

Denials Bleed You: Four Ideas to Fix It

Karen Minich-Pourshadi, for HealthLeaders Media, January 25, 2010

There are always interesting stories in the media about families being denied coverage for unusual reasons. Like the parents of 4-month-old Alex Lange, whose healthcare provider decided that a 17-pound baby was too big for his age and did not justify coverage. After backlash, the provider agreed to cover Alex and change its company policy so that weight would no longer be considered a pre-existing condition.

As insured individuals, we can all sympathize with the frustration a person feels when they are unjustifiably denied their medical coverage. From a CFO's perspective, claims denials are a daily occurrence, but they are no less frustrating when it means your hospital is bleeding hundreds of thousands of dollars annually. Claims denials and underpayments are one area that few CFOs would dispute could always use improvement. The challenge is with all the other "quick-fix" cost-cutting measures financial leaders are trying to implement, reviewing your claims denials for problems is often low on the list. That's a grievous error, especially when you consider that many healthcare experts believe as many as 90% of claims denials may be preventable through improved execution of verification, authorization, and clinical documentation.

As hospitals face declining marginal efficiencies from their facilities' cost centers, financial leaders must review, and in many cases revamp, their denials management best practices in order to capture a higher proportion of claims and increase collections.

Financial leaders need to work with their teams to identify, clarify, and quantify denials and underpayments in order to actually improve claims management. So to find out how to make improved claims management a directive that actually improves your revenue stream, I asked **Judith B. Suska, MBA, FHFMA, director at IMA Consulting**, a national independent healthcare management consulting firm which has worked with more than 200 hospitals and health systems, about some of the key components to getting your denials in order.

1. Build a denial recovery unit.

Some organizations look at volume and ask, "**Why are we seeing 1,000 denials?**" **only to discover these individuals are not eligible for insurance. Other facilities look at their dollars and ask basically the same question. The best approach depends on your hospital's charter for denial management created to help guide your task force, says Suska.**

Members of the task force should include a representative from any function that deals with revenue cycle such as patient access, health information management, case management, finance and there also needs to be clinical representation.

The key initial goals of your task force, which Suska recommends initially meet weekly or bi-weekly, should include determining

- what's a denial vs. a write-off
- how will denials and underpayments be tracked (manually vs. automated)
- how should this facility approach the issue

2. Collect information from the denial database.

If you don't collect the right information or you gather too little, you won't have any true understanding of the gobs of money your hospital could be losing every day to denials and underpayments.

"Regularly tracking and trending denial data is necessary," Suska says. "Denials can change from month to month, perhaps when you have a change in a payer contract or if you add an employee to a clinical group or there is a credentialing issue or a coding change. You have to pay attention closely in terms of volume of denials and also the types."

Who is denying your claims and why, should be the first place you look. The American Medical Association released the 2008 National Health Insurer Report Card which showed that greatest claim denials came not from a third-party payer, but from Medicare. With a count of records for Medicare at 6,938,431 the government adeptly denied 475,566 claims. The Medicare denial rate found in the study was on a weighted average basis, so roughly 1.7 times that of all of the private carriers combined. The third-party payer with the highest percentage of claim lines denials was Aetna, with a count of records at 637,239 they denied 43,317 claims, or 6.8%.

With neither the government nor other third-party payers about to change their processes, it behooves CFO to do more than encourage the team to simply refile rejected claims—actually that's a waste of time, effort and in the end dollars. Suska suggests that financial leaders "begin at the end" and look at the back office. Your business office should analyze the denials reports generated which can then be categorized by code, cause, or department—your task force will determine what data is most useful.

"Vigilance is key; you're looking for preventative measures to put into place and you also need to constantly be aware of any industry issues that may affect your claims, such as RAC. It's really never-ending," says Suska.

3. Consider automation.

Because claims denial is so unrelenting, it's worth investing in automation to track it. Think you can't afford it? If your facility is bleeding hundreds of thousands annually due to denials you have no choice or the facility could land in the red when reimbursement changes occur.

"It is very labor intensive to track and report on denials manually," Suska notes. "Consider investing in an automated tool."

Keep in mind, whether you use manual or automated processes for denials and underpayments, this process should always be the responsibility of numerous people at the hospital.

4. Know when to hold 'em and when to fold 'em.

Even organizations that have sophisticated denials management programs get denied, so knowing when to appeal a denial is equally important. Suska recommends culling a sub-committee from the task force and establishing monetary guidelines for determining which denials to focus on. The appeals process may also help you uncover whether any documentation issues need to be addressed.

Legislation and third-party payers are frequently changing and either of them can have a profound affect on your hospital's bottom line. While you cannot ignore these two critical elements, it is vital that your organization make every effort to get all the dollars you are owed while working within their defined perimeters. Reducing your claim denials and underpayments is a long-term approach to keeping your hospital financially sound.