Implementing an Effective Denials Management Program

Rochelle Dahmen, Revenue Cycle Manager
rdahmen@eidebailly.com
612.253.6591
Agenda

• Introduction
• Denials - An Overview
• Defining Denials
• Understanding Your Denials
• Managing Your Denials
• Conclusion
• Questions
Denials – An Overview
Denials – An Overview

• According to the American Medical Association (AMA), 25 – 30 percent of the country’s total health care expenditures are direct transaction costs and inefficiencies associated with the “claims management revenue cycle”.

• Substantial amount of resources are utilized while managing the basics of the claims revenue cycle
  • Lack of payment transparency
  • Inaccurate or unfair payment
  • Administrative hassle
  • Payment reconciliation and claims follow-up
Denials – An Overview

• According to recent estimates, gross charges denied by payers has grown to an alarming 15 to 20 percent of all claims submitted.

• The average cost to rework a claim is $25.00, according to the Healthcare Financial Management Association (HFMA).

• As many as 65 percent of claims denials are never worked resulting in an estimated 3 percent loss of net revenue.

• Roughly 67 percent of all denials are appealable.
Denials – An Overview

• In its most recent National Health Insurer Report Card from 2013, the AMA reported Medicare most frequently denied claim lines at 4.92 percent, followed by Aetna at 1.5 percent, United Healthcare at 1.18 percent and Cigna at 0.54 percent.

• Top Claims Adjustment Reason Codes:
  • 16 – claim lacks information or has billing/submission errors
  • 96 – non-covered charge(s)
  • 204 – this service/equipment/drug is not covered under the patient’s current benefit plan
  • 197 – precertification/authorization/notification absent
Denials – An Overview

Insurers: satisfaction, claims denied

PERCENTAGE OF CLAIMS DENIED, 2008-13

Source: American Medical Association’s National Health Insurer Report Card
Denials – An Overview

- Accurate claims payment is also measured as part of the insurer report card, with the following results:

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Aetna</th>
<th>Anthem</th>
<th>Cigna</th>
<th>HCSC</th>
<th>Humana</th>
<th>Regence (BCBS)</th>
<th>UHC</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracted fee schedule match rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Match Rate</td>
<td>96.69</td>
<td>91.64</td>
<td>97.46</td>
<td>92.60</td>
<td>97.92</td>
<td>85.21</td>
<td>98.13</td>
<td>99.66</td>
</tr>
</tbody>
</table>
Denials Defined
**Definition:** Denial of a claim is the refusal of an insurance company or carrier to honor a request by an individual, or his or her provider, to pay for a health care services obtained from a health care professional.
A true denial, or non-payment of a claim or claim line, is fairly obvious to detect but other payment and revenue opportunities should be monitored in the process as well.

- **Underpayment/Overpayment** – inaccurate payment from a difference in contract interpretation, pricing errors or other payment issues.

- **Lost Revenue** – can be in the form of undetected payment errors, incomplete or inaccurate billing, services missing from the bill.
Denials Defined

Common Denial Type Definitions

• **Soft Denial** – a temporary or interim denial that has the potential to be paid if the provider takes effective follow-up action.
  • Appeal not required.
  • Examples:
    • Pending receipt medical records
    • Denied due to missing or inaccurate information
    • Coding or charge issues
    • Pending itemized bill
    • Pending receipt of invoice
Common Denial Type Definitions – Continued

- **Hard Denial** – a denial that results in lost or written-off revenue.
  - Appeal is required
  - Examples:
    - No pre-authorization
    - Not a covered service
    - Bundling
    - Untimely filing
Common Denial Type Definitions – Continued

• **Preventable or Avoidable Denial** – a hard denial resulting from action or inaction on the part of the provider of services
  • Usually involve elective services that could have been delayed or deferred
  • Account for about 90 percent of denials
  • Examples:
    • Registration inaccuracies
    • Ineligible for insurance
    • Invalid codes
    • Medical necessity
    • Credentialing
Common Denial Type Definitions – Continued

- **Clinical Denial** – denials of payment on the basis of medical necessity, length of stay or level of care.
  - May be concurrent (while patient is still in-house)
  - or retrospective (after the patient is discharged)
  - Typically begin as a soft denial
  - Delay of payment where further medical or clinical clarification may be required
Common Denial Type Definitions – Continued

- **Technical or Administrative Denial** – a denial in which the payer has notified the provider, by way of remittance advice, with specific information describing why the claim or item was denied.
  - Typically done via remark code or reason code
  - Includes delay of payment where additional documentation is needed
    - Coding clarification
    - Requests for medical records
    - Itemized bills
Denials Defined

Commonly Misclassified Denials

• **Lack of Coverage** – a denial that results when non-covered services are provided
  • Usually the result of insufficient or ineffective insurance verification

• **Unpreventable** – hard denials resulting from the delivery of emergency services that could not have been delayed

