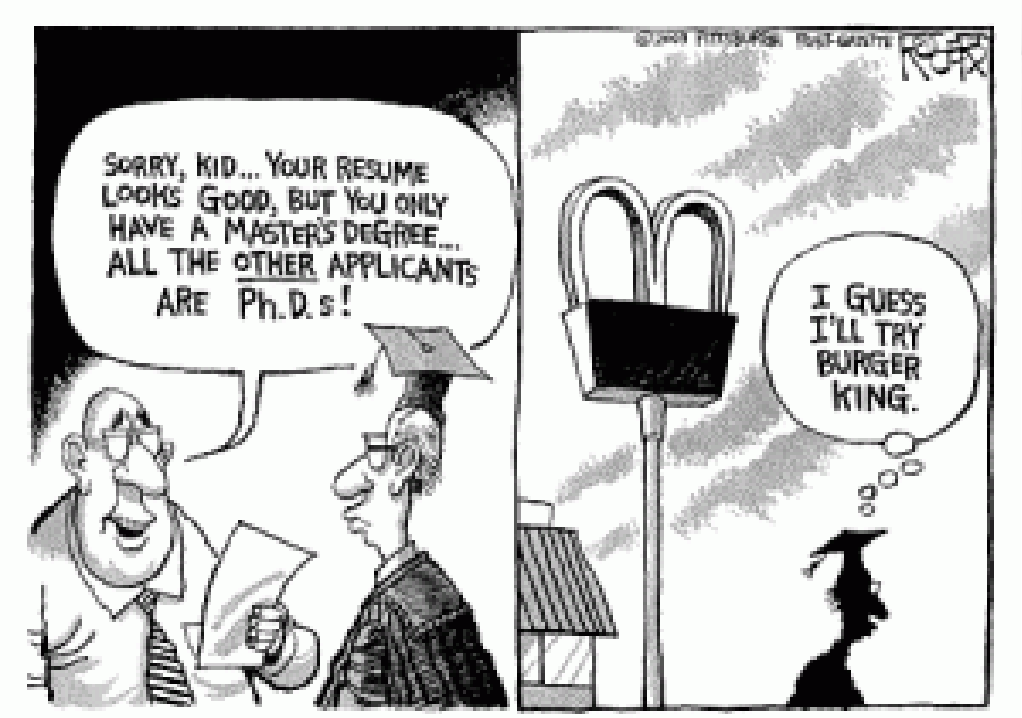
APPEAL ACADEMY

YOU MUST BREAK DOWN THE SILOS OR LOSE THE FIGHT BEFORE IT STARTS

- **The battle is NOT between the payers and the providers**
- **Most of the denials are avoidable, and those are caused by SILOS at the provider**

APPEAL ACADEMY

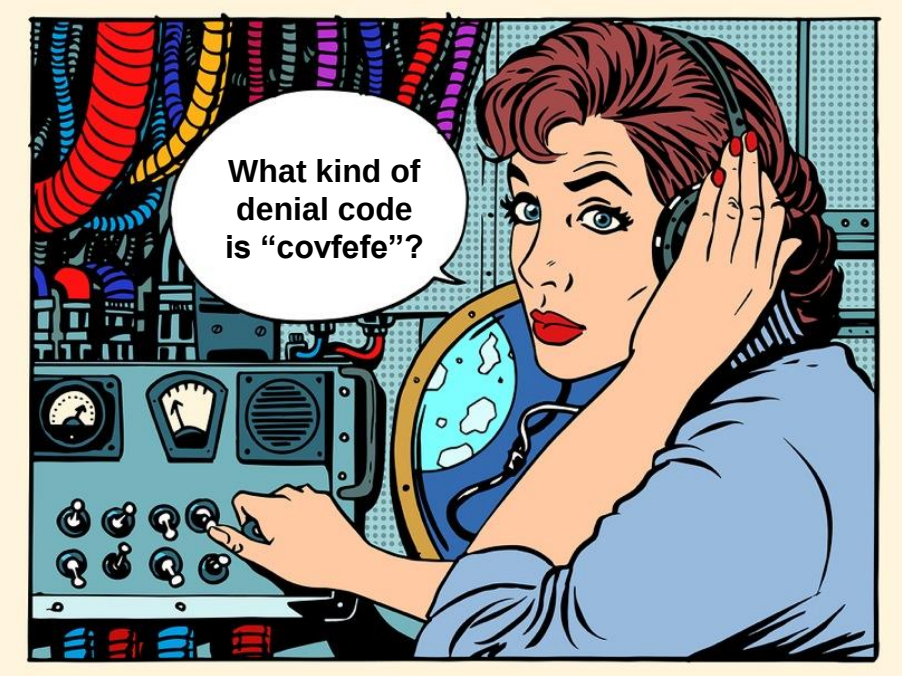
SOBERING AND UBIQUITOUS FACTS



- **RACTRAC Q3 2016:**
  - 33% OF RAC DENIALS APPEALED WERE OVERTURNED **when additional information was provided by the hospital to substantiate the original claim.**
- **An 800-Bed Hospital Example:**
  - 65% OF FAILED APPEALS (all types) WERE DUE TO NOT SENDING IN PROPER AND/OR COMPLETE RECORDS.

