6 Easy Steps to Reduce Billing Denials

Ever wonder why your billing is denied? Many times, the answer lies in the human factor – careless errors. We all know there are times when we cannot read the client's handwriting on their intake paperwork or on the doctor's notes. And then there are the typos and missing information.

When a claim is denied, it puts a crimp in the reimbursement process. If the denied claim is not caught in time, it becomes part of your Accounts Receivables. And that is definitely not where you want claims to go and die. So what can you do about it? Well, let's look at why some of your claims are denied (There are many more ways but these are the most common):

- Incorrect Date of Birth or Name
- Missing or incorrect Social Security Number
- ICD-9 Diagnosis code is inaccurate or non-billable
- Address of client is missing
- Non CMS 5010 Compliance
- Claims (**HCFA/CMS 1500**) filed with missing information
- Missing authorization number
- Missing **NPI** (National Provider Identifier)
- Incorrect **TIN** for provider
- Missing or incorrect modifier
- Claim is Not Filed on Time

Your practice can reduce claims denial by increasing its filing accuracy by following these easy steps:

1) Slow down (think like a tortoise: slow and steady wins the race)
2) Review claims before hitting the submit button
3) Verify Demographics (this may require a call to the client)
4) Ask the physician to clarify handwriting and notes
5) Ask another biller for assistance
6) If a claim has been denied, call the insurance carrier to ask why the claim was denied. Many insurance carriers have dedicated departments that only handle insurance claims.

With insurance companies tightening their belts and not paying for certain codes and procedures, now more than ever is the time to ensure accuracy and decrease denials. If your staff is not trained to handle denied claims, it is always recommended to outsource your denied claims to a billing service. **PIMSY EHR now offers full service billing**.

The claim was still denied… Now what? Appeal! The MGMA found that only 35% of providers appeal denied claims. Since payers frequently make mistakes and deny claims in error, that percentage should be much higher. **Inspect every single denied claim** to make sure it's correct and develop a denial management system in your practice. Task an employee with appeal duties. Otherwise, you're just allowing over 4% of the money you're owed to slip through the cracks!

Remember, a happy and efficient practice is a practice that has a low insurance claims denial percentage and a paid staff.

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