WAYSTAR

DENIAL PREVENTION PLAYBOOK

11 top causes of denials — and how to fix them

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In denial prevention, revenue cycle professionals live and die by codes.

CARCs and RARCs tell you why a claim was paid differently than it was billed — but by the time you get to a code, a denial has already happened. That's not ideal.

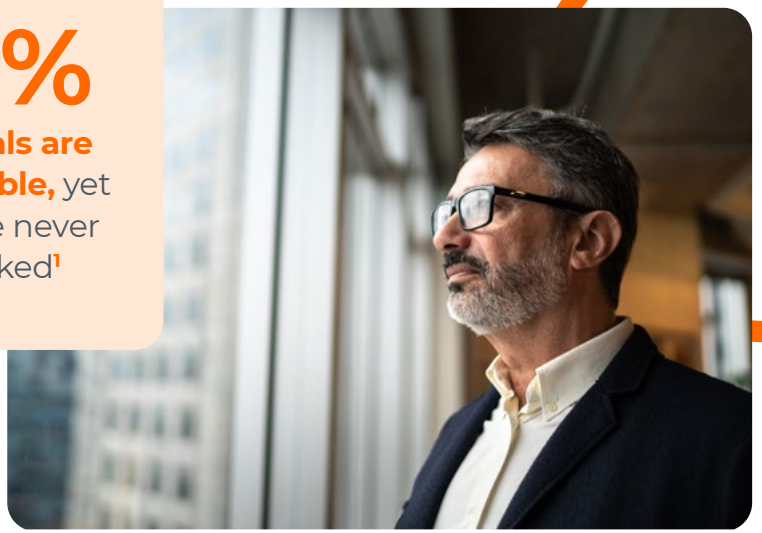
"The financial health of an organization can be measured in denials," says Matt Hawkins, Waystar CEO. "All parts of the revenue cycle are vital. But when 80% of healthcare finance leaders see a need to improve denial management, it's clear we've reached a tipping point."

This playbook was created to help you overcome 11 of the most common causes of denials. For each CARC, we offer:

+ A **description** of the denial
+ Possible **cause(s)**
+ Tips for **resolution**
+ Best practices for **prevention**
+ Opportunities for **automation**

63%

of denials are recoverable, yet most are never reworked[1]



Top 11 causes of denials

How to use this playbook

Simply click on the CARC to jump to that page, and bookmark this webpage for future use. To see specifics about automated denial-prevention solutions, **click here**.

1. **Duplicate or already paid | CARC 18, B13**
   A payer receives one or more claims they believe to be exact duplicates.
2. **Bundling + mutually exclusive denials | CARC 97**
   Benefit for service is included in payment or allowance for another service or procedure.
3. **Lack of information or submission/billing error | CARC 16**
   Claim or service lacks information OR has submission/ billing error(s).
4. **Prior-payer adjudication | CARC 23**
   Includes payments and/or adjustments. Indicates secondary or tertiary adjudication.
5. **Other payer | CARC 22, 24, 109**
   Care covered by another payer, under a capitation agreement, or via managed care plan.
6. **Authorizations | CARC 39, 197, 296, 302**
   Services denied when authorization or precertification was requested.
7. **Non-covered charges | CARC 96**
   Non-covered charges including patient-related concerns OR provider-related concerns.
8. **Modifier misuse | CARC 236, 4**
   Procedure or procedure/modifier combination is not compatible or is inconsistent.
9. **Lack of medical necessity | CARC 50**
   Services are not deemed a 'medical necessity' by the payer.
10. **Time limit expired | CARC 29**
    The time limit for filing has expired.
11. **Multiple or concurrent procedure rules | CARC 59**
    Processed based on multiple or concurrent procedure rules.

ONE

Duplicate or already paid | CARC 18, B13

CARC 18

Payer receives one or more claims they believe to be exact duplicates.

CAUSES

a. **The correction or change to a claim was not recognized by the payer.**

b. **Payer did not recognize different modifiers.**

Resolution: Contact the payer to reprocess.

Prevention: Unpreventable – payer error.

c. **Resubmission of claims batch. Only needed if both batches are denied as duplicates.**

Resolution: Identify the source of the error. If it's a clearinghouse, contact them to resolve. If it was internal, contact the payer to have one batch deleted and the other processed.

