

Medical Claims 101: How to Avoid Common Denial and Rejection Pitfalls for HealthySteps Services



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The HealthySteps National Office developed this comprehensive guide to highlight the most common pitfalls that lead to medical claim denials and rejections for HealthySteps services. It is intended for use by sites to increase efficient billing practices and maximize reimbursement for HealthySteps services.

What are Medical Claims and The Healthcare Revenue Cycle?

The healthcare revenue cycle is defined by the HealthCare Financial Management Association (HFMA) as, *“the set of all administrative and clinical functions that contribute to the capture, management, and collection of patient service revenue, which is translated into a medical claim.”*

A medical claim is a bill that healthcare providers or facilities submit to a patient’s insurance carrier for reimbursement. A medical claim includes a diagnosis and medical codes that describe the services rendered by a clinician, including procedure/service code(s) and billing modifiers (if applicable). Additional codes on a medical claim represent the place of service, provider information, patient demographics, and insurance information. This information allows the insurance carrier to determine if a service meets the established criteria for payment.

Medical claims management is an important component of the healthcare revenue cycle and encompasses the organization, billing, filing, updating (if necessary), and processing of medical claims related to a patient’s diagnoses, treatments, and medications. It begins with compiling a medical claim and submitting the claim to the insurance carrier(s). Once received by the insurance carrier(s), the claim is reviewed, and a determination is made as to whether the information submitted is satisfactory for reimbursement. If the insurance carrier finds any discrepancies and/or errors, the claim is either denied or rejected based on a stated reason. Working to correct and/or update a medical claim for resubmission to the insurance carrier is key to reaching the desired end result - reimbursement for services rendered. Claims management is critical because unmanaged denials and rejections may become abundant and result in “money left on the table” due to avoidable errors on the part of the provider or site.

Claim Denial vs. Claim Rejection

Claim Denials are claims that have been received and processed by the insurance carrier and have been deemed *unpayable* for a variety of reasons. These claim denials typically contain an error that was flagged after processing. Reasons for claim denials include:

- Provider credentialing issues,
- Non-covered services, per insurance carrier,
- Services are found to be medically unnecessary,
- Missing referral from primary care physician to specialist when required,
- Missing provider data,
- Incorrect patient information, and
- Incorrect point-of-service code (usually a two-digit code that represents the setting in which the service(s) were provided (e.g., pediatrics, emergency room, family medicine).

While it may seem simple to resubmit a claim for a second review by the insurance carrier, a claim that has been denied cannot be sent back without additional follow-up. First, the provider's billing department must determine why the claim was denied. Insurance carriers will usually provide a denial claim number and reason for the denial, pointing the medical biller and/or claims processor in the right direction for resubmitting the corrected and/or updated information required for claim re-processing. If a denied claim is resubmitted to the insurance carrier without the corresponding denial claim number, it will be considered a duplicate claim, resulting in a second denial. It is vital that the department responsible for billing, claim submissions, and/or claim appeals contact the insurance carrier(s) for information on the methods required for claims resubmission.

Rejected medical claims are claims that usually contain one or more errors that are found prior to the claim being processed by the insurance carrier. Insurance carriers will review a claim prior to processing for payment, and if an error(s) is found that they deem easy to resolve, they will not deny the claim, but rather reject it. A rejected claim is typically the result of:

- A coding error(s),
- A mismatched procedure and ICD-10 code(s), or
- A terminated patient medical insurance policy.

These types of errors can be as simple as a transposed digit from the patient's insurance policy number, or a medical claim sent to a former medical insurance carrier where the patient is no longer enrolled.

A provider can resubmit a rejected claim once the errors are corrected because the data never entered the insurance carrier's system (not processed). Some providers and facilities have electronic medical record systems that catch these errors before submission to the insurance carrier. However, even with a safety net in place, there may be times when the carrier's system finds the error. For the

claim management process, it is important to understand where such errors are tracked (at the provider-level, payer-level, or both) and quickly correct them since resubmission for payment for these claims is often straightforward.

Common Reasons for Medical Claim Denials

As discussed, medical claim denials are those claims processed and reviewed by the insurance carrier and deemed unpayable for an array of reasons. Knowing the most common pitfalls can help you and your site avoid them. One of the most common pitfalls resulting in medical claim denials is the lack of initial insurance carrier credentialing for newly hired clinicians and the absence of re-credentialing for those clinicians already rendering and billing for services.

