Implementing an Effective Denials Management Program

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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

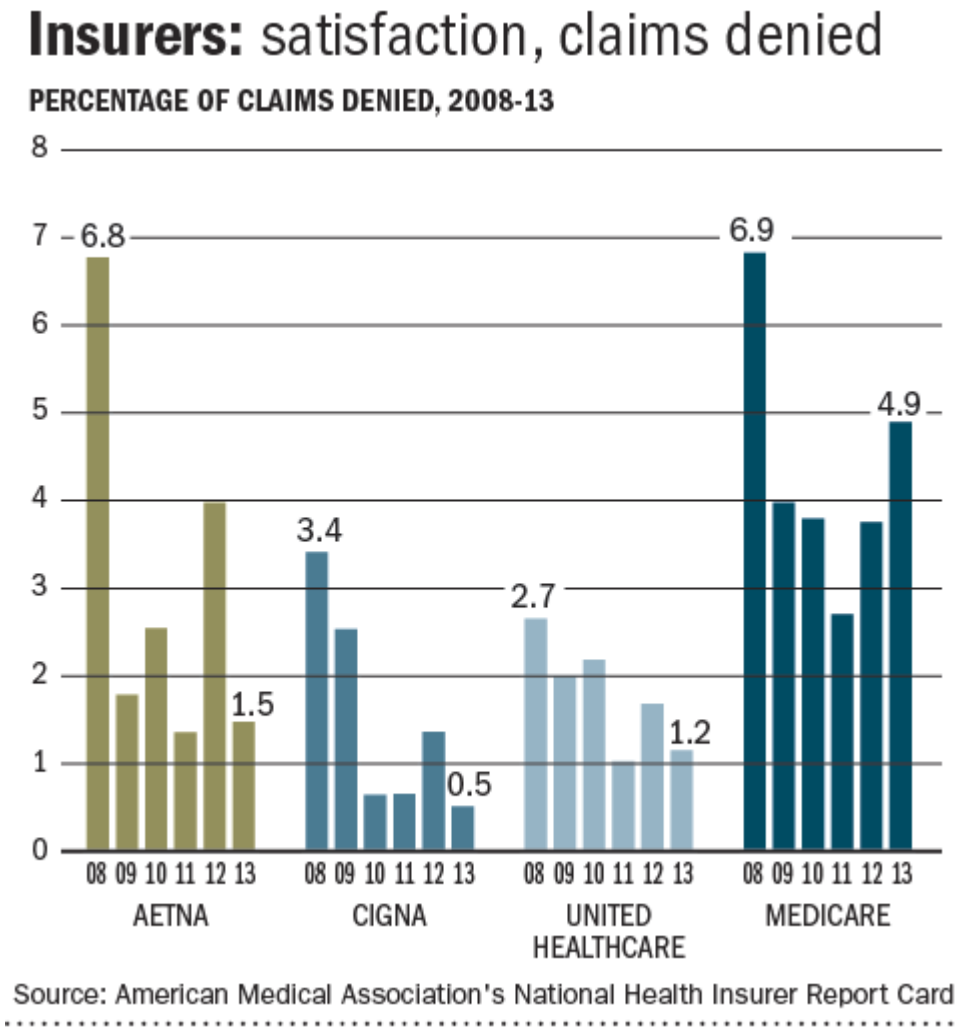
Denials – An Overview

- 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



Denials – An Overview

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

Insurer	Aetna	Anthem	Cigna	HCSC	Humana	Regence (BCBS)	UHC	Medicare
Contracted fee schedule match rate								
Match Rate	96.69	91.64	97.46	92.60	97.92	85.21	98.13	99.66

Denials Defined

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.

