

# Billing & Denial Resolution Process

Substance Abuse Prevention and Control  
County of Los Angeles Department of Public Health

All Treatment Provider Meeting, 1/28/20

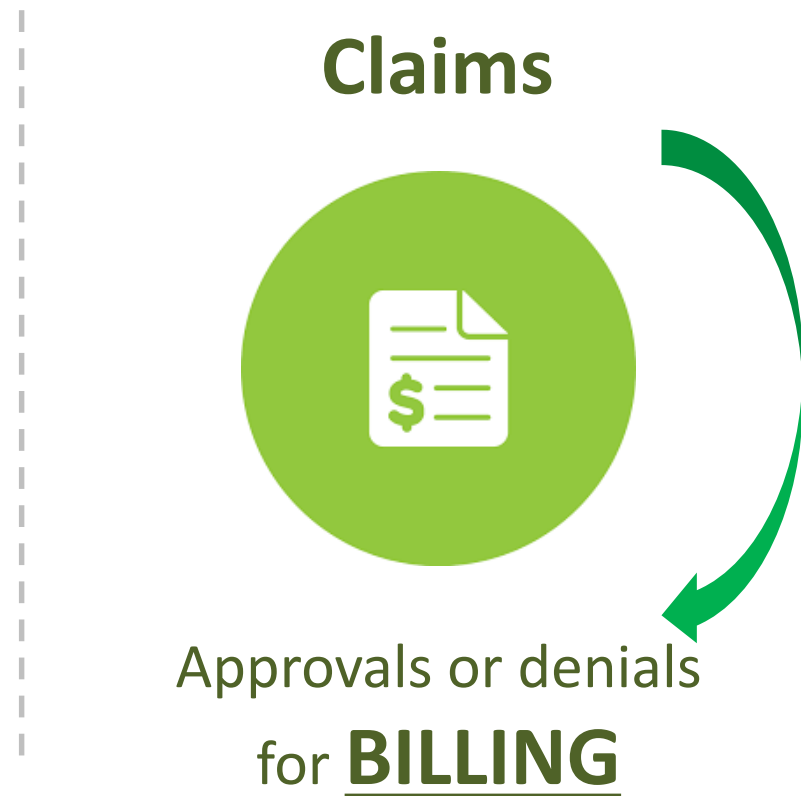
# Outline

- **Goal of Presentation**
  - To increase conceptual understanding of billing and denial resolution process
- **Foundational Knowledge**
- **Overview of Claims Process**
  - Primary Sage Users
  - Secondary Sage Users
- **Overview of Denial Resolution Process**
- **Strategies to Enhance Financial Sustainability and Claim Approval Rates**