Prevention: Confirm batch submission before submitting or resubmitting.

d. **Resubmission of a claim without making any changes.** Action is only needed if both claims are denied as duplicates.

Resolution: Contact the payer to process one claim.

Prevention: Confirm previous claim submission before resubmitting.

e. **Corrected claim contained incorrect claim indicators.**

Resolution: Resubmit for any payer except Medicare, which does not allow. If it's an electronic claim, resubmit with original ICN + code 7. If it's a paper claim (CMS 1500), put 1) the original ICN in the original reference box; and 2) code 7 in box 22.

Prevention: Confirm information entered before submitting a corrected claim.

f. **Charge-entry error.**
The payer may correctly deny a claim as a true duplicate because: 1) the same service was entered and submitted twice, or 2) an error made on similar services caused two claims to appear to be the same even though they were not.

Resolution: Correct the charges and resubmit.

Prevention: Consider adding a quick audit to your process when entering charges.

CARC B13

Payment for this claim or service may have been provided in a previous payment.

CAUSES

a. **Claim submitted as duplicate (or any other reason under CARC 18)**

   Resolution: None; It's paid.

   Prevention: See Duplicate denials.

b. **"Other service" was paid to a different provider.**

   Resolution: Ask the payer who the payment was sent to. Use the NPI registry. Determine if payer guidelines will allow the "duplicate" service, and, if so, appeal under that.

   Prevention: Unpreventable.

TWO

Bundling + mutually exclusive denials | CARC 97

The benefit for this service is included in the payment or allowance for another service or procedure that has already been adjudicated. Includes CARC 231 and CARC 236.

CAUSE

Per coding guidelines (NCCI edits):

1. Services billed together are **inclusive of each other.**
2. .Services billed together are **never allowed to be billed on the same date.**
3. Services were performed **within the global period** of a previously performed procedure.

RESOLUTION

A certified coder must review to determine a solution:

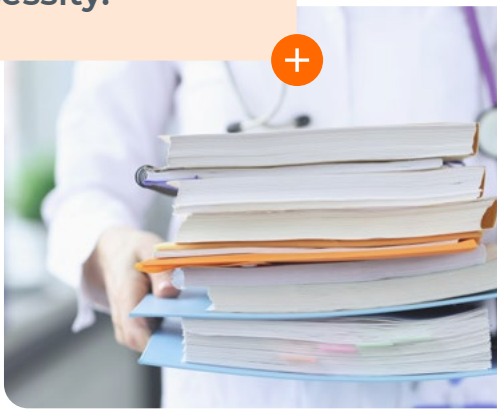
1. Append modifier(s) 25 or 59 - Services billed separately **were performed separately**
2. Append modifier(s) 24 or 79 - Services performed **weren't related to procedure with the global days**
3. Adjust/remove the charge(s)
4. Consider coding vs. payer guidelines

PREVENTION

Determine if the multiple procedures are billed accurately, with or without modifiers, using software or the NCCI edits document from CMS.

AUTOMATE IT

Use a solution to manage **CCI edits and medical necessity.**



THREE

Lack of information or submission/ billing error | CARC 16

Claim or service lacks information OR has submission/billing error(s). At least one RARC must be provided and will dictate resolution and prevention.

N4: MISSING/INCOMPLETE/INVALID PRIOR INSURANCE CARRIER(S) EOB

Cause: Primary payment adjudication information was not transmitted with secondary claim.

Resolution: Add information through clearinghouse website or billing software and resubmit.

Prevention: Enter primary payment information at the time of payment posting.