Denials Defined

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

Denials Defined

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

Denials Defined

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

Denials Defined

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

Denials Defined

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

Denials Defined

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

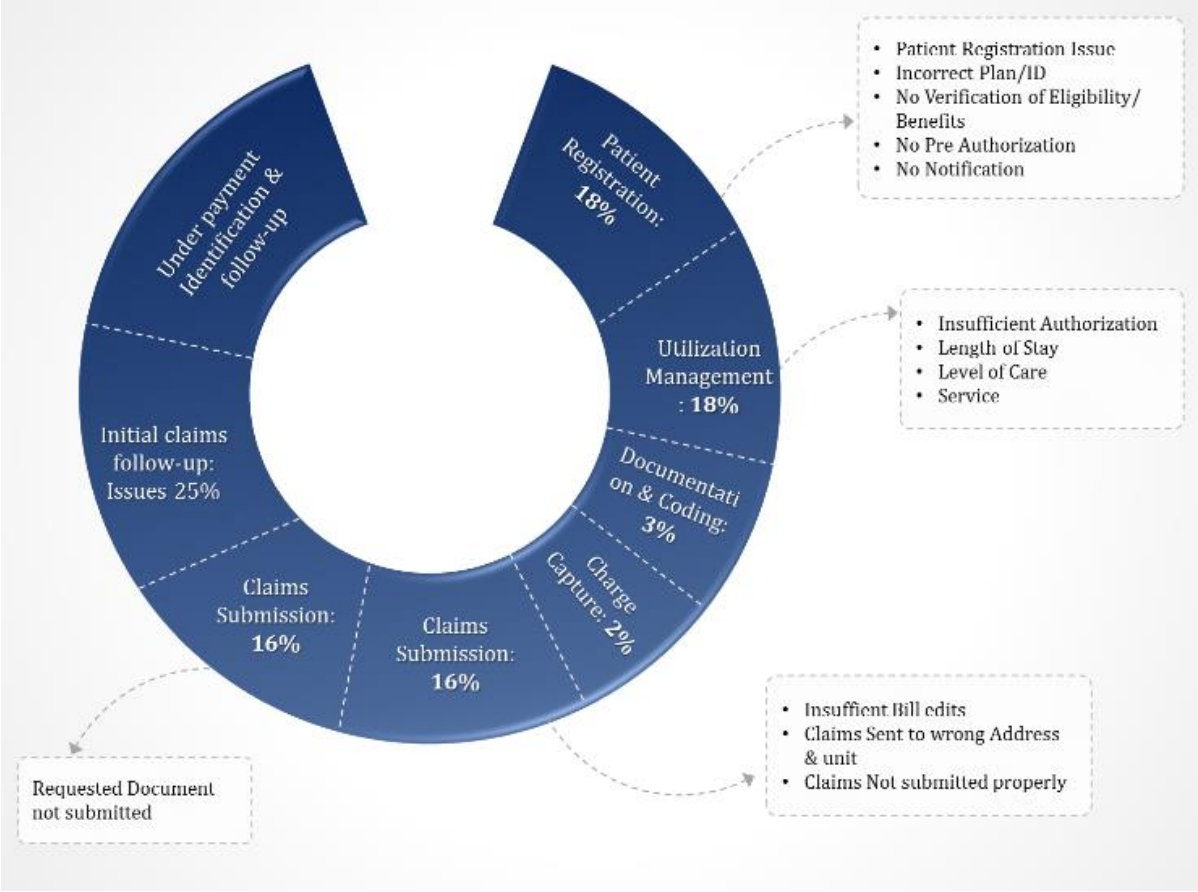
Understanding Your Denials

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

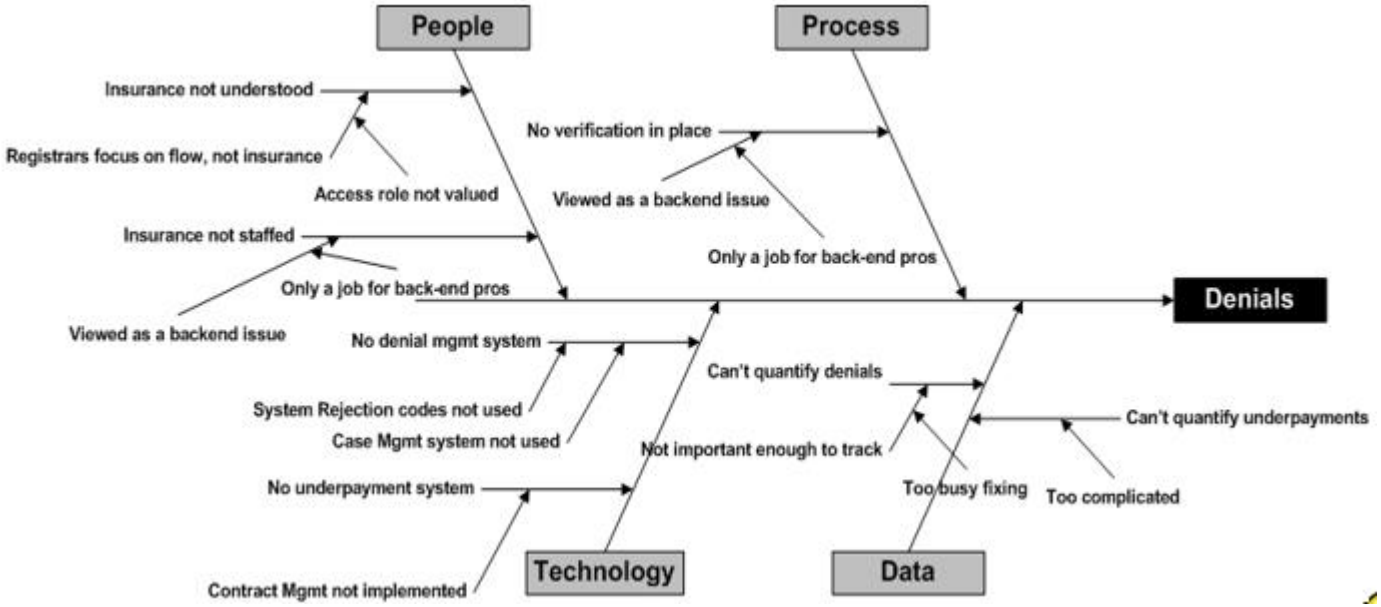
Example Breakdown of Denials



Understanding Your Denials

Analyze – Where do we need to focus our efforts

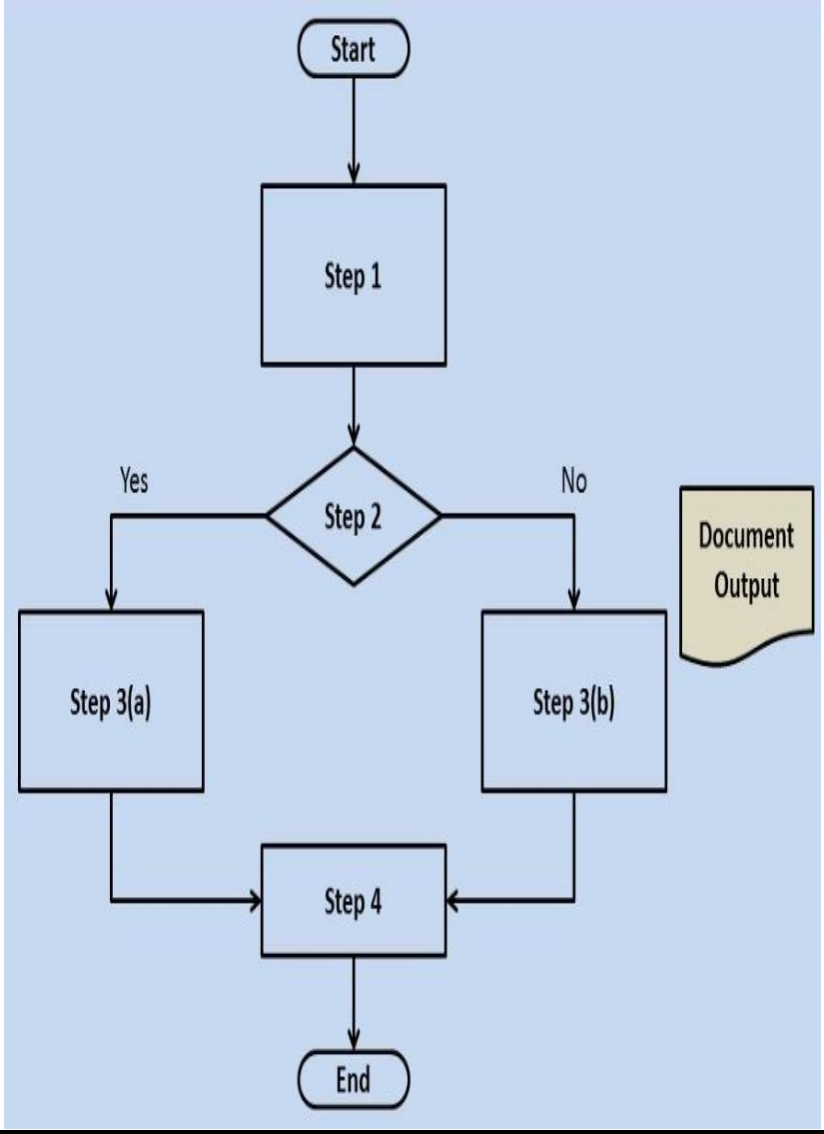
- Cause and effect relationships create a tangled web
  - Spreads the blame for denials across the revenue cycle
  - Also the place to determine the source of denials



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



Understanding Your Denials

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

Understanding Your Denials

Example of a Failure Mode and Effects Analysis (FMEA)

Process Step / Input	Potential Failure Mode	Potential Failure Effects	SEVERITY	Potential Causes	OCCURRENCE	Current Controls	DETECTION	RPN
What is the process step and Input under investiga-tion?	In what ways does the Key Input go wrong?	What is the impact on the Key Output Variables (Customer Requirements)?		What causes the Key Input to go wrong?		What are the existing controls and procedures (inspection and test) that prevent either the cause or the Failure Mode?		
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Understanding Your Denials

Analyze - Set Your Priorities

- Calculate a risk priority number (RPN)
  - RPN = severity x occurrence x detection
- Sort the FMEA in descending order by RPN.
  - Highlights the areas were 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 preformed 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

Managing Your Denials

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?

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Thank You!

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