HOW TO AVOID AND RESPOND TO DENIALS

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The transition to ICD-10 is fully behind us, including any grace periods that CMS provided to ease the burden of costly claim denials and processing delays. In reviewing statistics pre- and post-ICD-10 implementation, there are some encouraging findings; for the year ending 9/30/2016 as compared to the prior 12 months, the average payer processing time dropped from 20 days to 15, according to RemitDATA®. Although this data is encouraging, denials remain one of the most significant areas of lost revenue for providers and healthcare organizations. CMS reports that ~2% of claims were denied for having incomplete or invalid information following the end of the grace period, which is comparable to pre-ICD-10 levels. However, of all claims processed by CMS, 10.1% were denied, with the most common reported denials being use of an invalid ICD-10 code, non-specific ICD-10 code, and lack of medical necessity for services rendered.

This session will provide an overview of the most common coding denials and best practices in workflow and clinical documentation to ensure maximum reimbursement for services rendered. It will also include tools to assess your denial rate with targeted approaches to mitigate denials at initial claim submission.

Case studies of the more common coding challenges will be included in this course.