Denial Management

Delivery of Healthcare must be viewed as a business these days.

✓ If you are not profitable you can't keep doors opened for care.
✓ A strong denial management workflow and structure will help keep them opened.

Today's Discussion

- Identifying Denials
- Trends & Tips
- Strategies for Prevention
- Utilizing Some Tools
Denial Management

The only thing worse than a denial, is a denial that you don’t know you have..

Denial Management

- Constantly changing information
  - Patient & Payers
- Recovery & cost
  - 90% of denials are preventable/avoidable
  - 67% of those are recoverable
  - That leaves 33% never recovered
  - Average cost to re-work a claim: $15.00-$25.00 per claim

Source: HFMA (Health Financial Management Assoc.)

Denial Management

- Preventable / Avoidable
  - Timeliness
  - Expired Credentialing or Provider Enrollment
  - Registration inaccuracies
  - Charge “Bundling”
  - Incorrect Modifiers
- Unavoidable
  - Medical Necessity (some)
  - Additional information requested
Everyone’s GOAL
Get the claim paid and out the door once !!!!

Denial Management
What is the average denial rate for a “better” performing practice?
Less than 5%

Denial Management
• Average to normal office: 8% - 15%
• Big issues: Over 15% plus
*Determining factors can affect these percentages
Annual Practice Review

<table>
<thead>
<tr>
<th>Practice Review</th>
<th>Average # of claims per month</th>
<th>Total # of denials annually</th>
<th>Denial %</th>
<th>Average Cost to rectify</th>
<th>Financial Impact to Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss due to denial Management (rewritten claims)</td>
<td>300,000</td>
<td>45,000</td>
<td>15%</td>
<td>$75,000</td>
<td>$675,000</td>
</tr>
<tr>
<td>At good rate Loss due to denial Management (rewritten claims)</td>
<td>300,000</td>
<td>25,000</td>
<td>5%</td>
<td>$25,000</td>
<td>$225,000</td>
</tr>
</tbody>
</table>

**Identifying**

- What are your most common denials?
- How do you track denials?
- Upfront or backend errors?
- Does staff understand denials?

**WHO, WHAT, WHERE, WHEN & WHY**

- The source of denials allows you to educate and/or add resources where needed
  - Registration inaccuracies
  - Eligibility
  - Referrals / pre-archs missing
  - Charge entry errors
  - Coding and Modifiers
  - Credentialing
  - Interfaces
  - PMS set-up errors
  - Timeliness
  - What is root cause?
**Trends & Strategy**

- Weekly, monthly, yearly
- By category/provider
- By payer
- By dollar amount
- By user

- Measuring (start with)
  - Payment posting process
  - Insurance A/R Specialist
  - Your PMS (Practice Management System)
  - Outside tools and programs
  - Clearinghouse: EOB codes, reports, codes through ERA/835’s
  - Graph out trends/results for everyone: visual impact
  - Contracts loaded and updated

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**AMA Report Card**

- The next slides are results from the National Health Insurer Report Card (NHIRC) years 2008-2013 that address denials. [www.ama-assn.org/go/reportcard](http://www.ama-assn.org/go/reportcard)
- Metric 11 - Percentage of claim lines denied
  - Description: What percentage of claim lines submitted are 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.
- Metric 2 - First remittance response time (median days)
  - Description: What is the median time period in days between the date the physician claim was received by the payer and the date the payer produced the first ERA? If a payer did not provide the Payer Claim Received Date, the most current date of service that was reported on the claim was used to perform the calculation.
Know your numbers from reports,
It all ties together
<table>
<thead>
<tr>
<th>Payer</th>
<th>Message</th>
<th>Errors</th>
<th>Charges</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS MEDICAID 0979</td>
<td>Medicare entitlement information is required to determine primary coverage for beneficiary.</td>
<td>$270.00</td>
<td></td>
</tr>
<tr>
<td>AETNA 14079 60054</td>
<td>Provider/Subscriber/Submitted/Returned as unprocessable claim.</td>
<td>$270.00</td>
<td></td>
</tr>
<tr>
<td>BLUE CROSS NORTHERN CAROLINA 05536</td>
<td>Member ID must be valid.</td>
<td>$8,175.00</td>
<td></td>
</tr>
<tr>
<td>CIGNA 62308</td>
<td>Beneficiary: Benefit eligibility not found with entity. Acknowledgement/Rejected for Invalid Information.</td>
<td>$2,016.00</td>
<td></td>
</tr>
<tr>
<td>MEDCOST BENEFIT 25307 66162</td>
<td>Group Number required on claim.</td>
<td>$2,679.00</td>
<td></td>
</tr>
<tr>
<td>NC MEDICARE PART B 11502</td>
<td>Insured or Subscribers: Entity's contract/member number acknowledgement/Rejected for Invalid Information.</td>
<td>$393.00</td>
<td></td>
</tr>
<tr>
<td>TRICARE FOR LIFE TDDIR</td>
<td>INVALID SUBSCRIBER.</td>
<td>$393.00</td>
<td></td>
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Denial Management

