6 ways to avoid rejections and denials

Increase your percentage of 'clean' claims and improve your bottom line!!

Tip #1: Capture patient information upfront

Ensure the front desk obtains patient, demographic, insurance, and clinical information at time of scheduling/registration, since it can be more difficult to obtain later. Incomplete claims can't be submitted, so your staff spend time following up information, which reduces productivity and delays payment.

1

Tip #2: Verify eligibility & benefits

Check patient coverage, as this can change at any time, sometimes without the patient even being aware.

2

Tip #3: Check accuracy of information

Confirm patient information is not only complete, but correct. Inaccurate details cause rejections and denials, resulting in both rework and delayed payments.

3

Tip #4: Understand payer policies

Make sure your billers know the policies and rates for each payer, and keep your billing system rules engine updated. Payer procedures can change regularly, so it's important to stay current to avoid denials. Pay attention to denial trends which can indicate an unadvised change.

4

Tip #5: Use correct coding

Incorrect coding is a common cause of denials - using wrong codes, conflicting or confusing modifiers, mismatching medical codes, or omitting codes. Employ billers familiar with FQHC coding. Implement a training program that covers billing software and payer requirements, and promotes cross-training.

5

Tip #6: Avoid duplicate billing

This occurs when two claims are submitted for the same procedure. Not only does this waste valuable time and resources internally, it causes confusion for the payer, and will likely result in payment delays or overpayment (which then needs to be refunded).

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