To Our Healthcare Clients and Friends:

Payer denials cost healthcare organizations significant net revenue. Denied claims represent unpaid services and lost or delayed revenue. They also represent an increase in operating expense associated with the rework required to resolve the denial. Being able to understand the root-cause of denials is the best first step in resolving the issue, securing payment for services rendered and reducing expenses. In this edition of IMA Insights, we examine the importance of identifying the root-cause of denials and conducting on-going process improvement to both remediate denials and sustain the improvement.
BACKGROUND

Many healthcare organizations take a reactive approach to payer denials. The denied claim is resubmitted or the claim appeal is prepared, but time is not taken to understand the root-cause of the denials. As a result, the issue causing the denial continues to generate more and more payer denials. Payer payments continue to be delayed or not realized and services continue to be rendered and expenses incurred without the appropriate payment by the payer. The organization finds itself in a vicious cycle.

Hospital legacy systems have their limitations and denied claims can sometimes go unnoticed. Even worse, healthcare organizations sometimes adjust the denied claim using a contractual or an administrative adjustment instead of classifying them as operational denial write-offs. This can mask the magnitude of the financial impact related to payer denials.

By default, the business office is required to take on the role of being the department of corrections for all payer denials. Many business offices use spreadsheets to record and track denials.

CHALLENGES

Technical and some clinical denials are communicated from the payer to the provider using claim adjustment reason (CAR) codes. The organization’s electronic and manual payment posting processes include the posting of the CAR codes. CAR codes fall into one of three categories: informational, soft denials or hard denials. The informational CAR code, such as non-covered service or patient’s coverage not effective for the date of service, provides information related to why additional payment is not required by the payer. The soft denial CAR code requires a corrective action and claim re-submission. The hard CAR code denial requires research and an appeal to be prepared and submitted. Claim re-submissions or appeal submissions are required to be completed within timelines specified in the organization’s payer contract or specified payer requirements.

When CAR codes are not identified or followed up timely, the payer usually processes a payer denial for untimely filing. An untimely filing denial indicates that the provider has passed the timeline for resolution of the denial. Often, business office personnel write the account balance off to an operational denial write-off related to untimely filing. This process masks the true deficiency that caused the claim to be denied by the payer.

Clinical denial notifications are received by organizations via various other channels:

- Verbal communication between the payer and provider
- Fax notification from the payer or the third-party review agency
- Mail notification from the payer, the third-party review, or audit agency
- Email notification from the payer or the third-party review agency

Managing the various clinical denial notification channels and centralizing the information is very important to effectively managing denials. The hospital’s legacy system is not effective in managing clinical denials. Most case management applications have the ability to track peer review activities and outcome significance but do not manage the retroactive appeal or audit processes. Utilizing technology to centralize and manage audits, denials, and appeals provides the greatest return on investment.

INSIGHTS

Healthcare systems who take an organizational approach to understanding and resolving payer denials are the most successful with denials remediation. In these organizations, the Chief Financial Officer, and the Chief Medical Officer are typically the co-champions of the denial reduction initiative, and they usually appoint the respective Case Management and Revenue Cycle leaders to co-lead the initiative.

Conducting data analytics on the current fiscal year’s operational denial write-offs helps the organization identify the payer denials that resulted in lost revenue. The following data elements should be included in the operational denial write-offs analysis:
Once the data analysis is complete, a root-cause analysis should be conducted on the high dollar operational write-offs for both clinical and technical denial adjustment reasons. The root-cause analysis should focus on operational denial write-offs associated with dates of service in the current fiscal year.

The most efficient and effective approach to addressing specific payer denials initiatives is to organize Task Forces who report up to the Revenue Cycle Steering Committee and are charged with identifying the root-cause of a specific denial type and the associated process improvements needed to remediate that denial type on a go forward basis. Task Forces should be established to address both technical and clinical denials. Some examples of Denial Task Forces include:

- **Inpatient Medical Necessity Task Force**
  - Addresses medical necessity denials, downgrades from inpatient to observation and denied days

- **Readmission Task Force**
  - Addresses the root cause for the patient’s readmission to the hospital

- **Outpatient Medical Necessity Task Force**
  - Addresses lack of medical necessity to support outpatient surgery or outpatient testing

- **Surgery Scheduling Task Force**
  - Addresses inpatient only procedures as well as patient status changes pre and post surgery and securing authorization for additional services performed during surgery

- **Outpatient Authorization Task Force**
  - Addresses securing authorization for services that were performed, instead of or in addition to the services that were initially authorized

Addressing payer denials through bite-size manageable efforts allows an organization to obtain quick wins and build upon the momentum and success. Examples of process changes include:

- Assign case managers to review all surgical patient’s status pre and post surgery and to identify any additional procedures that need to be authorized by the payer
- Assign case managers to the Emergency Room to assist the physicians in assigning the appropriate patient status
- Provide quarterly training and education to physicians and surgical schedulers related to inpatient only procedures and other payer specific surgery requirements

On-going tracking and trending of denials helps the organization to determine if the process improvements put in place addressed the root-cause of the payer denial. Many organizations spend time and resources to plan and implement process improvements, but neglect to continuously review outcomes and make on-going improvements until the identified issue is resolved and the new processes are hard-wired.
SUMMARY

Payer denials cost healthcare organizations considerable time, money and resources. The key to mitigating revenue losses and payment delays from denials is awareness and action. Healthcare organizations will experience consistent, long-term results by identifying the root-cause of the organization’s denials and implementing sustainable process improvements.

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We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance, please do not hesitate to contact me at (484) 844-4025.

Truly yours,

Terri Donohue
Terri Donohue
Director