Effective Denial Management Programs/Systems includes:

- Distribution of statistics across payers, departments, providers, registration points, CPT codes, ICD9 (I10)
- Age of denials in relation to claim expiration, refilling deadlines
- Analytics of comparing periods, current status, pending actions, etc.
- Can ID under and over payments
- Route work automatically to users in customizable tasks
- Dashboard, can set reminders
- Reimbursement analytics compared by payers
- Appeal system
**Healthcare Financial Management Association (HFMA) Recommended Key Performance Indicators (KPI)**

<table>
<thead>
<tr>
<th>Measure: Denial Rate – Zero Pay</th>
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<tr>
<td><strong>Purpose:</strong> Trending indicator of % claims not paid</td>
</tr>
<tr>
<td><strong>Value:</strong> Indicates provider’s ability to comply with payer requirements and payer’s ability to accurately pay the claim</td>
</tr>
<tr>
<td><strong>Equation:</strong></td>
</tr>
<tr>
<td>% Number of zero paid claims denied</td>
</tr>
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<td>Number of total claims received</td>
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<th>Measure: Denial Rate – Partial Pay</th>
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<td><strong>Purpose:</strong> Trending indicator of % claims partially paid</td>
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<tr>
<td><strong>Value:</strong> Indicates provider’s ability to comply with payer requirements and payer’s ability to accurately pay the claim</td>
</tr>
<tr>
<td><strong>Equation:</strong></td>
</tr>
<tr>
<td>% Number of partially paid claims denied</td>
</tr>
<tr>
<td>Number of total claims received</td>
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<th>Measure: Aged A/R as a Percent of Billed A/R by Payer Group</th>
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<tr>
<td><strong>Purpose:</strong> Trending indicator of receivable collectability by payer group</td>
</tr>
<tr>
<td><strong>Value:</strong> Indicates revenue cycle’s ability to liquidate A/R by payer group</td>
</tr>
<tr>
<td><strong>Equation:</strong></td>
</tr>
<tr>
<td>[{\text{Total billed A/R by payer group}} - {\text{Total billed A/R by payer group} &lt; 30} - {\text{Total billed A/R by payer group} &gt; 90} - {\text{Total billed A/R by payer group} &gt; 120 days}]} / {\text{Total billed A/R by payer group}}</td>
</tr>
</tbody>
</table>

**Trends & Strategy**

- Weekly / Bi-Weekly meetings with the right people (a committee)
  - Billing manager
  - Registration manager
  - Coding Manager
  - Client Rep (billing services)

- Goals need to be set
  - Clean claim-paid rates
  - Resolution of existing denied accounts
  - Minimizing write-offs due to uncollected denials
**Trends & Strategy**

- Written Policy and Procedure
  - Work electronic and paper denials
  - Develop appeal letter templates for most common denial reasons—Pre-populated
  - If you can assign different types of appeals to different staff and cross train—i.e. Urgent/level 1/level 2
  - Know details and contacts to escalate denials if necessary—*State Insurance Commissioner/Attorney General
  - Use your denial data to compare payer by payer for your benefit
  - Registration steps and requirements

- Appeals
  - Talk with team and get top appeals done and work on pre-populated letters to save time.
  - Procedure code is being bundled & it is not suppose to be bundled per the CCI edits
  - When insurance is requiring more documentation Lev I and then have a Lev II
  - Materials not covered
  - Modifiers
  - Procedure being incidental to the related procedure
  - Refer to guidelines from coding rules, government regulations, court cases pertaining to your appeal. Build your case.

**Collaboration**

Each office should be collaborating with insurance companies.

- The rules are constantly updated and change
- Review contracts at a minimum yearly
- Review for underpayments and meet with them
- Discuss denial rates and issues
- Make sure you keep a good updated contact on file
Collaboration
The Right Team in Place
- Highly experienced team in correct roles
- Certified coders and billers in your specialty / specialties
- Auditing team or ability to audit
- Staff that is fluent in top carriers
- Outside consultants
- Training needs

Tips to think on
- Full understanding of what payer really wants
- Understanding and knowing root cause
- Do you have a senior denial team?
- Training of staff, patients, physicians
- Understand if denial can be corrected and resubmitted or does it require an appeal?
- Updates shared with staff
- Audits of staff and process

Tips to think on
- Goals set / best practices
- Written policies for handling denial management
- Follow-up
- Capturing all remittance information
- Obtain access to other systems (hospital to pull in needed information
- Identifying and managing underpayments
- Review payer contracts
**Tips to think on**

- Details of what can be wrote off
- Know payer guidelines
- Automate what you can – directly to the next step in workflow without requiring review
- Create report cards and do something with them
- Consider having a 3rd party consultant in to review your process
- Talk with peers

**Summary**

- Identifying and managing denials - measuring, tracking, training, follow-up
- Understanding and sharing trends and root cause - Collaboration!!
- Minimizing denials to maximize reimbursements
- Utilizing tools, technology, peers and others
- Be Proactive!!
Commit and invest to denial management to optimize what you deserve.

Thank you
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