Managing Denials

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As an experienced and knowledgeable healthcare leader you understand the importance of monitoring every aspect of your practice’s Accounts Receivable (AR). Information regarding patients and payers seems to constantly change and there is a shift in costs, from employer to employee that impacts collection efforts. Some days it appears that all parties are focused on doing everything they can “not to pay” for services rendered in good faith. The creation of a denials management process remains one of the most overlooked opportunities for revenue increase.

The reality is that denied claims are the “norm”. Medical claim denials, besides being an annoyance, must be investigated and understood because they negatively impact financial stability. Most practices fix the denials within their practice management systems; make notes (hopefully) and then move on to the next round of denials/correspondence and zero EOBs (explanation of benefits). Unfortunately, many practice management systems are not designed to review collective data from a historical viewpoint. The business office employees treat each denial as a single error instance and do not “learn” or think about how to alter the revenue cycle process to prevent mistakes from occurring again in the future.

Research published by the Health Care Advisory Board in 2008 showed that potentially 90% of denied claims are preventable through improved execution of verification, authorization and clinical documentation. The remaining 10% occurred due to random payor audits or outlier cases that do not actually reflect poor processes. Industry studies also report that 50% of denied claims are not refilled and that up to 67% can be recovered if appealed.

**Common Denial Problem Indicators**

How do you know if you have a denial problem in your organization? Review the list below and ask yourself if any apply to your practice.

- Average net revenue declining
- Many denials simply written off
- No feedback loop to responsible areas
- No ability to identify current status
  - Total denials (# and $)
  - Denials by payor
  - Denials by reason

If any of these problems exist in your practice you need to create a denials management program that focuses on evaluating adjudicated claim denials and prompt follow-up and resubmission of all denials.

**Payer Report Cards**

As you begin to evaluate the denials within your practice review the most current payer report cards. Take some time to review the information contained in the report(s) in order to compare and contrast with your practice experience. The American Medical Association’s 2012 National Health Insurer Report Card compared the performance of private, commercial payers (Aetna, Anthem, Cigna, Health Care Service Corporation (HCSC), Humana, Regence and United Health Care) against Medicare. This report provides physician practices with a reliable source of critical metrics (25 metrics in 2012) concerning the timeliness, cash flow, denials, transparency and accuracy of claims processing by health insurance companies. For example two of the many metrics reported are:

- Percentage of claim lines paid $0.00 for any reason (claim edits, denials and patient responsibility): Anthem lead the group at 27% and Medicare was the lowest at 11.10%
- Percentage of claim lines denied by the payer for reasons other than a claim edit (a denial is defined as: allowed amount equal to the billed charge and the payment equals $0.00): Anthem lead the group at 5.07% and Regence was the lowest at 1.38%. Medicare was 3.78%.

**Know Your CARCs and RARCs**

Reason and remark code sets are used to report payment adjustments in remittance advice transactions. A national code maintenance committee maintains the Healthcare Claim Adjustment Reason Codes (CARCs). Claim adjustment reason codes communicate an adjustment, explaining why a claim or service line was paid differently than it was billed. These are used only if an adjustment is made to a claim. The CARC list is updated three times a year in March, July and November.

The Centers for Medicare & Medicaid Services (CMS) maintains the Remittance Advice Remark Code (RARC) list, which is used by all payers. Remittance advice remark codes convey information about remittance processing or provide a supplemental explanation for an adjustment already described by a claim adjustment reason code. Each remittance advice remark code identifies a specific message as shown in the remittance advice remark code list. The RARC list is also updated three times a year in early March, July and November.

Your practice should review and analyze the Remittance Advice Remark Codes and the Claim Adjustment Reason Codes and use the results to educate your providers and employees. Having access to the denial reason/remark codes will allow your practice to understand what errors are causing most of your denied claims.

In the example below, there were 152 occasions where the practice provided services that were not covered. Knowing this, the practice could identify these services and have an ABN signed and collect the fee from the patient before providing the service. This example also demonstrates issues with precertification, medical necessity and the need to promptly provide complete information.

<table>
<thead>
<tr>
<th>CARC</th>
<th>Practice Volume</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96</td>
<td>152</td>
<td>Non-covered charge(s)</td>
</tr>
<tr>
<td>55</td>
<td>46</td>
<td>Procedure/Treatment is deemed experimental/investigational by the payer</td>
</tr>
<tr>
<td>197</td>
<td>98</td>
<td>Precertification/authorization/notification absent</td>
</tr>
<tr>
<td>226</td>
<td>135</td>
<td>Information requested from the Billing/Rendering Provider was not provided or was insufficient/incomplete</td>
</tr>
<tr>
<td>204</td>
<td>58</td>
<td>This service/equipment/drug is not covered under the patient’s current benefit plan</td>
</tr>
<tr>
<td>16</td>
<td>102</td>
<td>Claim/service lacks information which is needed for adjudication</td>
</tr>
<tr>
<td>50</td>
<td>23</td>
<td>These are non-covered services because this is not deemed a &quot;medical necessity&quot; by the payer</td>
</tr>
</tbody>
</table>

Analyzing and discussing denial details helps business office employees who do not have a complete understanding of the issues, specifically discuss how to “fix” issues (identify the source) and determine the best steps to prevent future denials, which results in consistent denials of the same type. Determining the source of denials allows you to add resources where needed. Based on denial type (registration/eligibility, referrals/pre-authorizations, charge entry, coding/medical necessity/duplicate claim, credentialing), the focus should be on correcting errors at the source rather than fixing them on the back end.

**Utilize Technology**

Look for and identify denial management partners. Many, if not most, Clearinghouses offer add-on services. Talk to your practice management vendor about denial management modules that are available for your system. There are many independent third party vendors that have freestanding denial management tools; which ones are financially reasonable and compatible with your practice management system?
Technology provides many options; make sure your practice is taking advantage of electronic remittance, electronic fund transfer, and electronic patient statements.

**Best Practice Strategies**

Once you decide to effectively manage the denial management process consider these strategies as you develop your solution.

- Use “root cause analysis”
  - Where and why is the error occurring?
    - Never a specific person, no finger pointing
- Use prospective prevention:
  - Create a Denial Management Team
    - Include all departments
  - Trend the type of denials over time
  - Educate employees and providers regarding their role in the Revenue Cycle and the denial process
- Make managers accountable for their departments - “fix where broken”
- Insist upon concise and timely documentation
  - Notes in collection area
- Focus on Front-end resolution/prevention
- Consider a “Denial Coordinator” to manage the process
- Build relationships with your payors
- Analyze denials and target appeals
- Prepare appeal letters:
  - Clinicians / MDs for medical necessity
  - Track results
- Leverage existing information technology infrastructure
- Define performance expectations and productivity indicators
- Create management- and executive-level performance monitoring tools and tracking reports
- Integrate responsibility for achieving financial results
  - Have your front office, business office and clinical managers work together on established goals
- Align specialized resources to ensure
  - Knowledge transfer + effective implementation
  - Change management
  - Focus on increasing cash and net revenue

As the operational leader in your practice it is not enough to simply understand where and when communication and documentation problems occur. Problems will not get corrected without an action plan, realistic expectations, staff education, and documented policies and procedures.

References:

1. AMA National Health Insurer Report Card