Quick Tip: Understanding the difference between a claim denial and a claim rejection is key to understanding how the follow-up of these claims should be conducted. Insurance carriers will identify if a claim is denied or rejected. If the claim(s) were never processed by the insurance carrier, due to errors they perceive could be corrected before processing, then it is a rejection. Rejections do not need an appeal or reconsideration for payment. On the other hand, if the claim was processed by the insurance carrier and denied, then a billing representative at your site may need to complete an appeal.

Credentialing of Clinicians

Medical credentialing is the process of obtaining, verifying, and assessing the qualification of a clinician so they can provide care at your site and be eligible to submit medical claims to insurance carriers. Credentials are documented evidence of qualifications such as licensure, education, and experience. Documentation must also include a list of all addresses where the clinician will render services and should be regularly updated as needed. Facilities usually have a credentialing specialist who is responsible for processing this paperwork for all clinicians. This ensures that insurance carriers have new or updated clinician information.

When a new clinician that can bill for services is hired, that individual must be credentialed with the practice's insurance carriers. Eligibility for medical insurance credentialing is state and medical insurance driven. The most common clinicians eligible for insurance credentialing are those who are licensed (e.g., licensed clinical social workers, licensed psychologists, licensed marriage and family therapists, licensed mental health counselors). Making sure that all the documents and information required for the credentialing process are in order and submitted to insurance carriers is key for clinician service reimbursement eligibility. If the insurance carrier(s) do not receive your new clinician's credentialing documents, their services will not be eligible for reimbursement.

Re-Credentialing of Clinicians

Re-credentialing is the process of periodic review and verification of a professional's credentials. All information submitted during the initial credentialing process is routinely re-verified by the insurance carrier(s).

One of the most common pitfalls in this process is the absence of timely filing of clinician re-credentialing documents. Typically, insurance carriers require re-credentialing to be done every 12-24 months, depending on the carrier. If the insurance carrier does not receive the re-credentialing documents within the established timeframe, they will cease reimbursement for that clinician's services, resulting in medical claim denials for the services that clinician has rendered.

Quick Tip: Ensuring that all the required credentialing documentation for a newly hired clinician is submitted to insurance carriers in a timely manner and that all existing credentialing documentation is current and re-submitted for re-credentialing will result in the processing and payment of medical claims.

Submitting Medical Claims for Non-Covered Services

Insurance carriers will also deny medical claims for services billed that they do not cover. Covered and non-covered services can vary from state to state and payer to payer. Payers often follow their state Medicaid guidelines; therefore, as a great start, medical billers can look to their state's Medicaid website for guidelines on the available billing codes for HealthySteps-related services. The National Office Policy & Finance team also has resources that sites can leverage to identify the types of HealthySteps-related services that may be provided.

Services can also be considered "non-covered" if the diagnosis on a claim is not approved as reimbursable when billed as the primary or sole diagnosis. For example, if the claim is submitted with a social determinant of health diagnosis (e.g., housing insecurity), as either the primary or sole diagnosis, and your state Medicaid agency does not recognize social determinants of health as primary or sole diagnoses for reimbursement, then insurance carriers will deny the medical claim for reimbursement.

Another example is when billing for unspecified diagnoses. ICD-10¹ was introduced to the medical billing world in October 2015, bringing over 14,000 new codes that provide a clearer picture of diagnoses that previously had to be reported as "unspecified." As a result, most carriers now deny claims where there is an unspecified diagnosis listed. Unless your state has approved the use for unspecified diagnoses or for a specific unspecified diagnosis, insurance carriers will regularly deny those claims. A common unspecified diagnosis considered by HealthySteps Specialists is "unspecified

¹ ICD-10 is the 10th edition of the standard transaction code set for diagnostic purposes. The codes represent diagnoses and symptoms that are billed to medical insurance carriers. ICD-10 codes tell the story of each patient encounter, describe etiologies of the disease process, and/or describe a patient's symptom(s).

counseling (Z71.9).” The professionals at your site responsible for medical billing or claims submissions should verify if such diagnoses are reimbursable.

Medical Necessity

Another reason why insurance carriers deny claims is if they find that the services rendered do not meet the medical necessity criteria.

The definition of medical necessity can vary with insurance carriers but often is defined as healthcare services or supplies needed to diagnose or treat an illness or injury, condition, disease, or its symptoms, and that meet accepted standards of medicine. When insurance carriers deny reimbursement for a claim due to lack of medical necessity, it is often because they deem the services rendered are not medically necessary for the diagnoses reported.

A common pitfall seen in claim denials for a HealthySteps-related service is submitting a claim for family psychotherapy without a supporting diagnosis. Supporting diagnoses are state and insurance carrier driven; therefore, medical billers should verify acceptable diagnoses prior to submitting these claims. For example, submitting a claim without a behavioral or mental health diagnosis for family psychotherapy services, when billing for the service in a state that requires one to support the medical necessity for the service, will result in a claim denial.