• **Demand** – claim sent to Medicare specifically for the purpose of obtaining a denial when a patient had signed an ABN
Commonly Misclassified Denials

- **Short Pay** – denials that occurs when a payer incorrectly pays a claim
  - Invalid case rate, per diem, or fee schedule amount
Understanding Your Denials
Understanding Your Denials

**Measure - Tracking and Trending**

• Before we can do anything to manage and prevent future denials we first need to understand the types and volumes of denials currently occurring

• Methods of Tracking and Trending:
  • Automatically through ERA
  • Automatically or manually through EOBs

• Automated tracking of denials does not always work effectively
  • Creation of a denial tracking worksheet
  • Manual spreadsheet, allows more detailed data collection
    • Payer, reason for denial, ability to appeal, date of denial, billing date, amount denied and amount recovered
Understanding Your Denials

**Measure** - Tracking and Trending

- Track denials for at least three months to develop a baseline ratio of denials to charges
- Review data and categorize top payers and reasons for denials
  - In terms of both volume of denials and dollar amount of denials
- Use the 80/20 rule to prioritize and focus efforts on denial reduction and elimination
Understanding Your Denials

Example Breakdown of Denials

- Patient Registration Issue
- Incorrect Plan/ID
- No Verification of Eligibility/Benefits
- No Pre Authorization
- No Notification

- Insufficient Authorization
- Length of Stay
- Level of Care
- Service

- Insufficient Bill edits
- Claims Sent to wrong Address & unit
- Claims Not submitted properly

- Utilization Management: 18%
- Documentation & Coding: 3%
- Claims Capture: 2%
- Claims Submission: 16%
- Initial claims follow-up: Issues 25%
- UnderPayment: Identification & follow-up
- Requested Document not submitted
Understanding Your Denials

Analyze – Where do we need to focus our efforts

- Cause and effect relationships create a tangled web
  - Spreads the blame for denials across the revenue cycle
  - Also the place to determine the source of denials
**Understanding Your Denials**

**Analyze** – Where do we need to focus our efforts

- Map out current clean claim process to identify any vulnerabilities in the process
  - Note any problems that could potentially occur that could result in a denial

![Diagram of steps](image-url)
Analyze - Perform a Failure Mode and Effects Analysis (FMEA) for each step that could potentially result in a denial

- Failure modes – what could go wrong?
- Failure effects – what would be the consequences of each failure?
  - Rate the severity of the effect on a scale of 1-10
- Failure causes – why would the failure happen?
  - Rate the likeness of the occurrence of failure on a scale of 1-10
- Detection mode – what controls are in place to prevent the failure from occurring or detect it should it occur?
  - Rate how easy it is to detect failure on a scale of 1-10
**Example of a Failure Mode and Effects Analysis (FMEA)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the process step and Input under investigation?</td>
<td>In what ways does the Key Input go wrong?</td>
<td>What is the impact on the Key Output Variables (Customer Requirements)?</td>
<td>What causes the Key Input to go wrong?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Analyzing Your Priorities

• Calculate a risk priority number (RPN)
  • RPN = severity $\times$ occurrence $\times$ detection

• Sort the FMEA in descending order by RPN.
  • Highlights the areas where corrective actions can be focused
  • Set priorities on the biggest problems first

• Use the 80/20 rule as a cut off point to start
  • As a rule of thumb 80 percent of issues are caused by 20 percent of the potential problems
Managing Your Denials
Managing Your Denials

Improve - Determine Corrective Actions Needed from FMEA

• Generate appropriate corrective actions for:
  • Reducing the occurrence of failure modes
  • Improving the detection of failure modes

• Assign responsibility for each of the actions

• Set target completion dates

• Once completed, reassess and rescore the severity, probability of occurrence and likelihood of detection for the top failure modes
  • Determines the effectiveness of the corrective actions taken
Managing Your Denials

**Improve** – Develop a Zero Tolerance mindset for preventable or avoidable denials

- Totally within the control of an organization
- Caused by either actions or inactions in the revenue cycle process
- Two questions that should be asked when a denial occurs:
  - Is the denial preventable?
  - How could a preventable denial have occurred if we had the appropriate process and controls in place?
Managing Your Denials

Improve – Develop a Zero Tolerance mindset for preventable or avoidable denials

- Process improvement efforts should focus on breakdowns in denials prevention processes
  - These should be identified in the FMEA
  - Examples:
    - Communication issues
    - Verification of patient information and insurance
    - Inaccurate or missing documentation
Managing Your Denials

**Improve** - Prevention Areas Throughout the Revenue Cycle

- Patient Access
- Ancillary Services
- Case Management
- Health Information Management
- Patient Accounting
- Information Systems
- Compliance
Managing Your Denials