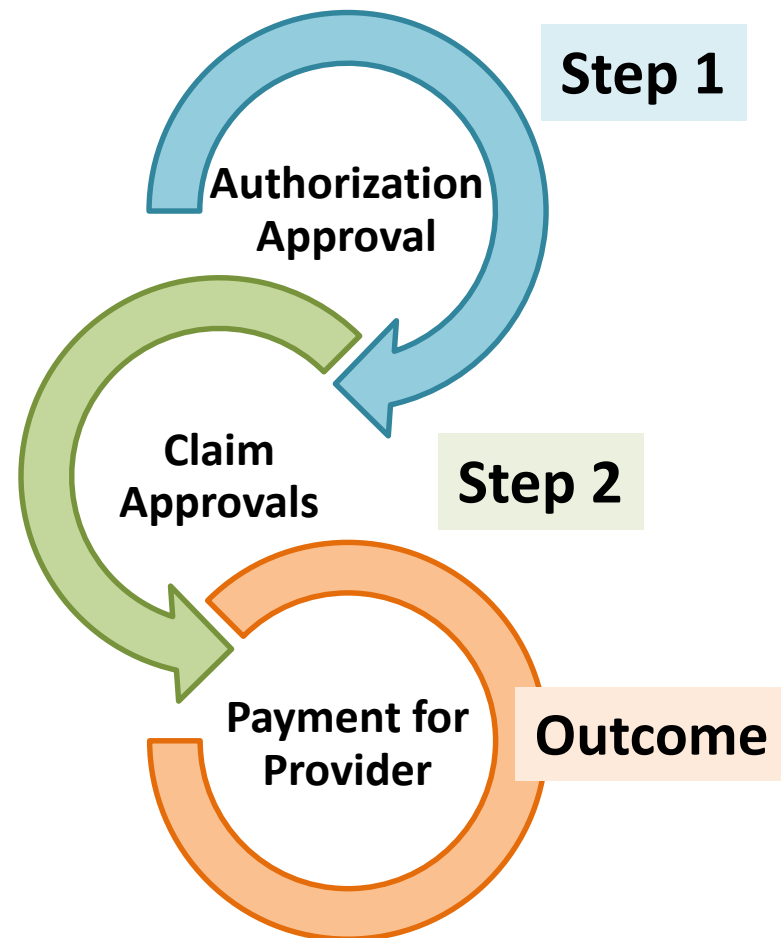
## Foundational Knowledge – Relationship Between Authorizations and Claims

- Authorizations and claims are linked, but are **DIFFERENT** and separate and distinct



## Foundational Knowledge – Relationship Between Authorizations and Claims (cont'd)

- Authorizations must be submitted first
- Claims cannot be submitted without an approved authorization
  - If a claim is submitted for either a pending or denied authorization, the claims for services on that authorization will be denied
- Authorizations must be approved for claims to be approved!



## Foundational Knowledge – Claims Process

- **There are 2 levels of claims adjudication (aka: approvals or denials)**
  - **1<sup>st</sup> Level** → Local rules that may result in approvals or denials
  - **2<sup>nd</sup> Level** → State rules that may result in approvals or denials
    - For this reason, there are situations where SAPC may approve claims at the 1<sup>st</sup> level of adjudication, but where the State may deny that same claim, which requires providers to correct the State denial (2<sup>nd</sup> level adjudication) in order to avoid SAPC recouping the claims that were initially approved and paid.



## Foundational Knowledge – Claims Process (cont'd)

- The claims process for Primary and Secondary Sage Users is different in how claims are submitted to SAPC
  - **Primary Sage Users** submit claims to SAPC directly through Sage
    - **Pre-Adjudication** → It is best practice for Primary Sage Users to submit claims through the “pre-adjudication” process in Sage that will check claims before they are submitted to detect and fix denial reasons before 1<sup>st</sup> level adjudication. Primary Sage Users need to pre-adjudicate their claims.
  - **Secondary Sage Users** submit claims to SAPC through an 837 file via SFTP (Secure File Transfer Protocol)
    - 277CA will identify basic formatting errors prior to adjudication, but Secondary Sage Users should leverage a similar “pre-adjudication” process as available in Sage if available in your EHR