Quick Tip: Apart from California and Massachusetts, most states require a mental health diagnosis when rendering mental health services such as family psychotherapy. Because of this requirement, the absence of a mental health diagnosis will result in a claim denial. The professionals at your site responsible for medical billing and/or claim submissions should verify which HealthySteps related services require a mental health diagnosis.

Medical insurance carriers have pre-determined categories of diagnoses that support medical necessity for the reimbursement of services, so the first step is to be aware of the kind of diagnoses that will cover the services you are billing for. When billing for behavioral/mental health services, most states require a mental/behavioral health diagnosis to support the need for the service. This guideline, although widely adopted, is state propelled and there can be variances in states. An example of a variance can be seen in California, where their Family Health Benefit offers preventive individual and dyadic supports via psychotherapy when certain psycho-social risk factors are present. <https://filessysdev.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf> .

Medi-Cal, California’s Medicaid system, supports the medical necessity for family psychotherapy when any of their approved risk factors are present in either the parent/caregiver or child. They have pre-determined diagnosis codes that represents the risk factors and reimburse for family psychotherapy when a claim is submitted with the codes. California’s Family Health Plan is a great benefit supporting preventive dyadic supports and the HealthySteps National Office cannot wait to

see other states follow their lead in reimbursing for preventive dyadic services.

https://cachildrenstrust.org/wp-content/uploads/2020/05/Dyadic_final_May2020.pdf

Another example can be seen in Massachusetts, where up to six sessions of individual and/or family psychotherapy are recognized for reimbursement for preventive behavioral health services.

<https://www.mass.gov/doc/managed-care-entity-bulletin-65-preventive-behavioral-health-services-for-members-younger-than-21-0/download>

Referrals

A primary care physician (PCP) keeps track of all medical records for patients and provides routine care. Some insurance carriers require a referral to a specialist from the patient's PCP to establish the kind of specialized care the patient needs and why. Without such a referral, a payer may not cover the cost of the specialist's care. Typically, Health Maintenance Organizations (HMOs) and Point of Service (POS) plans require a patient to obtain a referral before seeing a specialist. Preferred Provider Organizations (PPOs) and Exclusive Provider Organizations (EPOs) typically do not. If a referral is required and not obtained, the result will be a claim denial.

There are exceptions to this rule. In some states, insurance carriers do not require patients to obtain referrals to specialists who provide behavioral health services (e.g., psychiatrist, psychologist, licensed social worker) if they are employed by your facility, i.e., a part of your site's provider network. Although a referral may not be required by insurance carriers for services rendered by behavioral health clinicians within your site's provider network, a PCP may still need to initiate services via a warm handoff to a behavioral health specialist. A documented statement of the PCPs decision to recommend a patient for behavioral health services should be placed within the note of the patient's PCP visit, prior to beginning behavioral health services.

The staff at your site responsible for medical billing or referral management should verify with insurance carriers if referrals for services are required.

Common Claim Rejections

Claim rejections involve those claims that were not processed or accepted by the insurance carrier. Knowing the most common reasons for rejections can help you and your site avoid them.

Terminated Medical Insurance Policy

One of the most common reasons for claim rejections is when claims are submitted, and the patient's insurance policy has been terminated. It is not uncommon for patients to change plans based on regular enrollment cycles or changes in coverage options. A patient's medical insurance policy

information should be kept current within a site's database to ensure successful claim submissions to the correct insurance carrier.

Coding Errors

Insurance carriers will reject claims submitted with mis-matched procedure and ICD-10 codes, outdated billing codes, and missing billing modifiers.

- **Mis-matched procedure and ICD-10 codes:** ICD-10 codes are diagnosis codes. If a claim is submitted with an ICD-10 code(s) that does not correlate to the procedure code being billed, the insurance carrier will reject the claim without reviewing or processing it. An example of a mismatched procedure and ICD-10 code is when a physical health diagnosis is submitted as the only diagnosis with a behavioral or mental health procedure code(s). This would result in a rejection.

Outdated billing codes: Each year new, changed, and deleted billing codes become effective on October 1st for ICD-10 codes and January 1st for CPT² (procedure codes). Submitting outdated codes on a claim will result in claim rejections. It is important to work with your Information Technology (IT) Department each year to ensure that all billing codes in your Electronic Medical Record (EMR) are updated to prevent the billing of outdated codes.