N489: MISSING REFERRAL FORM

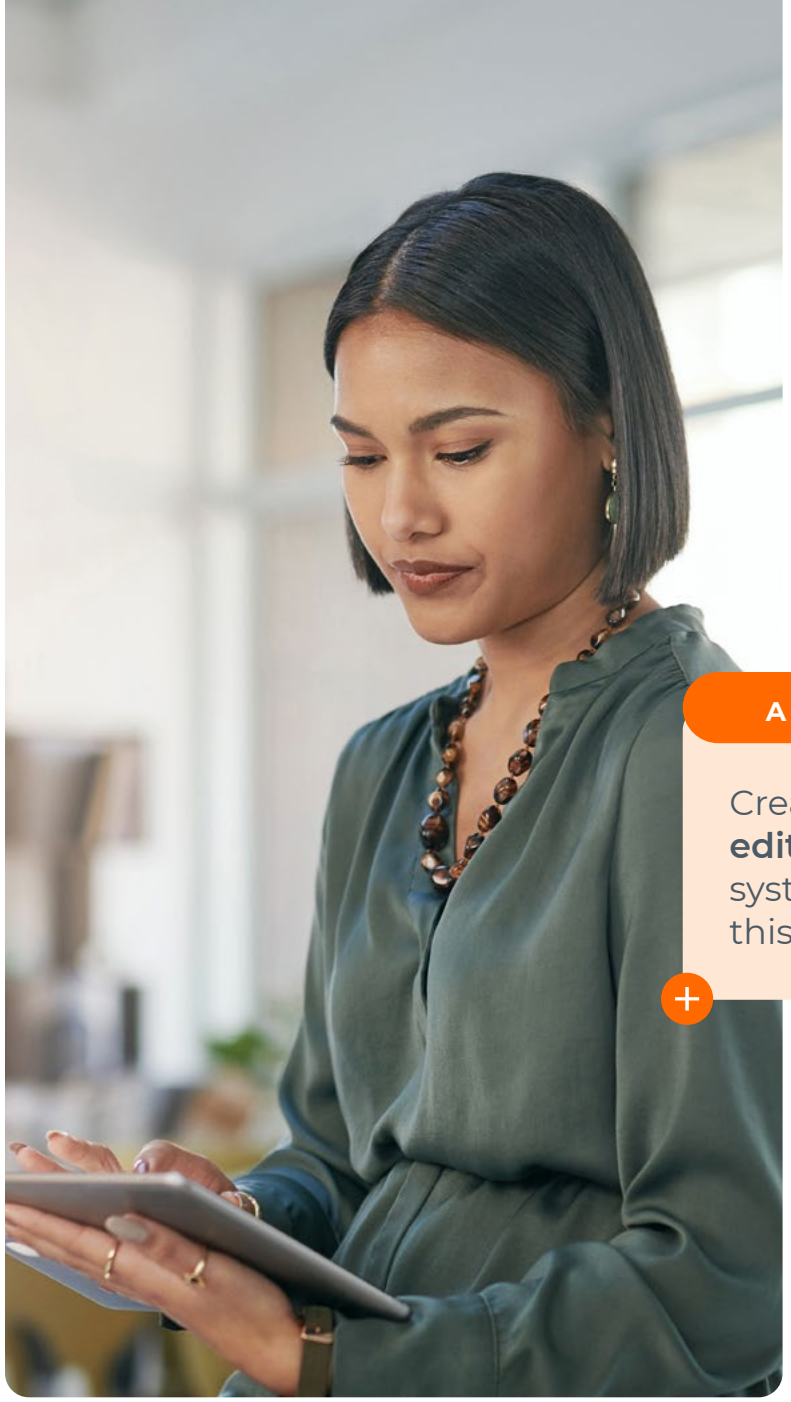
Cause: Authorization or referral information was not transmitted or not recognized by the payer.

Resolution: Resubmit with required information. If the form was submitted, call the payer.

Prevention: Ensure information is submitted with the initial claim.

AUTOMATE IT

Use **a secondary submission tool** to auto-populate information for you.



THREE: LACK OF INFORMATION OR SUBMISSION/ BILLING ERROR | CARC 16

M47: MISSING/INCOMPLETE/INVALID PAYER CLAIM CONTROL NUMBER

Cause: A claim was submitted with resubmission code 7, but original ICN was not on the claim.

Resolution: Add the original ICN and resubmit OR remove resubmission code 7 if not corrected.

Prevention: Teach your team the required fields for corrected claims.

AUTOMATE IT

Create a **custom edit** in your system to identify this field.

FOUR

Prior-payer adjudication | CARC 23

The impact of prior payer(s) adjudication including payments and/or adjustments. Indicates secondary or tertiary adjudication. Use only with Group Code OA.