## Foundational Knowledge – Claims Process (cont'd)

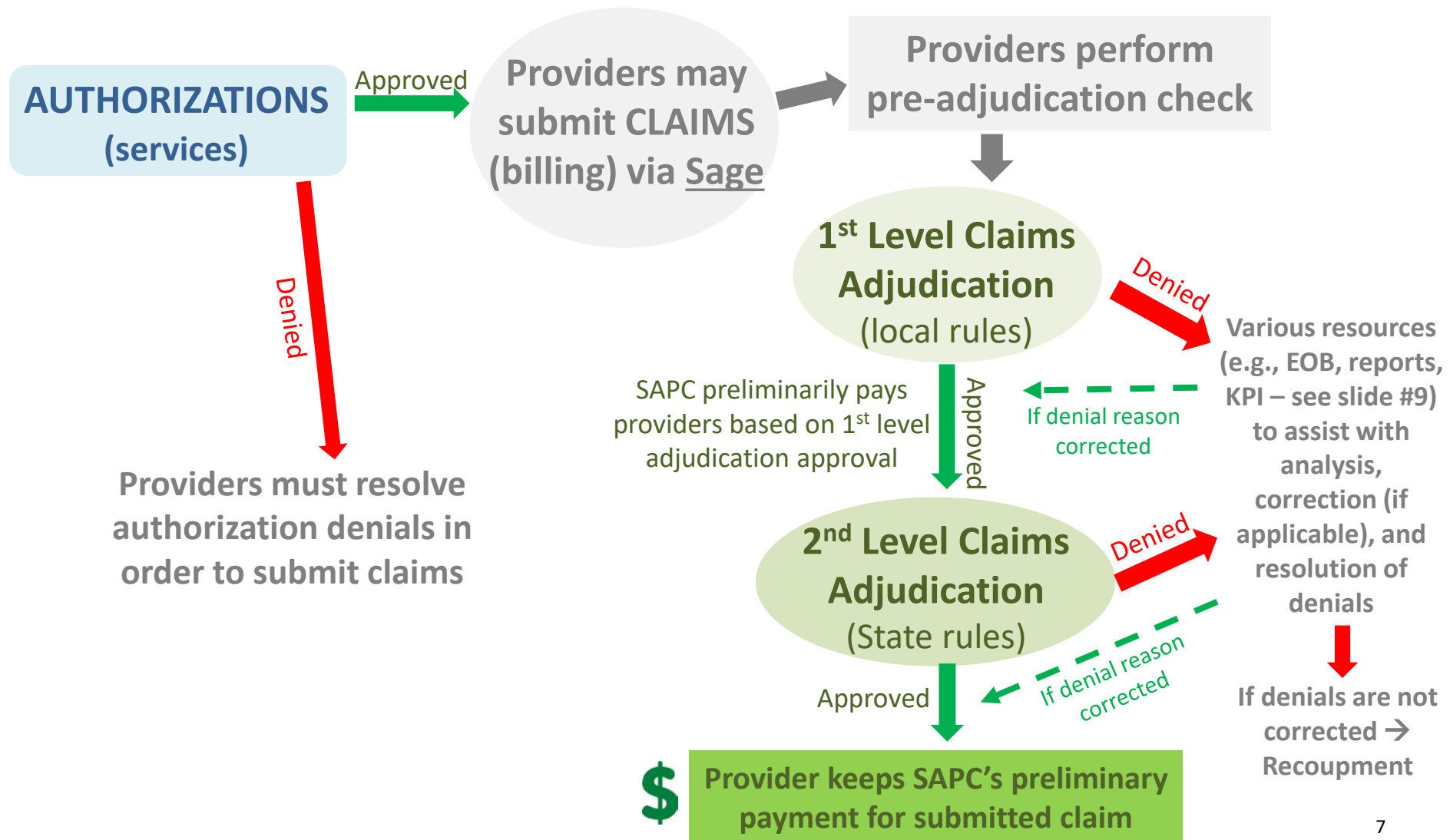
- **Authorizations**

- If authorization is APPROVED → Provider can submit claims
- If authorization is DENIED → Provider needs to correct the authorization denial in order to successfully submit claims associated with the denied service