Submitting claims without a billing modifier: Submitting claims without a billing modifier, when one is required, can result in rejected claims or reimbursement for one service as opposed to all services billed. Billing modifiers are two alpha or numeric codes appended to billing codes. They do not change the description of the service, but they enhance the insurance carrier's understanding of the services rendered. Insurance carriers' requirements for billing modifiers vary from state to state. For example, in some states, billing modifiers identify the professional licensure of the clinician that rendered the services reported on a claim. Omitting this identifier will lead to a rejected claim. A billing modifier may also be required when a clinician is billing for two distinct services on the same day. Omitting the modifier that identifies two separate and distinct services billed on the same day can lead to the insurance carrier reimbursing for one of the services billed without considering the other service(s). For example, when billing for two different screenings that utilize the same billing code, a modifier may be required to advise the insurance carrier that two different screenings were rendered. If the modifier is omitted, insurance carriers might assume the second CPT code is a duplicate, thus only considering and reimbursing for one screening.

² Current Procedural Terminology (CPT) codes is a standard code set used to report professional services rendered by providers. The codes represent medical and/or surgical services and procedures that are billed to medical insurance carriers. CPT codes, paired with ICD-10 codes, tell the story of each patient encounter.

Revenue Codes

Revenue codes are 4-digit numbers used on medical claims to provide additional information to insurance carriers, such as where the patient received treatment and/or the type of services rendered. Revenue codes are important because the insurance carrier pays medical claims based on the rates attached to revenue code(s). Diagnosis and procedure codes are also matched with revenue codes. If the revenue code submitted does not match the diagnosis or procedure code(s), the claim will be rejected for processing. For example, if the services billed on a claim are preventive pediatric services and the claim submitted includes a revenue code assigned to the operating room, the claim will be rejected.

Over the years the number of healthcare facilities incorporating an electronic health and medical record (EMR) system has grown. As such, the transition from paper to electronic medical records has become standard procedure among many healthcare institutions. As technology and innovation evolve, so too have electronic medical record systems. Among the many innovations is the ability to electronically submit claims to insurance carriers. Because claims are being submitted electronically, much of their required data is pre-programmed information entered in the EMR system. This includes the revenue codes that represent the areas in your facility where services are rendered. If claims have been denied due to an incorrect pre-programmed revenue code for the area in which your site is electronically billing for, you should advise your administrative office, or your IT Department for remediation of the error.

Selection of a Primary Care Provider/Facility

For primary care services, many insurance carriers require their policyholders to select a primary care physician (PCP) or facility for their care and the care for all family members on the policy. If the policyholder does not select a PCP, the insurance carrier will automatically assign one. Since some insurance carriers will only reimburse for the assigned PCP or office, they will deny all claims submitted with a different PCP other than the one on file.

If the policyholder changes their and/or their child's assigned PCP to a PCP at your site, they will have to call the insurance carrier to document the desired change. Although selecting a PCP is the patient or policy holder's responsibility, the site may want to assist the patient with this outreach to ensure there are not barriers (e.g., technology or language barriers) that would prevent the insurance carrier from making the necessary changes. Additional reasons for claims denials and rejections are included below.

Invalid Patient Demographic Data

Submitting a claim with a different name, gender, or date of birth other than what is listed in the medical carrier's database will result in a rejected claim. Ensuring that all patient demographic data is up to date and entered correctly in the system will prevent these types of denials.

If your site has verified with the patient or policyholder that all data is correct, the patient should contact their insurance carrier to make the appropriate demographic data corrections. The site may want to assist the patient with this outreach to ensure there are not obstacles (e.g., technology or language barriers) that may prevent the insurance carrier from making the necessary changes.

Health Plan Contracted Reimbursement Rates

If you are questioning reimbursement for services because you are receiving either less amounts or no reimbursement for mental/behavioral health services, then contacting the department at your site or facility that negotiates reimbursement rates will assist you in better understanding reimbursement.

Health plans have reimbursement rates for covered services that are negotiated when your facility contracts with the health plan. If a claim is submitted to the insurance carrier with charges that exceed those negotiated reimbursement rates, the insurance carrier will still process the claim, but will only reimburse the allowed amounts according to the contract's negotiated rates. If you are in a state that has opted into allowing insurance carriers to "carve-out" mental/behavioral services, and you are not receiving reimbursement for these services, then making certain you are billing the correct insurance carrier is essential.