APPEAL ACADEMY

WHAT'S IN YOUR DENIALS? TODAY?



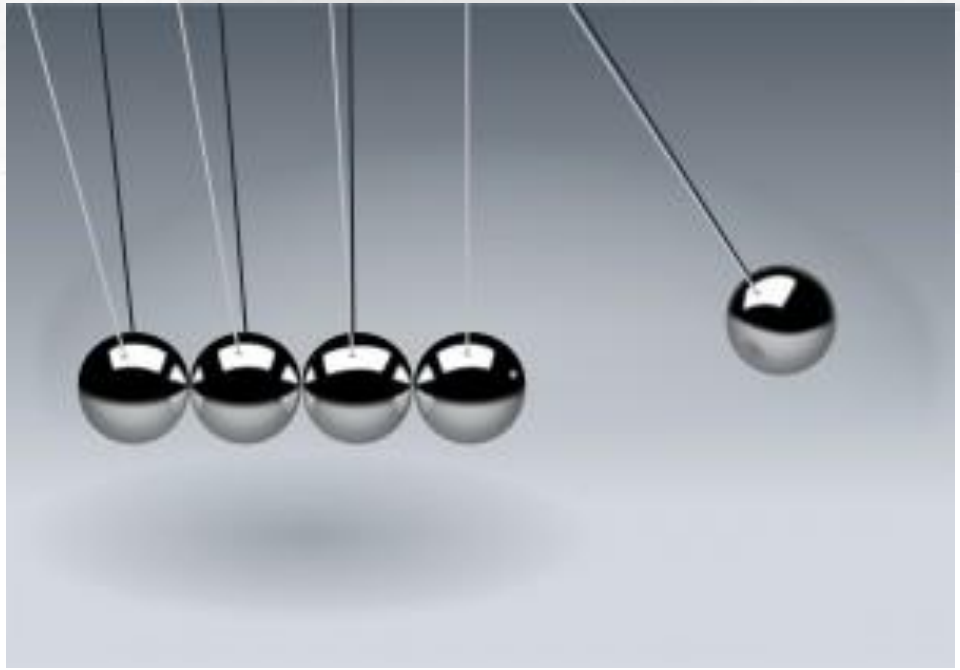
- **Use of Denial Queues…**
- **Trend your Top 5 Reasons for Denials – DAILY**
- **What is the denial *language* telling you?**

APPEAL ACADEMY

FOLLOW-UP AND CONFIRM – DO NOT DROP THE BALL!

- **Make sure your NEW processes get ingrained**
  - Just because you install a new process doesn't mean it keeps getting used
  - Assign Project Managers and hold accountable
  - If you have them, use your Six Sigma folks

“For every action, there is an equal and opposite reaction.” – Isaac Newton

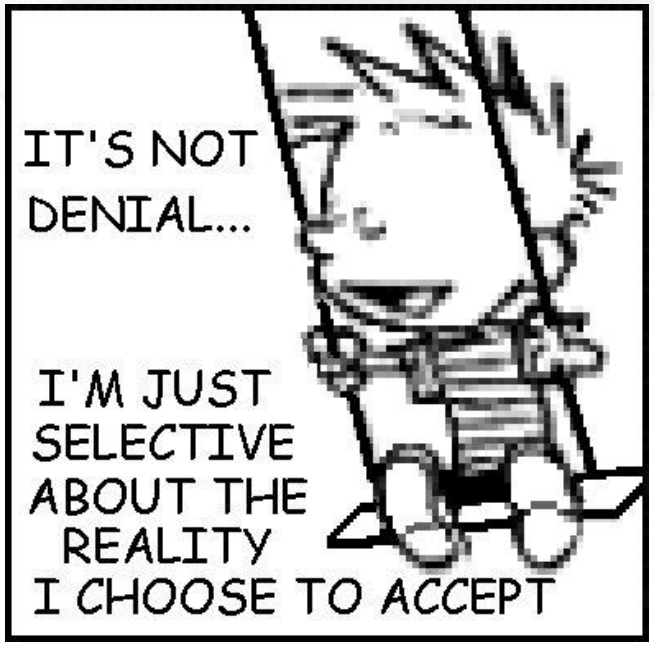


- **What are the unintended consequences of your denial management processes?**
  - Must be rooted in FACTS
  - Overcorrection can lead to claim submission delays

CHECK YOUR PRIORITIES…

- **Prioritize correctly**
  - Teams may focus on “low-hanging fruit”
  - High-dollar denials are certainly important…
  - BUT NOT at the expense of the 10 lower dollar denials that total more than the 1 big one!
  - Are there issues seen that may generate more denials NEXT month, or next YEAR?