- **Claims**

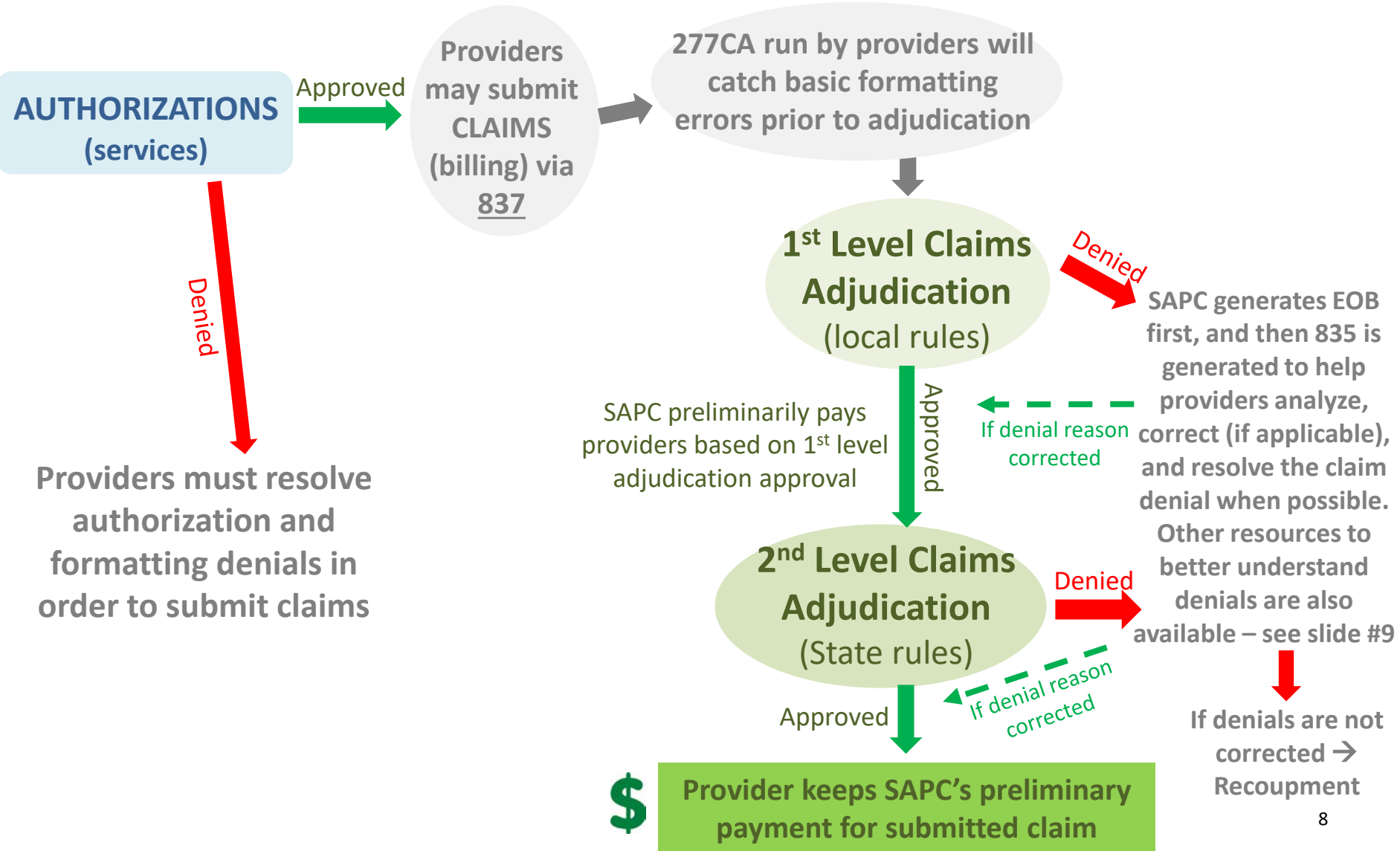
- Denials and approvals of claims can occur at each level of the adjudication process (1<sup>st</sup> level – local rules; 2<sup>nd</sup> level – State rules)
- **Denials need to be corrected at each level of adjudication for a claim to successfully go through (e.g., ALL denials need to be corrected before claims are approved and for providers to be paid on that claim)**

# Overview of Claims Process – PRIMARY Sage Users





# Overview of Claims Process – SECONDARY Sage Users



# Foundational Knowledge – Resources Available for Denial Resolution

Name of Denial Resource	Primary Sage Users	Secondary Sage Users
EOB	X	X
835	X	X
Services Denied in MSO Report	X	X
Treatment History Display	X	X
Bill ENum Report	X	
Check/EFT Report	X	X
KPI	X	X

