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Fig. 1 A report from Doctrix, an analytics platform, listing denials sorted by reason code.
Courtesy of Karen Zupko

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Practice Management

The Details of Denials Matter

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Editor's note: *AAOS partners with KarenZupko & Associates (KZA) on the organization's coding education, and KZA often provides content for* AAOS Now. *For more information, visit aaos.org/membership/coding-and-reimbursement.*

It is interesting how orthopaedic surgeons react when they see a denial report for the first time. They often react first with surprise, followed by a perplexed question: "Why didn't anyone inform me about this earlier?"

Failure to share denial reports on a regular basis—whether monthly or quarterly—raises important concerns. The feedback loop is broken. Sometimes, it is simply beca

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not aware of how to find or generate a denial summary report. Other times, there seems to be a deliberate effort to hide the costly impact of denials from surgeons. Denial details are like fingerprints—they belong to someone.

Surgeons and other healthcare staff can make costly mistakes that result in denials, despite correct coding. Factors such as understaffing, inadequate training, flawed patient registration, limited software knowledge, and a lack of accountability for sloppy work can all contribute to denials. Therefore, establishing a strong feedback loop in the office is crucial. It helps both surgeons and staff members improve, ultimately leading to reduced appeals and fewer write-offs.

Error reductions directly translate to financial gains. By focusing on enhancing skills and addressing the root causes of denials, both surgeons and staff can make a positive contribution to the practice's bottom line.

The following is an abbreviated example of common reason codes for claim denials and how to "decode" them:

- **CO-97:** CO stands for "contractual obligation." In this example, the benefit for this service is included in the payment/allowance for another service.
- **OA-23:** OA stands for "other adjustment." Reimbursement is adjusted as it may be covered by another payer per coordination of benefits.
- **CO-29:** The time limit for filing has expired.
- **OA-18:** This reason code is used for a duplicate claim.
- **CO-16:** The claim/service lacks information which is needed for adjudication.
- **CO-252:** An attachment or other documentation is required to adjudicate this claim/service.
- **CO-234:** This procedure is not paid for separately. At least one remark code must be provided.
- **CO-119:** This code indicates that the benefit maximum for this time period has been reached.

Fig. 1 shows a report of denial from Doctrix, an analytics platform that works behind many practice management software programs. The options on the top bar of the report are versatile and allow users to run the report in many different ways. In this figure, denials are listed by reason codes. Users can also examine denials based on the carrier, which gives valuable insights when deciding whether to keep or drop a plan.

Looking at results by doctor or department lets users make meaningful comparisons. In the consulting world, it is particularly helpful to compare physicians within th

subspecialty to see, for example, who might benefit by more training on diagnosis coding or unbundling rules. Analyzing denials by department shines a light on potential causes of revenue leaks. For example, physical therapy denials might offer clues about cash-flow challenges.

Keep in mind that this figure is an abbreviated summary of possible denial codes. Looking at the example of denials for code CO-29, the figure shows that the impact of late filing exceeds $1 million. Users need to evaluate this figure in relation to their fee schedule multiplier. For instance, if an orthopaedic practice sets fees at four times the Medicare rate, they would need to divide those denial dollars by four to get a clearer picture. Still, a quarter of a million dollars due to late filing is a significant financial setback.

Late filing raises some important questions because it often involves issues with both surgeons and staff. How did this happen? Was it because multiple surgeons consistently lagged behind in dictating and submitting charges? Or was it a staffing problem within the practice? Perhaps the staff focused more on appeals than on filing new claims. Having an adequate workforce would pay off if late filing or late appeals were major causes of denials. In that scenario, the staff would more than make up for their own costs.

On the other hand, when it comes to CO-16 denials, it is the surgeon's responsibility, as they are the only ones authorized to make diagnoses. When reviewing a denial report, look into the frequency of a specific denial, the associated costs, and whether there is an uneven distribution of this denial among surgeons.

As an example, the author discovered an interesting pattern during a review of a spine practice. Among a group of five surgeons with a similar payer mix, there was a significant difference in denials over a six-month period. Further investigation revealed that one surgeon had a really aggressive approach to unbundling, resulting in five times more denials compared to his colleagues. Just because it is billed does not mean carriers will pay it.

If an orthopaedic surgeon is still complaining about the 2 percent Medicare reimbursement cut without taking the time to review their denials, they are missing out on a very profitable time investment. Seeing four additional patients or performing 10 more procedures that end up being denied is definitely not profitable.

Surgeons may ask, "Is assessing denial codes not the responsibility of the administrator, chief financial officer, or revenue cycle director?" Denial management is a shared responsibility, without a doubt. Take the example of a group of academic surgeons who closed the feedback loop: They scheduled denial meetings twice a month and n

these visits with the billers were included in their contracts. This practice led to a better bottom line and proved to be a smart use of everyone's time.

Karen Zupko is president of KZA, a consulting and education firm that has partnered with AAOS to deliver annual coding and reimbursement workshops.

Submit a Coding Question to AAOS

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- AAOS member name and member ID number
- deidentified, completed operative report
- diagnosis
- indication for procedure
- physician's suggested coding for the operative note provided

These services are available to current AAOS members for 10 free inquiries per year. However, subscribers of AAOS Code-X are granted unlimited question submissions annually.