PAY ATTENTION: POSSIBLY THE BIGGEST CHALLENGE YOU FACE TODAY



- **Payers often use the *wrong* denial codes….**
- **So…. Are your denials *categorized* correctly?**

(HINT: If you use EPIC or GE… check!)

APPEAL ACADEMY

EXAMPLE: Poor "Translation" meant writing off ~$15M per year…

Can you explain this translation? Yeah…me neither.

Perhaps CMS can?

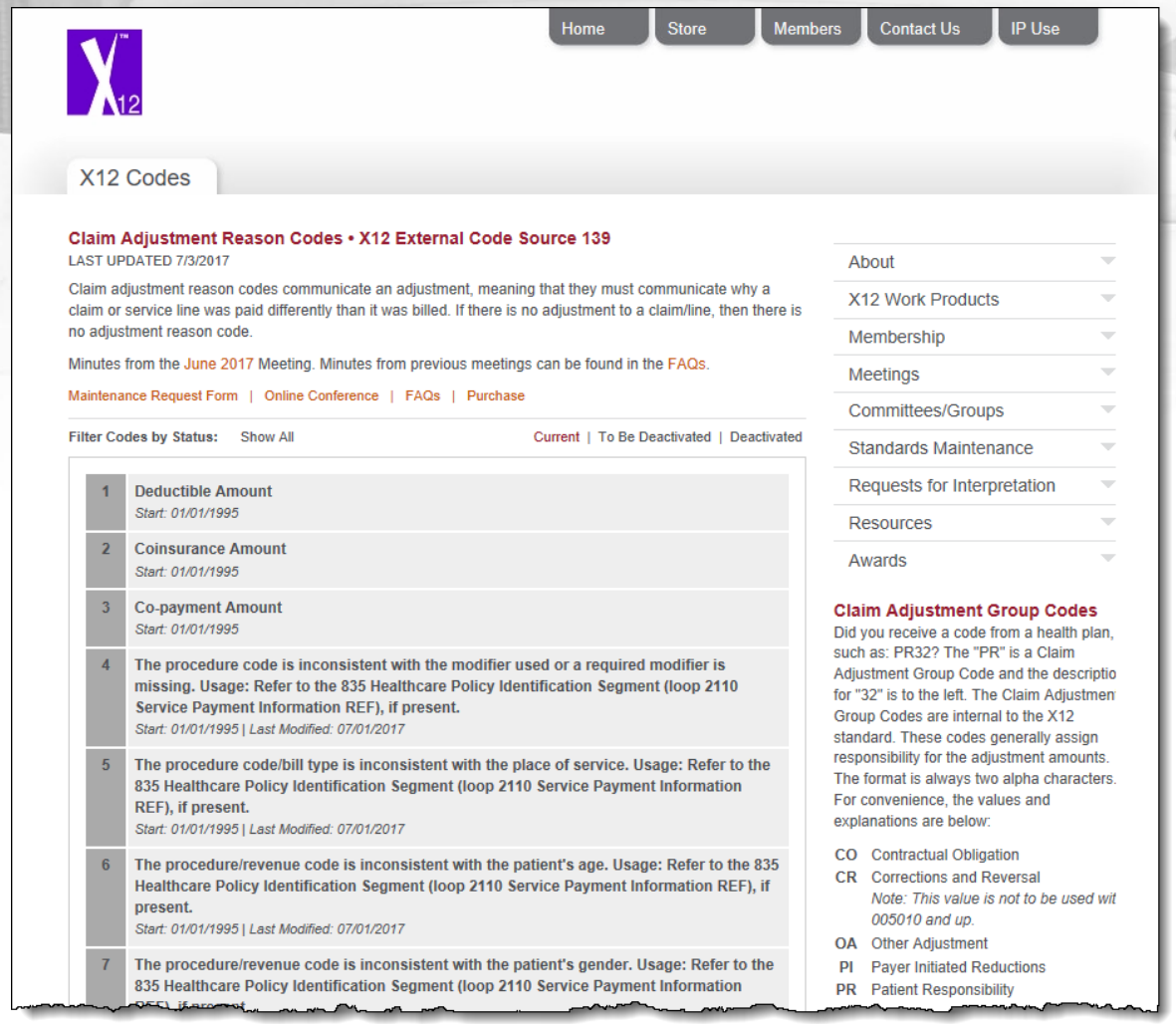
Sometimes, things get lost in translation…

- **RAs or 835s arrive with CARC (denial codes) that "suggest" additional documentation be submitted (250, 251, 252).**
- **The EMR system reads those codes as "denials" and they may NOT be forwarded to the HIM folks to get records sent out…**
- **This causes delays in finally being recognized as "not really a denial" and finally gets sent to the right people…**

  (But often, some of the additional documentation is not present in the electronic system, so it takes too much time to find, digitize and submit)

- **If the appropriate records are not sent out in time, the claim is not recoverable. Period.**

Claim Adjustment Reason Codes – CARC Denial Codes



Home | Store | Members | Contact Us | IP Use

X12 Codes

Claim Adjustment Reason Codes • X12 External Code Source 139

LAST UPDATED 7/3/2017

Claim adjustment reason codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

Minutes from the June 2017 Meeting. Minutes from previous meetings can be found in the FAQs.

