DENIAL MANAGEMENT:

Field-tested techniques that get claims paid

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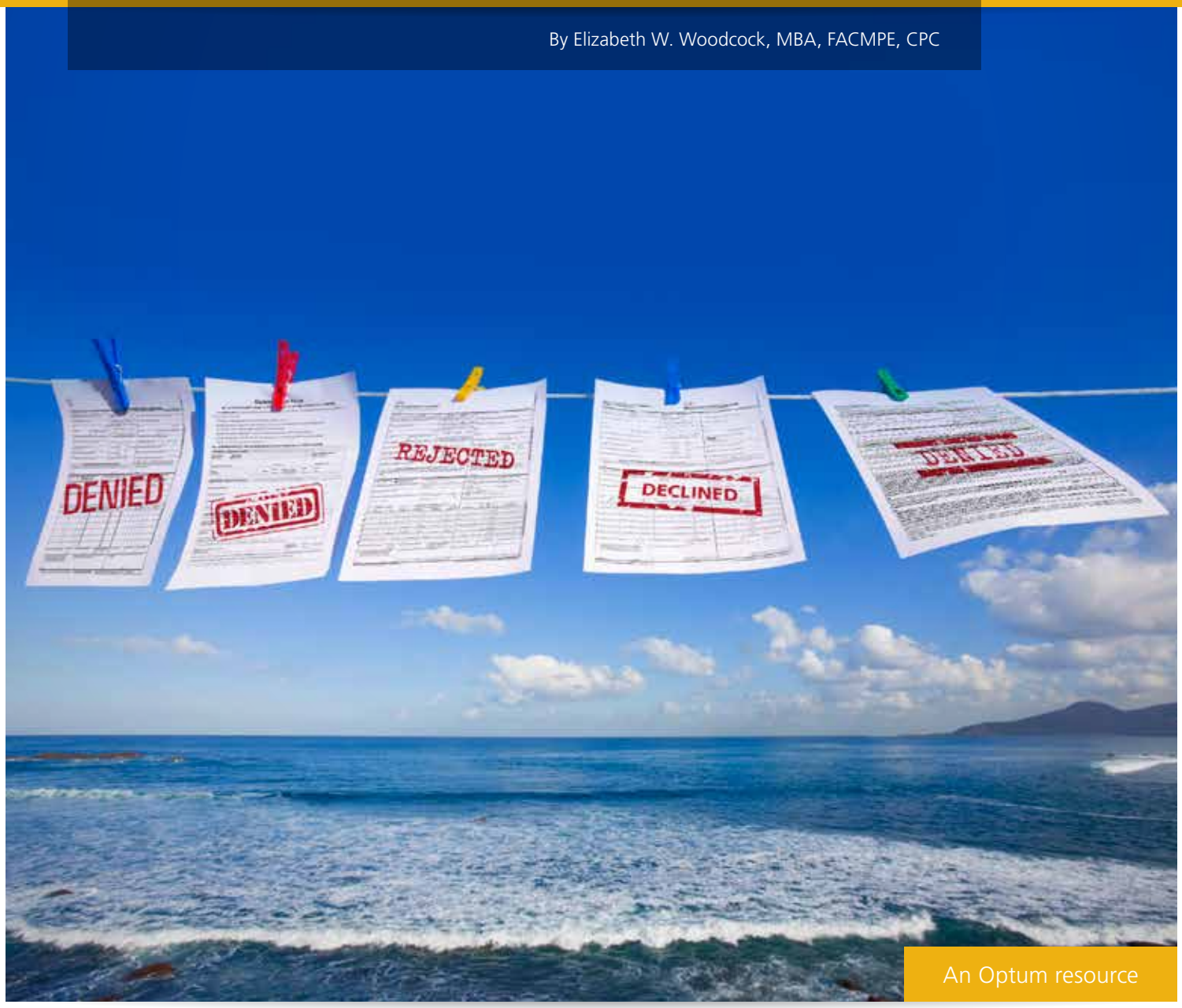

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Objectives

Failing to adequately work denials from insurers translates to lost revenue for your medical practice. Presenting the four steps to effective denial management — **I**dentify, **M**anage, **M**onitor and **P**revent — this white paper provides the reader with knowledge to:

- Recognize opportunities to identify and correct the issues that cause claims to be denied by insurers.
- Classify denials by reason, source, cause and other distinguishing factors.
- Develop and assess effective denial management strategies.
- Implement strategies that engage patients, referring physicians and others to effectively appeal and reverse unfounded denials.