CAUSE

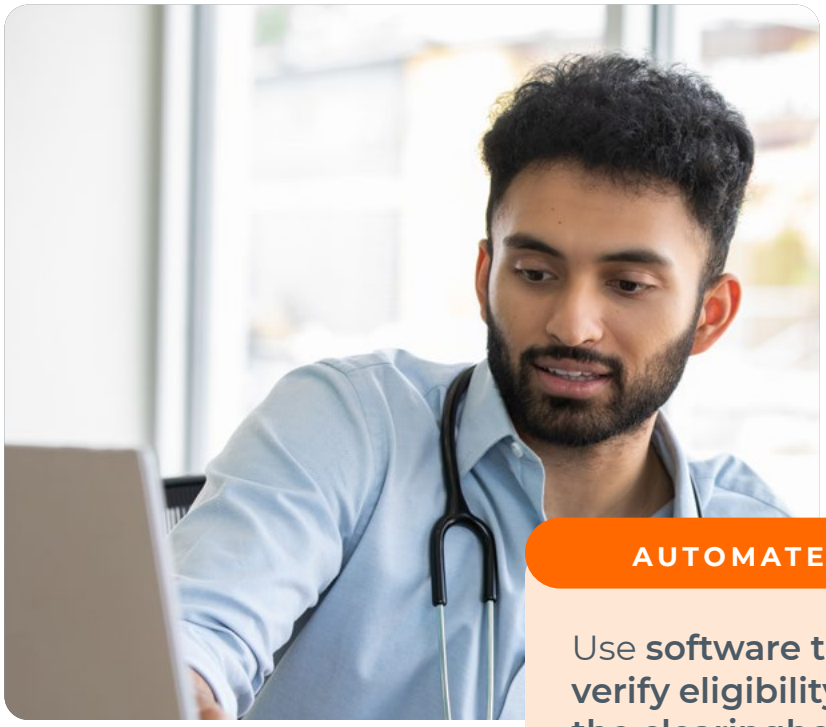
A claim is processed as secondary or tertiary.

RESOLUTION

Take no action unless the claim should have been processed as primary. If it should have been primary, check eligibility and verify placement the payer has on file.

PREVENTION

Create processes to confirm the correct placement of insurances 1) at the time of registration, and 2) on the claim before it's submitted.



AUTOMATE IT

Use **software to verify eligibility with the clearinghouse** upon submission.

FIVE

Other payer | CARC 22, 24, 109

These codes have specific descriptions but are often used interchangeably by payers.

CARC 22

Care may be covered by another payer per coordination of benefits (COB). A record in the insurance database indicates the patient has medical coverage under more than one policy.

CAUSES

1. Patient is covered under multiple policies and the incorrect one was billed.
2. The subscriber has not updated their COB with the payer.
3. "Should" not be used for managed care (CARC 109 or 24).
4. "Should" not be used for workers' comp, should be billed, or other third-party liability.

Resolution: Verify placement the payer has on file. Resubmit to correct payer. Ask patient to update COB information.

Prevention: Create processes to confirm the correct placement of insurances (1) at the time of registration, and (2) on the claim before it's submitted.

CARC 24

Charges are covered under a capitation agreement or managed care plan.

CAUSE

Subscriber is enrolled in a managed care plan, which has a different payer ID/address.

Resolution: Verify eligibility for managed care plan and resubmit to correct plan.

Prevention: Confirm the correct placement of insurances (1) at the time of registration, and (2) on the claim before it's submitted.

AUTOMATE IT

Verify eligibility with the clearinghouse when the claim is submitted.

CARC 109

Claim or service not covered by this payer or contractor.

CAUSE

1. The patient is in a SNF or a different DME MAC region.
2. The claim was submitted to the incorrect MAC.
3. The claim is covered under an HMO policy for the date of service.

Resolution: Send the claim or service to the correct payer or contractor.

Prevention: Confirm the correct placement of insurances 1) at the time of registration, and 2) on the claim before it's submitted.

SIX

Authorizations | CARC 39, 197, 296, 302

The following CARCs are often used interchangeably and can be resolved the same way.

CARC 39

Services denied when authorization or precertification was requested.

CARC 197

Precertification, authorization, notification, or pre-treatment was absent.

CARC 296

Precertification, authorization, notification, or pre-treatment is valid but does not apply to the provider.