Maintenance Request Form | Online Conference | FAQs | Purchase

Filter Codes by Status: Show All | Current | To Be Deactivated | Deactivated

1	**Deductible Amount** *Start: 01/01/1995*
2	**Coinsurance Amount** *Start: 01/01/1995*
3	**Co-payment Amount** *Start: 01/01/1995*
4	**The procedure code is inconsistent with the modifier used or a required modifier is missing. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
5	**The procedure code/bill type is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
6	**The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.** *Start: 01/01/1995 | Last Modified: 07/01/2017*
7	**The procedure/revenue code is inconsistent with the patient's gender. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information**

About
X12 Work Products
Membership
Meetings
Committees/Groups
Standards Maintenance
Requests for Interpretation
Resources
Awards

Claim Adjustment Group Codes

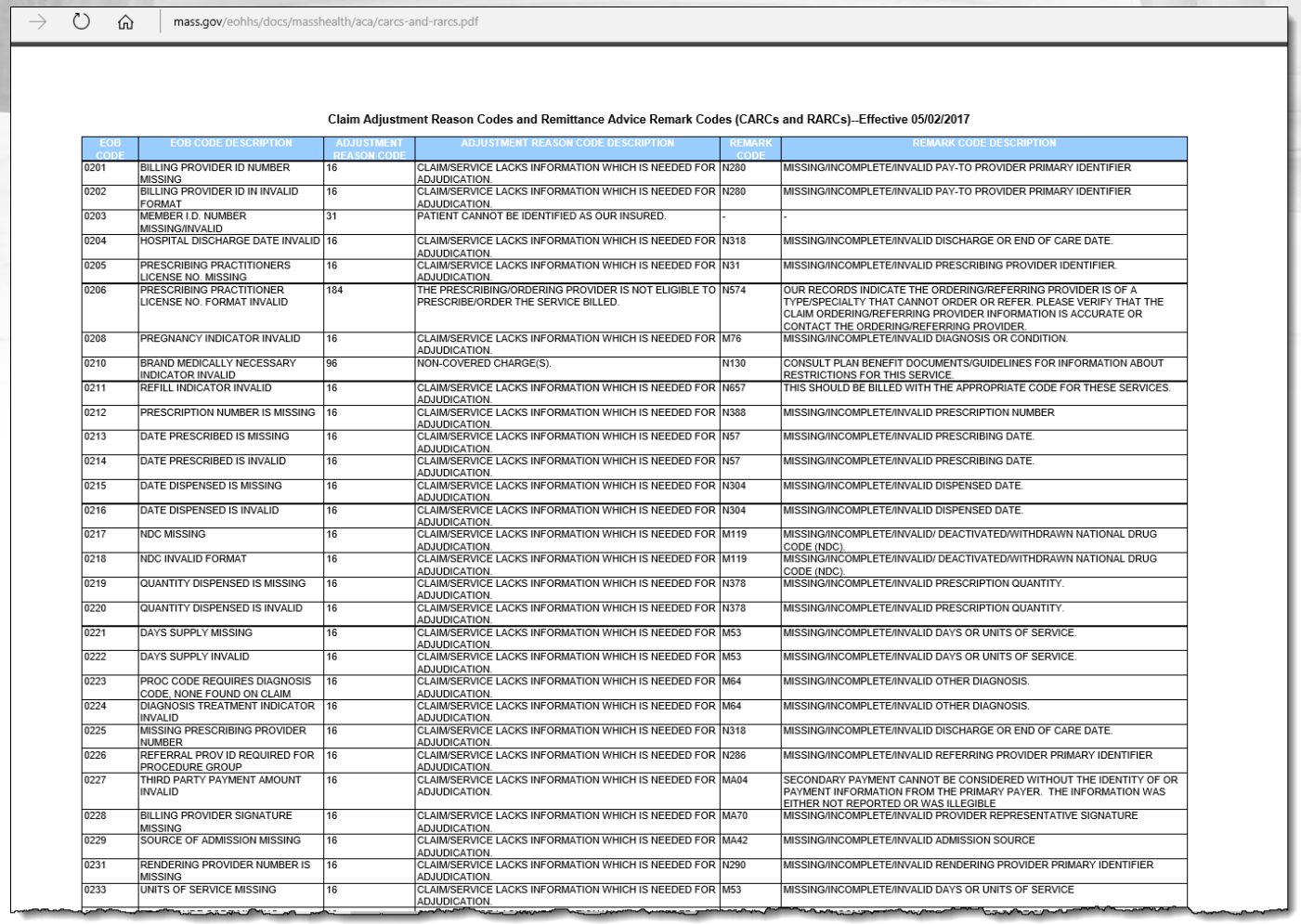
Did you receive a code from a health plan, such as: PR32? The "PR" is a Claim Adjustment Group Code and the descriptio for "32" is to the left. The Claim Adjustmen Group Codes are internal to the X12 standard. These codes generally assign responsibility for the adjustment amounts. The format is always two alpha characters. For convenience, the values and explanations are below:

