CASE STUDY

enhanced revenue solutions by INFINX

Successfully Captured Revenue Previously Denied for Medical Necessity for a Multi-Facility Orthopedics and Sports Medicine Practice

The Background

Referred by an existing client, Enhanced Revenue Solutions by Infinx (ERS), initiated an account receivable (AR) project for a four-location advanced orthopedics and sports medicine group in the greater Houston, Texas area. With a full complement of sports and rehabilitative services, including orthopedic surgery, physical therapy, sports medicine, interventional spine treatment, and chiropractic medicine, the practice was experiencing inflated AR and a high number of denied claims.

The Overall Scope

The client requested that ERS complete an overhaul of the ARs, including claims from 2018 and 2019. During the process, we identified a significant number of denied claims due to a lack of documented medical necessity as determined by various insurance payers through the practice's coding of services. These claims were denied and sat unresolved in their aged AR until the start of this project.

While this severely impacted the practice's revenue and bottom-line, it also exposed them to potential fines and legal ramifications through miscoding or inaccurate coding and billing practices.

As an illustration of the overall problem, the US Department of Labor estimates that one in seven claims is initially rejected or denied by insurance — or about 200 million out of 1.4 billion claims annually.

Our Solution

While our AR team worked to optimize the practice's outstanding receivables, questionably coded claims were isolated and forwarded to ERS's Nurse Code Reviewer for specialized oversight. It was quickly determined that the practice had some significant documentation process deficiencies, and a coding team that missed or was reluctant to challenge the providers in their documented findings.

In order to prevent denials caused by under-coded or under-documented claims, the patient's claim must demonstrate the correct status (i.e., admission versus observation) in the right setting/location (i.e., hospital versus practice), in addition to the correct CPT and ICD-10-CM codes to support medical necessity and must correspond with the provider's documentation.

The most common reasons for medical necessity denials include:

- Invalid diagnosis codes
- Incorrect CPT codes
- Incorrect level of service
- Payer policy criteria not met
- Incomplete medical documentation supporting claim

Our Specific Examples

Using Medical Necessity Criteria (MNC) and evidence-based clinical guidelines, our Nurse Code Reviewer was able to compare the rejected claims in question with the medical documentation available through the EHR/EMR and the appropriate insurance payers' policies to determine where the inconsistencies resided.

Example #1

- Patient A, utilizing a national insurance payer, was seen for bone stimulation, non-invasive, spinal (E0748)
- Claim was filed and denied with diagnosis code for Fracture of T12, severe spinal stenosis, severe kyphosis
- Payer policy review determined that for the patient to meet MNC, they must have met one of the following: failed fusion where nine months has elapsed since the last surgery, following multilevel fusion surgery (3 or more vertebrae) or following spinal fusion surgery where there is a history of previously failed spinal surgery
- It was determined by our Nurse Code Reviewer (through review of the hospital record, as well as the practice chart), the patient had previous spinal surgery in 2014 and did not improve, which led to this second surgery in 2019. This constituted qualification for failed fusion surgery that was not billed on the original claim
- ERS corrected the claim, including the diagnosis code for failed fusion surgery, and resubmitted the claim for processing. The claim was processed and paid.

Example #2

- Patient B, utilizing a national insurance payer, was seen for an MRI or the shoulder
- Claim was filed and denied with diagnosis code for an MRI of the right shoulder
- After review of the medical documentation and the rejected claim, it was determined that the wrong diagnosis code was used and resulted in an insufficient MNC determination by the payer
- The claim was corrected and resubmitted on behalf of the practice and was processed and paid

Our Final Plan and Results

Review, Revision, and Resubmission of Mis-coded Claims — As ERS processed the AR, claims with questionable coding issues were forwarded to the Nurse Code Reviewer for resolution. Once changes were determined, claims were resubmitted for final adjudication.

Training for Providers and Coding Team — The practice determined that they would resume AR management's responsibilities and revenue stream. To do so effectively, ERS was engaged to provide a comprehensive training program for the providers and the coding team that included orthopedic-specific procedures and timelines for documentation, and coding specifics designed to maintain their AR and continue to improve their revenue.

Contact us at info@enhancedrevenuesolutions.com to request a Health Check to see what we can do for your bottom-line.