CARC 302

Precertification, authorization, notification, or pre-treatment time limit has expired.

CAUSES

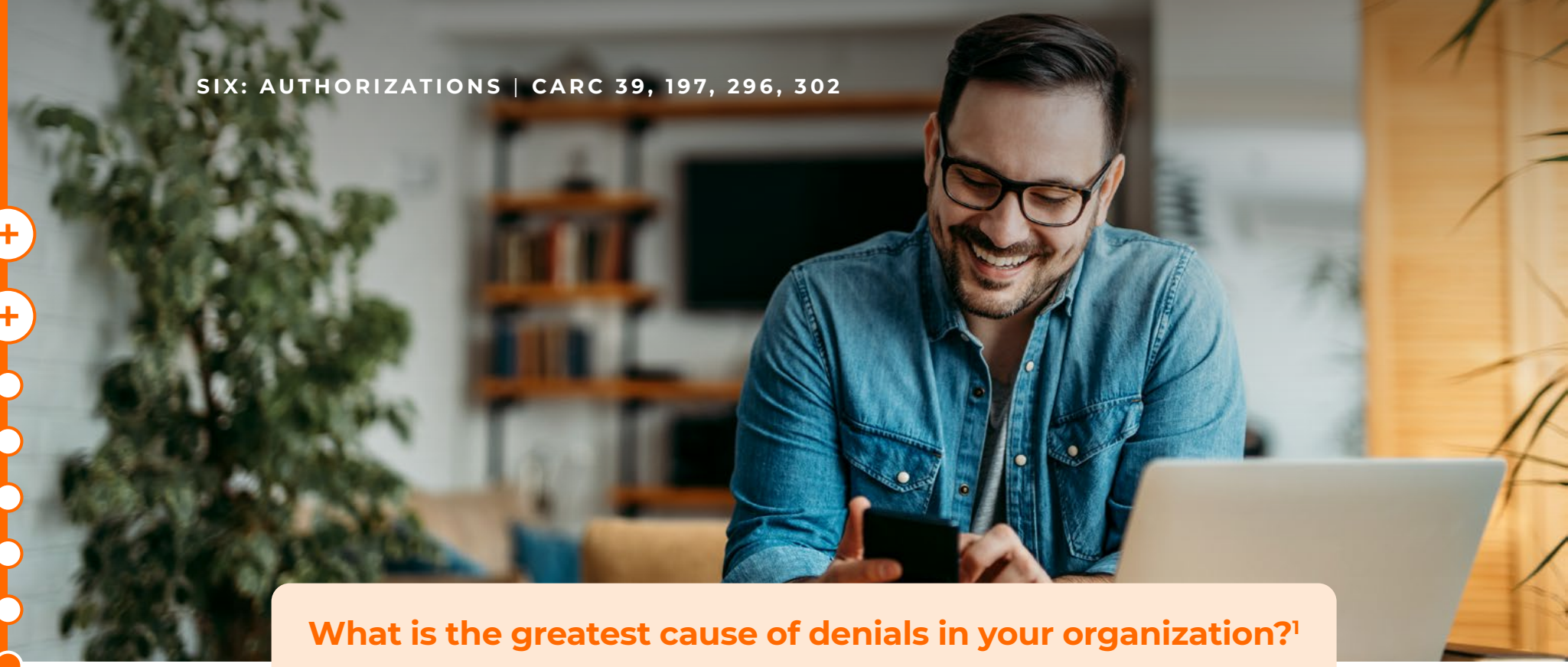
1. Authorization number not submitted on claim.
2. Authorization not obtained or not obtained timely.
3. Information on the authorization is incorrect (codes, dates, etc.)
4. Payer error: The payer told the provider information was not required or mishandled the information.

Resolution: Contact the payer to find out why the claim is being denied, what information they need to reprocess, and their guidelines for retro authorization.

Prevention: Obtain authorization before services are rendered. Know payer guidelines, document everything, and confirm authorization numbers are submitted on claims.

AUTOMATE IT

A tool for **custom edits** will allow you to review claims for auth numbers before submission.