CO Contractual Obligation
CR Corrections and Reversal
Note: This value is not to be used wit 005010 and up.
OA Other Adjustment
PI Payer Initiated Reductions
PR Patient Responsibility

"Claim adjustment reason codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code."

http://www.x12.org/codes/claim-adjustment-reason-codes/

Claim Adjustment Reason Codes (CARC) & Remittance Advice Remark Codes (RARC)



mass.gov/eohhs/docs/masshealth/aca/carcs-and-rarcs.pdf

Claim Adjustment Reason Codes and Remittance Advice Remark Codes (CARCs and RARCs)--Effective 05/02/2017

EOB CODE	EOB CODE DESCRIPTION	ADJUSTMENT REASON CODE	ADJUSTMENT REASON CODE DESCRIPTION	REMARK CODE	REMARK CODE DESCRIPTION
0201	BILLING PROVIDER ID NUMBER MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N280	MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER PRIMARY IDENTIFIER
0202	BILLING PROVIDER ID IN INVALID FORMAT	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N280	MISSING/INCOMPLETE/INVALID PAY-TO PROVIDER PRIMARY IDENTIFIER
0203	MEMBER I.D. NUMBER MISSING/INVALID	31	PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.	-	-
0204	HOSPITAL DISCHARGE DATE INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N318	MISSING/INCOMPLETE/INVALID DISCHARGE OR END OF CARE DATE.
0205	PRESCRIBING PRACTITIONERS LICENSE NO. MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N31	MISSING/INCOMPLETE/INVALID PRESCRIBING PROVIDER IDENTIFIER.
0206	PRESCRIBING PRACTITIONER LICENSE NO. FORMAT INVALID	184	THE PRESCRIBING/ORDERING PROVIDER IS NOT ELIGIBLE TO PRESCRIBE/ORDER THE SERVICE BILLED.	N574	OUR RECORDS INDICATE THE ORDERING/REFERRING PROVIDER IS OF A TYPE/SPECIALTY THAT CANNOT ORDER OR REFER. PLEASE VERIFY THAT THE CLAIM ORDERING/REFERRING PROVIDER INFORMATION IS ACCURATE OR CONTACT THE ORDERING/REFERRING PROVIDER.
0208	PREGNANCY INDICATOR INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	M76	MISSING/INCOMPLETE/INVALID DIAGNOSIS OR CONDITION.
0210	BRAND MEDICALLY NECESSARY INDICATOR INVALID	96	NON-COVERED CHARGE(S).	N130	CONSULT PLAN BENEFIT DOCUMENTS/GUIDELINES FOR INFORMATION ABOUT RESTRICTIONS FOR THIS SERVICE.
0211	REFILL INDICATOR INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N657	THIS SHOULD BE BILLED WITH THE APPROPRIATE CODE FOR THESE SERVICES.
0212	PRESCRIPTION NUMBER IS MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N388	MISSING/INCOMPLETE/INVALID PRESCRIPTION NUMBER
0213	DATE PRESCRIBED IS MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N57	MISSING/INCOMPLETE/INVALID PRESCRIBING DATE.
0214	DATE PRESCRIBED IS INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N57	MISSING/INCOMPLETE/INVALID PRESCRIBING DATE.
0215	DATE DISPENSED IS MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
0216	DATE DISPENSED IS INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N304	MISSING/INCOMPLETE/INVALID DISPENSED DATE.
0217	NDC MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
0218	NDC INVALID FORMAT	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	M119	MISSING/INCOMPLETE/INVALID/ DEACTIVATED/WITHDRAWN NATIONAL DRUG CODE (NDC).
0219	QUANTITY DISPENSED IS MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N378	MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY.
0220	QUANTITY DISPENSED IS INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N378	MISSING/INCOMPLETE/INVALID PRESCRIPTION QUANTITY.
0221	DAYS SUPPLY MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.
0222	DAYS SUPPLY INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE.
0223	PROC CODE REQUIRES DIAGNOSIS CODE, NONE FOUND ON CLAIM	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	M64	MISSING/INCOMPLETE/INVALID OTHER DIAGNOSIS.
0224	DIAGNOSIS TREATMENT INDICATOR INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	M64	MISSING/INCOMPLETE/INVALID OTHER DIAGNOSIS.
0225	MISSING PRESCRIBING PROVIDER NUMBER	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N318	MISSING/INCOMPLETE/INVALID DISCHARGE OR END OF CARE DATE.
0226	REFERRAL PROV ID REQUIRED FOR PROCEDURE GROUP	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N286	MISSING/INCOMPLETE/INVALID REFERRING PROVIDER PRIMARY IDENTIFIER
0227	THIRD PARTY PAYMENT AMOUNT INVALID	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	MA04	SECONDARY PAYMENT CANNOT BE CONSIDERED WITHOUT THE IDENTITY OF OR PAYMENT INFORMATION FROM THE PRIMARY PAYER. THE INFORMATION WAS EITHER NOT REPORTED OR WAS ILLEGIBLE
0228	BILLING PROVIDER SIGNATURE MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	MA70	MISSING/INCOMPLETE/INVALID PROVIDER REPRESENTATIVE SIGNATURE
0229	SOURCE OF ADMISSION MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	MA42	MISSING/INCOMPLETE/INVALID ADMISSION SOURCE
0231	RENDERING PROVIDER NUMBER IS MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	N290	MISSING/INCOMPLETE/INVALID RENDERING PROVIDER PRIMARY IDENTIFIER
0233	UNITS OF SERVICE MISSING	16	CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.	M53	MISSING/INCOMPLETE/INVALID DAYS OR UNITS OF SERVICE