• **Patient Access – Scheduling**

• **Potential Denials**
  - Failure to obtain prior authorization / pre-certification
  - Inpatient-only procedures performed on an outpatient basis
  - Accurate patient data not captured prior to the visit

• **Best Practices**
  - Ensure staff are familiar with payer contract requirements
  - Non-emergent services scheduled at least a day in advance to allow time to obtain prior authorization
  - Electronic “hard-stop” for surgical codes on inpatient only list
  - Medical necessity is validated
  - OK to delay
Managing Your Denials

- **Patient Access** – Pre-Registration

- **Potential Denials**
  - Pre-certification not obtained
  - Non-covered services
  - Invalid insurance information

- **Best Practices**
  - Complete insurance information is obtained
  - Line item level insurance verification is performed
  - Non-covered services reviewed with patients so self-pay collection process can begin
Managing Your Denials

• Patient Access – Registration

• Potential Denials
  • Pre-certification is not obtained
  • Member is not eligible under coverage provided
  • Non-covered services

• Best Practices
  • ABNs are issued for non-covered services
  • Registrar is focused on financial clearance
  • Staff trained to recognize complete orders
  • Insurance verification performed
  • Patient demographics validated
Managing Your Denials

• Ancillary Services

• Potential Denials
  • Medically unnecessary services
  • Failure to obtain necessary authorization

• Best Practices
  • Staff are educated about National and Local Coverage Determinations and can explain coverage to patients
  • Trained to issue ABNs
  • Staff trained to recognize complete and accurate orders
Managing Your Denials

• **Case Management**

• **Potential Denials**
  • Clinical documentation does not support stay or level of care provided
  • Clinical documentation is not provided in a timely manner

• **Best Practices**
  • Reviews inpatient admissions and observation stays prior to discharge to verify stay meets criteria for coverage
  • Communicates with physician if stay does not meet coverage criteria
  • Provides information to payers in a timely fashion
  • All denied services are appealed
  • Initiates discharge planning at admission
Managing Your Denials

• Health Information Management

• Potential Denials
  • Coding issues
  • Untimely submission of requested medical records

• Best Practices
  • Records are coded in a timely fashion
  • Coding quality is validated – outside firm is preferred
  • Physician are queried for unclear or missing documentation
  • Physician documentation education is provided
  • Can remove incorrectly posted charges when identified
Managing Your Denials

• Patient Accounting

  • Potential Denials
    • Untimely filing
    • Incorrect codes due to chargemaster issues
    • Incorrect or missing billing edits in claims scrubber

  • Best Practices
    • Rejected claims are corrected in a timely manner
    • Monitors incorrectly entered charges
    • Denied claims are appealed
    • Fluent in payer contracts
    • Contract management software is current
    • Chargemaster is audited and updated regularly
Managing Your Denials

• Information Systems (IS)
  • Potential Denials
    • Interface issues resulting in incorrect or incomplete information transfer
    • Inadequate reporting resulting in poor denials analysis
  • Best Practices
    • All IS systems installed timely and upgraded as needed
    • Ad-hoc reports prepared and audited for accuracy
    • Extract denial information from electronic 835 remittance advice
    • Documentation collected electronically
Managing Your Denials

• Compliance

• Best Practices
  • Appropriate audits of performance are conducted:
    • Remittance Advice Reviews
    • Write-off Adjustments
    • Zero Payment Claims
    • Registration and Insurance Verification Quality
    • Coding Accuracy
    • Chargemaster Accuracy
  • Educational programs offered as needed for non-medical and medical staff
**Control** – How do we know improvements are working?

- Well-established process for updating Denials Tracker and creating new action plans as needed
- Creation of a Revenue Cycle team
- Benchmarking is critical
  - Short-term goal should be an improved denials ratio from one month to the next
  - Strive towards industry standard Key Performance Indicators (KPIs)
Managing Your Denials

Key Performance Indicators for Denials

- Medicare Return to Provider rate (RTP): 3.0%
- Overall claim denial rate (% of total claims submitted): <5.0%
- Denial write-offs (% of monthly net revenue): <3.0%
- Clean claim submission rate: >85.0%
Conclusion
Conclusion

Addressing denials can be an extremely large project

• Expect significant time and resource commitment at the start
• Payer requirements change frequently
  • Need to stay on top of changes to optimize revenue capture
• Significant return on investment may be achieved
  • Get the right players on the team – all areas of revenue cycle are represented
  • Create an environment accountability
  • Provide feedback to staff – celebrate the victories
• Start tracking denials as soon as possible
Questions?

This presentation is presented with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns, as the contents of this presentation are intended for general informational purposes only. Viewers are urged not to act upon the information contained in this presentation without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and additional information can be submitted to your Eide Bailly representative, or to the presenter of this session.
Thank You!

Rochelle Dahmen, Revenue Cycle Manager
rdahmen@eidebailly.com
612.253.6591