# Overview of Denial Resolution Process

- **3 Step Process** → “D-C-R” = “Do Claims Right”

## 1. Diagnose Denial

- Review applicable denial resolution resources (e.g., EOB, 835, etc.) and reference the Denial Crosswalk to “diagnose” the denial reason.
- Some denial reasons are correctable whereas others cannot be corrected (e.g., patient eligibility). Correctable denials can move to Step 2 below.

## 2. Correct Denial Reason

- Providers need to correct the denial to move to Step 3 below.
- Depending on the denial reason, correcting denials may involve modifying or adding information from the original claim, correcting dates, etc.

## 3. Resubmit Claim

- Once denials are corrected, the claim needs to be resubmitted for adjudication (processing).

# Strategies to Enhance Financial Sustainability and Claim Approval Rates

- **Ensure tight clinical and financial operations, and alignment between these two areas organizationally**
  - Clinical work by counselors and clinicians is directly linked to billing:
    - Approved authorizations are the first step that enables the submission of claims. Billing staff need to understand the relationship between authorizations and claims, and the fact that an approved authorization is needed before claims can be submitted
    - Activities performed by counselors and clinicians appear on the Provider Activity Report that let Primary Sage Users know what services can be claimed
      - Note: Provider Activity Report does NOT capture draft notes (“Documents in Draft Report” captures this)
    - Staff that document well and know how to submit authorizations that result in approval will simplify the claims process (e.g., denials are sometimes related to incorrect service dates related to documentation)

## Strategies to Enhance Financial Sustainability and Claim Approval Rates (cont'd)

- **Submitting a successful claim the first time and avoiding claim denials is the most efficient way to maximize billing**
  - Average approval rates to achieve optimal operational efficiency should ideally be > 85 – 90% (denials rates of 10 – 15% or less) → This means that denial resolution would only be applicable for 10 – 15% or less of claims submitted
  - Provider agencies with denial rates > 15% are encouraged to evaluate their clinical and financial processes to identify areas of potential improvement
  - **For Primary Sage Users → Utilize the “pre-adjudication” check in Sage to pre-emptively catch and correct potential denials before claims submissions**
    - Using this pre-adjudication check is best practice and needs to be routine for all Primary Sage Users
  - **For Secondary Sage Users → 277CA process will catch basic formatting errors prior to adjudication, but should leverage a similar “pre-adjudication” process as available in Sage if available in your EHR**

## Strategies to Enhance Financial Sustainability and Claim Approval Rates (cont'd)

- **When claims denials occur, staff performing billing functions must be adequately trained and have a full conceptual and operational understanding of the claims and denial resolution process**
  - Understand the two levels of claims adjudication, and how denials at either level need to be resolved for provider agencies to be paid
  - Understand how to interpret EOBs, 835s, and other applicable denial resolution resources and the Claim Denial Crosswalk to efficiently resolve denials → Diagnosing denials, correcting denials, and resubmitting corrected claims
- **Provider agencies should establish financial benchmarks to monitor their financial health against (e.g., historical averages) so they are aware and can investigate when revenue or approval rates dip below benchmarks... Earlier problem identification = smaller problems to fix**

## Strategies to Enhance Financial Sustainability and Claim Approval Rates (cont'd)

- **SAPC is committed to supporting its provider network – use us as a resource**
  - Finance:
    - Baba Yates ([byates@ph.lacounty.gov](mailto:byates@ph.lacounty.gov));
    - Christopher Anwary ([canwary@ph.lacounty.gov](mailto:canwary@ph.lacounty.gov))
  - Sage: David Hindman ([dhindman@ph.lacounty.gov](mailto:dhindman@ph.lacounty.gov))
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