This is a list provided by the State of Massachusetts, Executive Office of Health and Human Services (EOHHS).

You need to check with your own state, your MAC, and your other payers to get the appropriate lists and guidance.

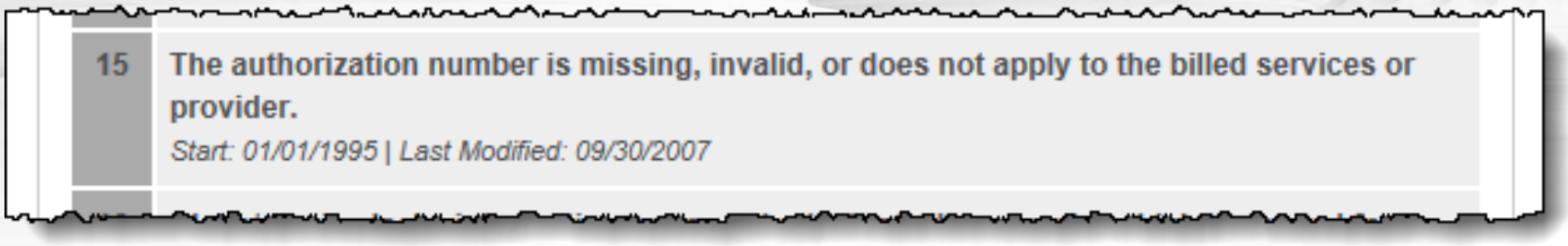
Such lists are updated OFTEN, so need constant attention and maintenance.

(Somewhere in your hospital is a "dictionary" of these codes.)

http://www.mass.gov/eohhs/docs/masshealth/aca/carcs-and-rarcs.pdf

APPEAL ACADEMY

Common CARC Denial Codes that Often Prove to Be Improperly Used

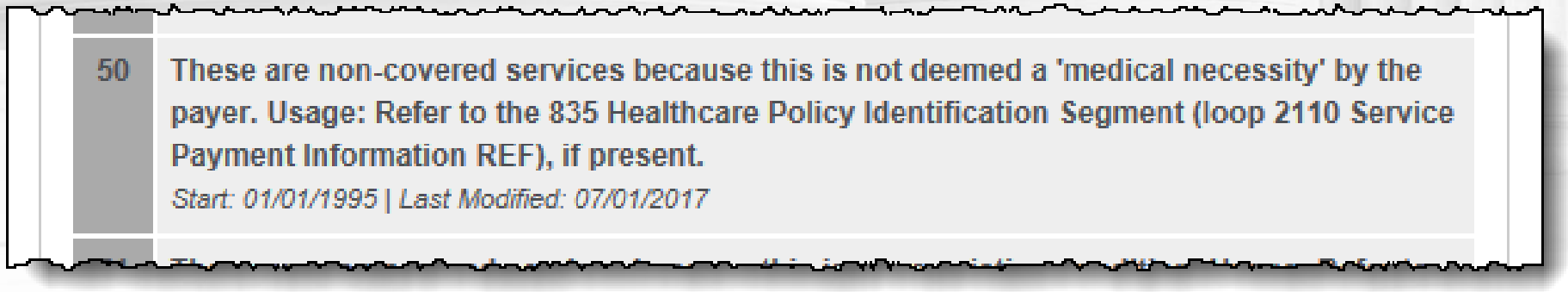


- **Needs to be checked…**
- **Is this really about the number?**
- **OR - Is this really about a lack of documentation to support medical necessity?**
- **If this is really about the number, WHY did it happen?**