What is the greatest cause of denials in your organization?[1]

According to a recent HFMA survey, leaders reported:

39.7%
prior authorization

20.3%
registration + eligibility

18.2%
coding + billing

SEVEN

Non-covered charges | CARC 96

Non-covered charge(s) can be categorized under patient-related concerns (PR-96) such as benefits OR provider-related concerns (CO-96) such as coding. At least one RARC must be provided and will dictate resolution and prevention.

N425: STATUTORILY EXCLUDED SERVICE(S).

Billed service is statutorily excluded from coverage under Medicare.

Resolution: The patient is responsible for the balance. However, you can have a certified coder review documentation and submit a correction if needed.

Prevention: Remind coders to review the codes they've assigned before billing. If the excluded services are billed regularly, create a custom edit for pre-billing review.

N56: PROCEDURE CODE BILLED IS NOT CORRECT/ VALID FOR SERVICE OR DATE OF SERVICE.

N115: DECISION BASED ON A LOCAL COVERAGE DETERMINATION (LCD).

Wrong diagnosis (DX) code was used on the claim for CPT code billed.

Resolution: Check the LCD to confirm that the procedure code/DX combination is payable. See if any modifier is missing. Have a coder submit a corrected claim if changes are made.

Prevention: Before billing out, review the coding against LCD guidelines.

AUTOMATE IT

Find a solution that can **make CCI and medical necessity edits**, and ensure you have it turned on for all payers within your solution.

EIGHT

Modifier misuse | CARC 236, 4

CARC 236

Procedure or procedure/modifier combination is not compatible with another procedure or combination provided on the same day.

CARC 4

Procedure code is inconsistent with modifier used.

CAUSES: THE MODIFIER

1. Should have been appended and wasn't
2. Was appended but wasn't required OR
3. Was appended to the CPT or HCPCS code but wasn't appropriate due to a coding, billing, or payer guideline

Resolution: Certified coder should review medical documentation to determine which modifier should be used or if it should be removed.

Prevention: Assign a staff member to stay current with modifier guidelines and inform the team.

AUTOMATE IT

Use coding software to review modifier usage before billing claims, and create **custom edits** within your system to prevent claims from going out until they're reviewed.

NINE

Lack of medical necessity | CARC 50

Services are not deemed a ‘medical necessity’ by the payer.

CAUSE 1: IF PAYER FOLLOWS MEDICARE GUIDELINES

The claim is missing a diagnosis code on the LCD for the denied procedure.

Resolution: Look up procedure LCD, review approved diagnosis, and submit corrected claim.

Prevention: Ask your clearinghouse to create an edit to identify LCD mismatches.

CAUSE 2: IF THE PAYER DOESN’T FOLLOW MEDICARE GUIDELINES OR YOU FIND THE DIAGNOSIS/PROCEDURE COMBINATION DOES MEET LCD GUIDELINES

It does not meet the clinical policy guidelines.

Resolution: Review policy to identify changes to make for that service date and future dates.

Prevention: Educate providers and coders on the payer’s clinical policy guidelines.

AUTOMATE IT

Use coding software to **create custom edits** as needed.

TEN

Time limit expired | CARC 29

The time limit for filing has expired. Each payer has timely filing guidelines based on date of service or receipt. If there's a different limit in the provider's contract with the payer, that will override the payer's billing guidelines.

CAUSE

When a claim is denied for timely filing, the payer 1) believes a guideline has not been met, or 2) a corrected claim or appeal/reconsideration was errantly processed as initial.

RESOLUTION

Confirm the limit before accepting a denial. Then, submit proof of timely filing:

+ Electronic acceptance report
+ The claim number if it has a date in the middle, indicating received date
+ Return receipt from USPS
+ Electronic date/time stamp in payer portal

PREVENTION

Create a list of timely filing limits for each payer and filing type, as well as processes based on shorter timely filing limits so AR teams have time for resolution.

AUTOMATE IT

Some solutions will auto-generate a letter for proof of timely filing.

ELEVEN

Multiple or concurrent procedure rules | CARC 59

Processed based on multiple or concurrent procedure rules. While this is not technically a denial, you will have an associated adjustment amount.

AUTOMATE IT

Create a custom edit or **use coding software** to identify correct procedure order.

CAUSE

Multiple procedures billed were run through the payer's MPPR (multiple procedure payment reduction) edit.

