To Our Healthcare Clients and Friends:

Payer denials represent one of many revenue cycle challenges where prevention really is the best cure. There is always a cost associated with a claim denial. Whether it is the cost of researching the claim, filing an appeal, coordinating the provider response, or writing-off the claim, the provider experiences an increase in operating expenses, or a reduction in net revenue, or both with each denied claim. In the aggregate, these costs can be substantial.

HFMA and AAHAM have established a benchmark of ≤4.00% of gross revenue for denials. Our experience at IMA Consulting indicates that hospital write-offs due to denials usually range from 1.5% to 3.5% of net revenue. How much would that represent for your facility? Regardless of the benchmark used, it is clear that hospitals are losing a significant amount to denials. Assessment findings are conclusive; denial management is usually one of the top 10 opportunities for revenue cycle improvement.

In this edition of IMA Insights, we will outline some recommendations for achieving excellence in denial management processes that will help providers effectively record, report, prevent, and appeal denials to help improve their financial wellbeing.
BACKGROUND

Although denials from insurers have been affecting the collectability of claims and causing significant losses of revenue for many years, hospitals have not adopted a standardized approach to record, report, prevent, and appeal them. Perhaps this is because there is not a dominant industry leader in the denials software arena that could have helped establish a denials "best practice" methodology. Perhaps it is because until HIPAA, there were no standardized denial codes. This made it more difficult for providers to design a comprehensive denial management system without maintaining separate denial code translation tables for each payer.

Many providers have taken a reactive approach to denials management, focusing more on the appeals process. Some have used their ingenuity to develop homegrown solutions that are more proactive in nature. Almost all have much to gain by improving their denial management process.

CHALLENGES

Hospitals have developed denial management processes that attempt to use the best of the tools available to them to address their needs. For most, this includes using data from the patient accounting system, EDI system, case management system, decision support system, and homegrown databases and spreadsheets. We see few clients that have purchased formal denial management systems, although there are such systems available. In addition, providers have many different organizational approaches to identifying, preventing, and appealing denials. As noted, there is no standard methodology or best practice commonly employed by the hospital industry to deal with denials, with the possible exception of the appeals requirements of common payers.

Payers have an obvious incentive to deny or delay payment, if they are able to do so while complying with any prompt payment statutes. The more claims that are denied, the more difficult it becomes for a facility to effectively manage its denials, and the more likely it is that a payer will pay less than might otherwise be the case.

The primary responsibility for denial management may be assigned to Patient Accounting, Patient Access, Case Management, Denial Management (if this department exists), Revenue Integrity (if this department exists), Health Information Management (HIM), or a vendor (if applicable). Staffing in these departments is often limited, making it more difficult to accomplish the tasks necessary to manage denials. Primary responsibility notwithstanding, a multidisciplinary approach is required for best results.

INSIGHTS

While there may be as many different iterations of denial management processes as there are hospitals, there are characteristics that we believe can improve the effectiveness of any denial management process. Few hospitals have all the characteristics recommended below, but striving to implement these ideas will serve to enhance the processes already in place.

Infrastructure

- Establish a multidisciplinary team to serve as the Denial Management Task Force. This team should include Patient Accounting, Patient Access, Case Management, Denial Management or Revenue Integrity, HIM, Information Technology, and the vendor, if one is utilized. The executive sponsor should be someone at the Vice President level, such as the Chief Financial Officer or Vice President, Revenue Cycle. This will give the team the necessary clout to do its job properly. Others may be brought into the group on an as-needed basis, but the number in the core group should be held to manageable levels.

- Define the Task Force’s objectives and approach to problem resolution.

- Schedule regular Task Force meetings, at least monthly, and review the denial data on a routine basis. The Task Force will review individual denials to determine why they occurred, what procedures can be implemented to prevent the same denial in the future, and what training needs to occur.

- Determine the key performance indicators (KPIs) that will be used in the denial management process.

- Compare facility performance against industry benchmarks. Benchmarks may come from a variety of sources, including but not limited to Healthcare Financial Management Association (HFMA), American Association of Healthcare Administrative Management (AAHAM), Hospital Accounts Receivable Analysis (HARA), and any state or local data that may be available.
• Develop and implement a communication plan to ensure denial data and KPIs are distributed to all who need that information, and that there are focused discussions regarding denials, how to avoid them, the process for filing appeals, and following-up on those appeals.

Recording Denials
• Establish a central repository for denial tracking and reporting. This can be a part of an existing system, such as patient accounting or EDI, or it may be a separate system or data base.
• Develop a standard set of denial codes (maximum 25) to record the denials.
• Document clear definitions for the denial codes, and establish a crosswalk between the X12 835 codes for denials and the denial codes in the data base (not all 835 codes will be classified as denials).
• Establish responsibility for addressing each denial code, by department.
• Record as many denials directly from the 835 as possible.
• Conduct staff training to ensure that manually recorded denials are assigned to the correct denial code.
• Create denial write-off codes in the patient accounting system that correspond to the denial codes in the denial management system.
• Ensure that both denials and write-offs are tracked, and that everyone understands the difference. Denials are those claims for which an insurer has refused or partially refused payment, and a write-off occurs only after the denial is deemed uncollectable.

Reporting Denials
• Develop reports from the denial management system to report denials by type and by responsibility for the denial.
• Develop reports from the patient accounting system to report write-offs due to denials, by type of denial.
• Set goals for both denials and write-offs, and track the actual results monthly. Goals should include maintaining write-offs due to denials at < 2% of net revenue.

Preventing Denials
• Ensure that staff members are well-trained in payer pre-admission, admission, discharge, and billing requirements. This will help to reduce some of the preventable denials, such as failure to obtain necessary pre-certification or referrals, non-covered services, inappropriate level of care, medically unnecessary services, inadequate documentation, untimely filing, etc.
• Publish timely filing requirements, by payer, for billers, follow-up representatives, coders, and other applicable staff to ensure deadlines are always met.
• Limit denial exposure through routine attempts to negotiate no denial or limited denial clauses in future contracts with major payers.

Appealing Denials
• Ensure that timely and assertive clinical representation is available for providing support for clinical appeals.
• Ensure that relevant staff members have access to, and understand, payer contracts, Medicare/Medicaid regulations, and state insurance regulations to more effectively contest denials.
• Use qualified vendors or attorneys to assist in contesting denials, if necessary.
SUMMARY

Implementing these recommendations will help to achieve the ultimate goal of minimizing denials and the associated write-offs. A gap analysis comparing current processes to those discussed above will provide some indication of the extent to which your denial management program can be improved. If you are now identifying and tracking preventable denials, you will already have some idea of the amount of net revenue that can be saved through process improvement efforts. At a time when self-pay obligations are rising and margins are shrinking, the hospital industry can hardly afford to overlook an obvious source of increased net revenue.

*** *** *** *** *** ***

We are pleased to have the opportunity to present this information to you. If you have any questions or need assistance in improving your denial management program, please contact Kim Hollingsworth, Partner, Rick Power, Senior Consulting Manager, or John Thompson, Senior Consulting Manager, at (866) 840-0151.

Truly yours,

Chris Karman
Director