Common CARC Denial Codes that Often Prove to Be Improperly Used

- **Needs to be checked…**
- **Did this really happen? Were you told to do it anyway and it "will get fixed" later?**
- **Was it authorized for the physician but not the hospital?**

Common CARC Denial Codes that Often Prove to Be Improperly Used



50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. *Start: 01/01/1995 | Last Modified: 07/01/2017*

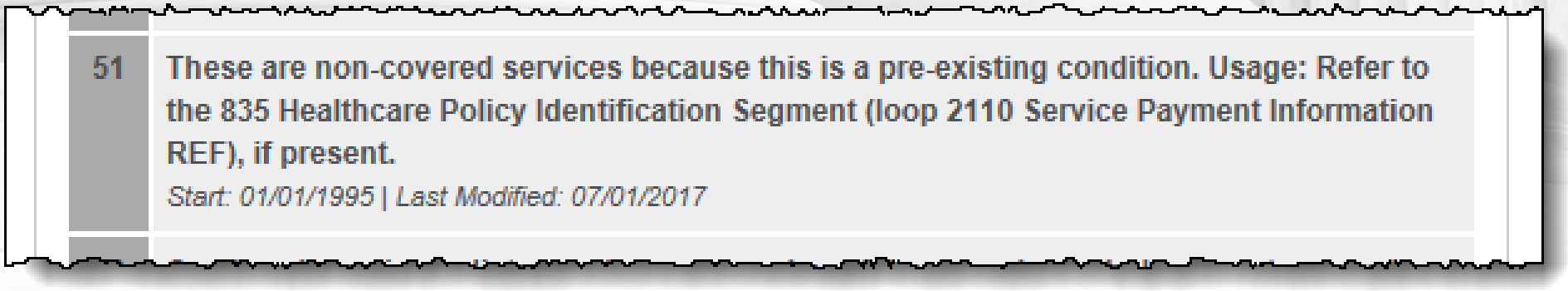
- **What does it mean… "not deemed a medical necessity"?**
- **This is often used as a "dumping ground"**
- **Possibilities:**
  - Clinical disagreement?
  - Lack of documentation?
  - Erroneous code? (should be missing preauth or similar)

Common CARC Denial Codes that Often Prove to Be Improperly Used

16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. *Start: 01/01/1995 | Last Modified: 07/01/2017*

- **What does it mean… "lacks information"?**
- **And what's lacking?**

Common CARC Denial Codes that Often Prove to Be Improperly Used



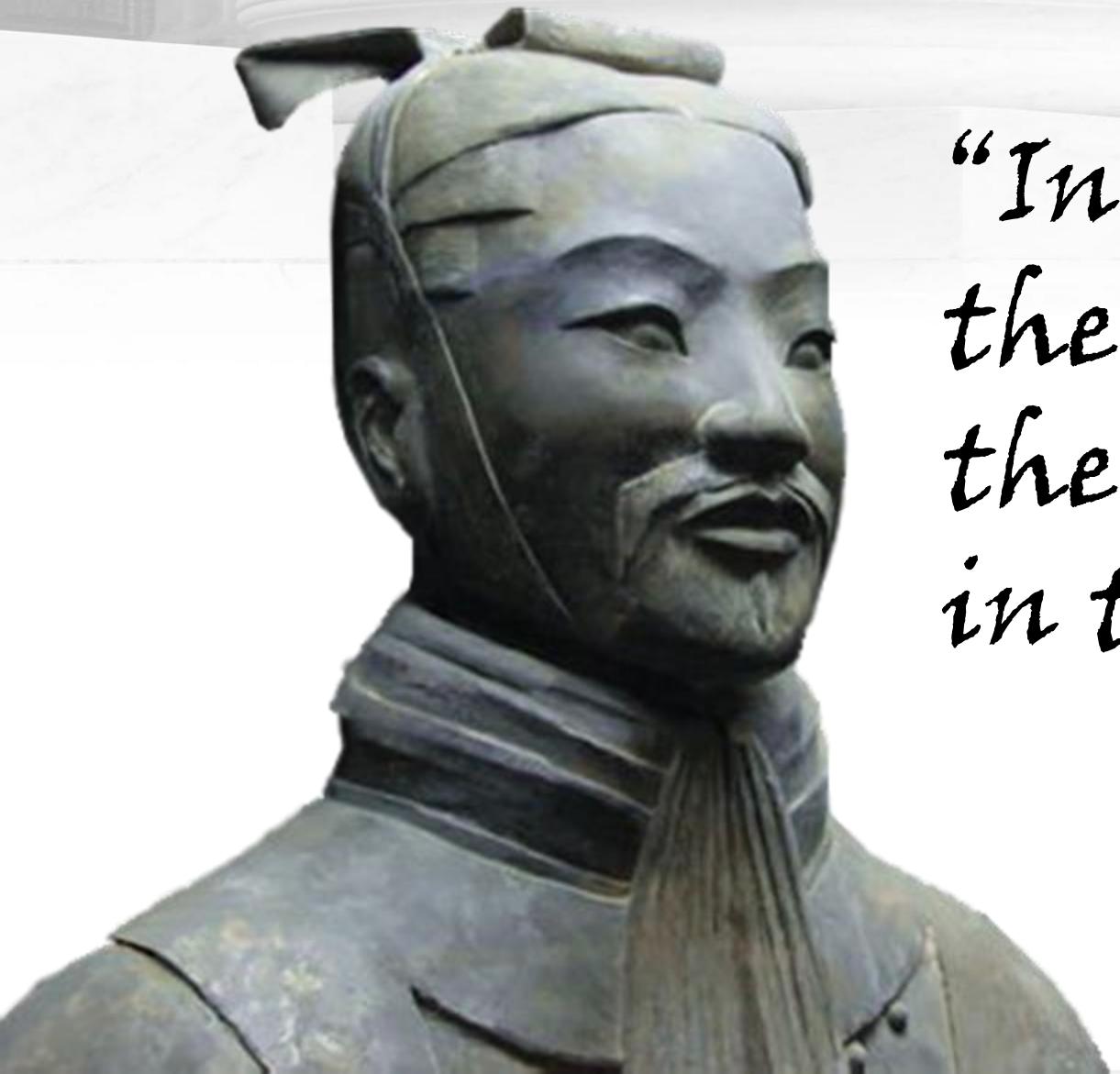
- **Yeah… this could show up again, soon.**