RESOLUTION

If they weren't reduced based on RVU, reorder the procedures and resubmit as a corrected claim or as a reconsideration. Review for proper placement of modifier 59.

PREVENTION

Educate coders/charge entry to enter multiple procedures in order of RVUs highest to lowest, and on appropriate use of modifier 59.

Conclusion

Now that you know how properly worked denials can unlock effectiveness and efficiency, it's time to find the right tools.

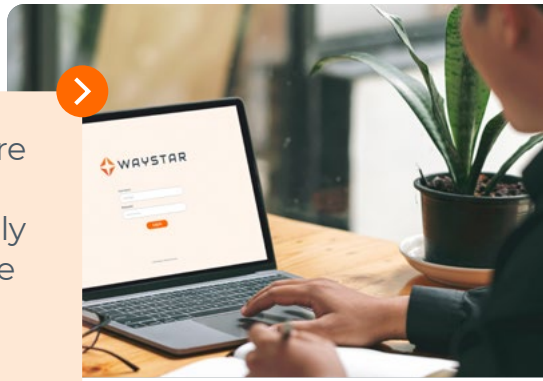
As you evaluate solutions, remember: the best denial prevention tools will help you make the most of the money you've already spent. Stakeholders don't always realize that a denials solution can reduce your cost-to-collect while maximizing your investment in your HIS/PM system. All systems have flaws, but none has everything. Waystar can help you fill those gaps.

WAYSTAR'S *DENIAL + APPEAL MANAGEMENT* CAN HELP YOU:

- Prioritize workable denials using predictive analytics + probability of payment
- Automatically route denials to the right team or queue
- Improve patient collections using **Propensity to Pay**
- Provide real-time, one-click **eligibility verification** within the denials platform

WAYSTAR CAN ALSO OPTIMIZE YOUR APPEALS WORKFLOW SO YOU CAN:

- Leverage pre-populated payer-specific forms to auto-generate appeals content for you
- Submit paperless appeal packages
- Resubmit appeals with a single click
- Discard an appeal in draft status before it's sent
- Easily link between appeals and the denial listing
- Submit electronic Medicare appeals to CMS via esMD

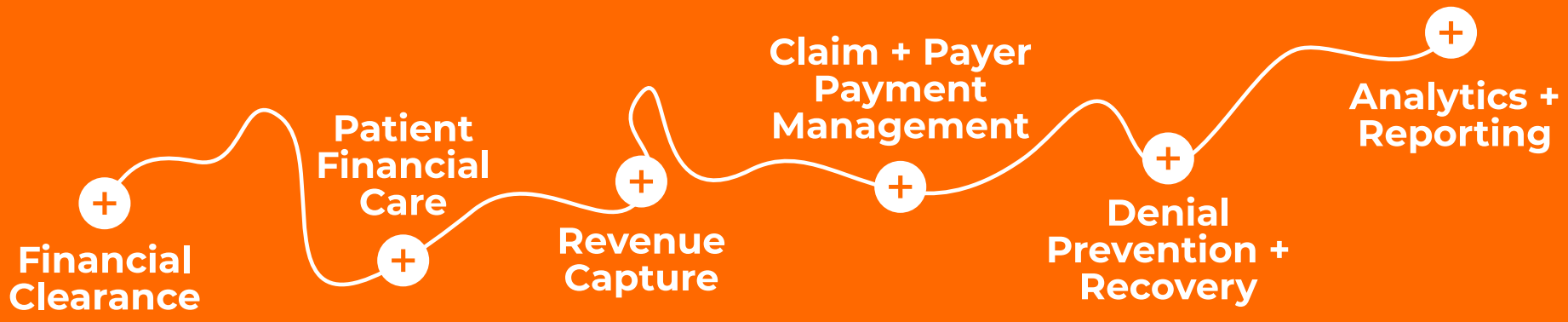


"Today, providers are investing significant time and resources to manage denials. We're seeing success among clients that address the root cause on the frontend, and then use intelligent automation to help staff prioritize which denials to work when. Not only does this approach dramatically decrease denials, but it enables providers to dedicate more time to higher-impact efforts and patient care."

– Matt Hawkins, CEO of Waystar.

[1]*Report: HFMA research + insights on denials in healthcare*

A platform designed for providers + patients



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