The Top 10 Reasons Medical Claims are Denied

1. Incorrect Patient ID Information

When a medical claim is filed inaccurately, the health insurance plan likely can't identify the patient in order to request payment or apply the client information to the corresponding health insurance account.

A few of the most common filing mistakes when filling out patient identifier information:

- The subscriber or patient's name is spelled incorrectly
- The subscriber number is missing or invalid
- The subscriber group number is missing or invalid
- The patient or subscriber's date of birth on the claim doesn't match the one provided in the health insurance plan's system

2. Requires Precertification or Prior Authorization

Many services classified as "non-emergency" require prior authorization. Pricey radiology services such as CT, MRI, and ultrasound; certain surgical procedures and inpatient admissions often require prior authorization.

Most services that require prior authorization will be denied by an insurance carrier. If the services provided are considered a medical emergency, they won't be denied. Although, the provider could try to get a retro-authorization within 24-72 hours following the services, depending on the guidelines.

3. The Coverage was Terminated

Pre-verifying insurance benefits before performing services notifies the medical office if the coverage is active or terminated. This allows you to collect more up-to-date insurance information or identify the patient as self-pay.

4. Non-Covered or Excluded Services

These services refer to certain medical services that are excluded from the patient's insurance coverage. Patients must pay-in-full for these services.

It's important to contact the patient's insurance carrier prior to providing services. It's poor practice to bill a patient for non-covered charges without notifying them of the financial responsibility prior to the procedure.

5. Coordination of Benefits

This may include:

- Missing EOB (estimate of benefits)
- The other insurance is primary
- Patient hasn't updated their insurance information with the insurer

Coordination of benefits refers to when a patient has 2+ health insurance plans. Certain rules must be considered to decide which play pays primary, secondary, etc.

6. Request for Medical Records

When a claim requires further documentation before adjudicating the claim, some health insurers may request medical records. The records requested include (but aren't limited to):

- Patient discharge summaries
- Radiology reports
- Operative reports
- Medical history
- Physical reports
- Physician consultation reports

7. Bill Liability Carrier

When a claim is coded as an auto- or work-related accident, some carriers refuse to pay until the auto insurance or workers compensation carrier has been billed.

If a service is accident-related, all the following third-party liability insurance should be filed as primary:

- Motor Vehicle or Auto Insurance (no fault, policy or Med Pay)
- Worker's Compensation Insurance
- Homeowners Insurance
- Malpractice Insurance
- Business Liability Insurance

8. Timeliness of Filing

Each insurance carrier has unique due dates and requirements. A few examples:

- Tricare: Claims should be submitted within one year following the date of service.
- United Health Care: Please refer to the provider agreement for filing limits.
- Aetna: Unless state law or other exceptions apply:
    - Physicians have 90 days from the date of service to submit a claim for payment.
    - Hospitals have one year from the date of service to submit a claim for payment.

9. Missing or Invalid HCPCS or CPT Codes

Standard codes are required to identify services and procedures - this system of coding is referred to as Healthcare Common Procedure Coding System (HCPCS and pronounced "hicks picks.")

Your medical coders must stay up to date on all HCPCS codes. Changes to this coding system are updated/discarded/revised periodically.

10. No Referral on File

Although not as common as the other reasons on this list, some services require a patient to obtain a referral from their family physician prior to performing procedures.