(More about this on Friday during our Healthcare Reform Discussion Panel)

AFTER You Know What's Going On…

- **NOW: put a TEAM (the right kind of team) on the denials, by issues/reasons, and by Payer**

  - Medicare, Medicaid, other Govt
  - Commercial Managed Care
  - Other Commercial



"Invincibility lies in
the defense;
the possibility of victory
in the attack."

Sun Tzu

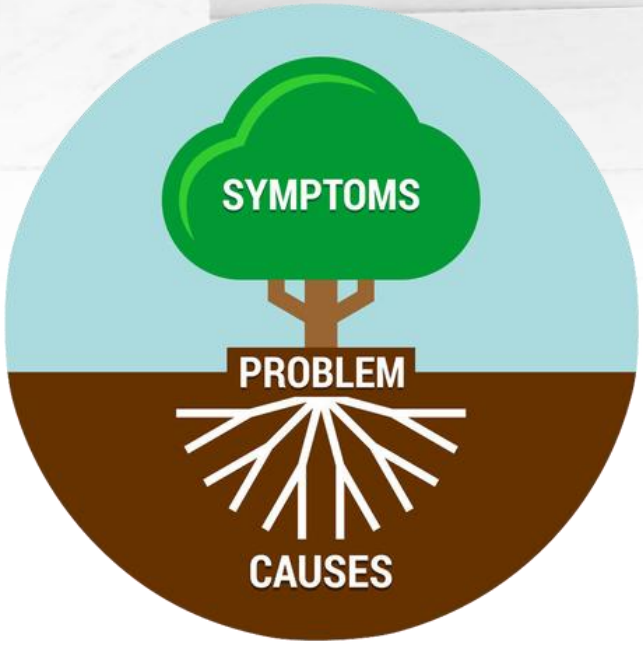
APPEAL ACADEMY

How to Prioritize Dealing with Denials

"The ringing in your ears—I think I can help."

- **Each Team Must Separate:**
  - Avoidable vs. Non-Avoidable Denials
- **Then, Concentrate on the Avoidable…**

Dealing with the Source of the Denials



- **What was the root cause of those Preventable denials?**
  - Wrong or No Authorization
  - Wrong Status or Status Change
  - what specific spot inside your Revenue Cycle was the cause of the problem…
- **Example: When PFS sends records request to HIM, does the right stuff get sent out?**

Existing Silos are Still Hurting You…

- **Example:**

  A Clerk tasked with delivering records for review to an outside vendor (paid via a flat fee) winds up quitting the job. No one informs the rest of the RCM team, and the records simply do not get sent out anymore, while the vendor continues to get paid… for doing nothing.

- **WHO (IF ANYONE) IS RESPONSIBLE FOR TRACKING THIS KIND OF STUFF?**

A Sure-fire Method of Planning to Fail

NEVER NEVER NEVER NEVER NEVER NEVER …

RELY ON THE BACK END TO FIX YOUR PROBLEMS

APPEAL ACADEMY

"There is no instance of a nation benefitting from a prolonged war."

Sun Tzu

APPEAL ACADEMY

Many Thanks and Good Luck with All Your Appeals!

Ernie de los Santos
Founder & Faculty Chair

Appeal Academy | Top Gun Audit School
http://appealacademy.com

erniedls@appealacademy.com

Mobile & Office: 1-760-792-3858

APPEAL ACADEMY