If you are receiving claim denials for mental/behavioral health services, there could be a chance that those services are carved-out of the medical insurance carrier you are billing. In the mental health field, the most common form of a carve-out is when mental health benefits are removed from a policy holder's coverage and are provided by a separate insurance company via a contract the policy holder's coverage has with that separate company. A carve-out insurance plan is a supplement to a person's standard health insurance plan. Billing the carve-out insurance plan for mental/behavioral health services is key to avoiding claim denials for those services. If you are billing from an electronic medical record (EMR), the system may be set up to automatically bill the carve-out insurance carrier associated with the policy holder's medical insurance carrier, when mental/behavioral health services are being billed for. Once you have obtained information on the carve-out insurance, from the department at your site or facility that negotiates medical insurance carrier contracts, you or that department can then reach out

Quick Tip: Service reimbursement rates are negotiated into medical insurance contract terms and reimbursement will not exceed those contracted rates. If you are in a state where medical insurance carriers can opt into carving out mental/behavioral health services, make certain that claims for those services are being submitted to the correct carve-out insurance.

to your Information Technology (IT) department, to discuss the EMR's capability in auto-billing the correct insurance carrier for mental/behavioral health services, when they are furnished.

Request for Medical Records

Insurance carriers may place the processing of claims on hold if they feel the need to fully assess and determine compensation for the medical expenses being billed. When this occurs, the carrier may request the medical records for those claims they are considering for processing. Carriers will take this opportunity to review a clinician's medical documentation to not only support medical necessity for the services being billed for, but also for documentation deficiencies. If either are found, the claim(s) will be denied for reimbursement.

Although complete medical documentation for the services rendered to a patient is required for insurance reimbursement, it is also important for promoting patient safety and delivering quality care. In addition, complete and accurate medical documentation should be connected to service codes. Each service (billing) code has a service description linked to it, with corresponding documentation requirements.

A common documentation requirement seen with HealthySteps-related service codes is the need to document time associated with delivering services to a patient. Services such as health and behavior interventions, psychotherapy, psychological testing, and developmental testing are time-based, requiring the documentation of the time spent rendering the service itself. If other services are being rendered during the same visit, do not include the time spent rendering those other services with the time used for the time-based service. (e.g., If you render services for a screening (not time-based) and a developmental test (time-based) during the same visit, do not incorporate the time spent rendering the screening with the time spent rendering the developmental test. Your documentation of time should only be of that spent rendering the developmental test). Considering this, a start and stop time is the most compliant method of documenting the time spent rendering the time-based service. Omitting this in the medical record note is one of the most common pitfalls resulting in claim denials due to documentation deficiencies.

Correct and accurate medical record documentation for the services being billed will avoid medical claim denials. It is a critical aspect of billing within the revenue cycle process in the health care industry. Detailed medical records can help clinicians validate their reimbursement to insurance carriers when a conflict with a claim has been issued.

Timely Filing of Claim Submissions

Timely filing of claim submissions occurs when a site files a medical claim within an insurance carrier's determined time limit. Timely filing deadlines make it easier for insurance carriers to process claims. Different carriers will have different timely filing limits. Most carriers allow 90 days from the date of

service for a claim to be filed, but there may be exceptions. Checking insurance carriers' timely filing guidelines is highly recommended.

Common ways to remain within timely filing limits are:

- Timely filing begins with the date of service and not the date a clinician's notes are signed. Making certain to sign your notes as soon as possible is a way to avoid claim denials for timely filing.
- Timely release of medical billing/charge entry also assists in timely filing. Well-timed assignment of medical codes and charge entry of these codes assist in releasing the medical claims to the medical insurance carrier within their determined time limit.
- Responding quickly to requests for more information will also assist in meeting a payer's time limit for claims. There may be times an insurance carrier will request medical records for services that are being billed. Some carriers will continue to work from the date of service, although they request medical records after the fact. Speedy responses to their requests will ensure timely filing.

Submitting timely claims with correct demographic information, place of service, and the proper medical codes that represent the diagnoses and services rendered to patients, is not only essential for facilitating communication between care providers regarding patients' health and their care, but it also provides correct information to the insurance carriers. Providing correct information to the insurance carriers can be important in facilitating future healthcare reform, as claim information is what is looked upon when the need for reform is being researched and considered. Many factors are involved in implementing and enforcing a change in healthcare, and the information obtained from medical claims assists in compiling regional data on diseases, services provided to treat and ameliorate these diseases and even the length of time the care is provided. In addition to providing correct data regarding patients and the diagnoses and care rendered, claims are utilized for insurance carrier reimbursement, resulting in sustainability of your site/facility and programs, such as HealthySteps.

The medical billing process is a journey, and it begins from the moment a patient checks in for their appointment and successfully ends with reimbursement for services rendered. Although the importance of correct and complete medical claims information is clear, we understand that claim processes can present its challenges, and the HealthySteps National Office is here to assist you by providing this document that can better help you understand common claim denials when rendering HealthySteps services, and ways you can avoid them.