Readers will discover field-tested techniques and best practice tools and resources to help their practice effectively manage its denials — and ensure a healthy bottom line.

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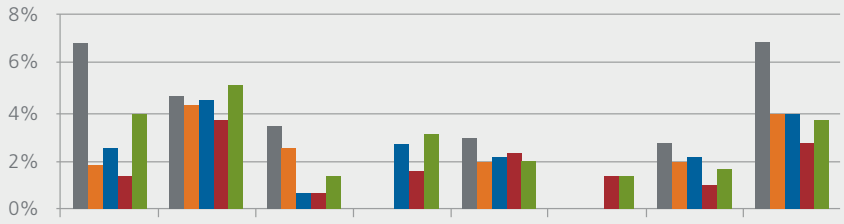
Identify Manage Monitor Prevent

> The first step in a successful claims resolution approach is to identify not only that a claim has been denied, but also the reason for the denial.

Physicians transmit millions of claims to insurers every day. Most claims are adjudicated promptly and for the full contracted amount, but a notable minority is returned unpaid. Indeed, the American Medical Association reports that between 1.38 percent and 5.07 percent of claims are denied by insurers on the first submission. (See Figure 1.) Even the best-performing medical practices experience a denial rate of 5 percent, reveals the Medical Group Management Association in its 2012 Performance and Practices of Successful Medical Groups report.

Denied claims represent unpaid services — and lost or delayed revenue to your practice. Importantly, they also signify an avoidable cost to the medical practice. Employees' time spent managing and — ideally — resolving denials saps significant resources from the medical practice's business office. Medical practices that lack a focused strategy for denial management are more apt to see denials unfavorably resolved or, as is all too common, left to languish and eventually be written off as bad debt. Consider Figure 1 — claim denials are highly variable by insurer, necessitating a carefully constructed process to optimize revenue for a medical practice.

Figure 1: Denied claims by insurer



	Aetna	Anthem	Cigna	HCSC	Humana	Regence	UHC	Medicare
2008	6.80%	4.62%	3.44%		2.90%		2.68%	6.85%
2009	1.81%	4.34%	2.56%		2.03%		2.02%	4.00%
2010	2.57%	4.50%	0.67%	2.67%	2.18%		2.21%	3.82%
2011	1.38%	3.62%	0.68%	1.59%	2.33%	1.36%	1.05%	2.73%
2012	4.00%	5.07%	1.39%	3.06%	1.97%	1.38%	1.71%	3.78%

Source: 2012 National Health Insurer Report Card, American Medical Association. Question: "What percentage of claim lines submitted are denied by the payer for reasons other than a claim edit?" According to the survey, a denial is defined as the allowed amount equal to the billed charge and the payment equals $0.

While it's easy to throw up your hands in frustration, it is business-critical to develop and optimize proven techniques that get claims paid. This white paper serves to outline field-tested techniques that get claims paid by using the four-step IMMP process — Identify, Manage, Monitor and Prevent.

Step 1:

Identify

"While unpleasant to receive, claim denials — particularly the information about the type, number and source of the denial — are invaluable business intelligence for a medical practice."

The first step in a successful claims resolution approach is to identify not only that a claim has been denied, but also the reason for the denial. When adjudicated claims are returned unpaid, the insurer will indicate the reason on the accompanying explanation of payment. These indicators, known as claims adjustment reason codes (CARC), are applied at the line item — CPT® code — level. Each CARC may be further explained in an accompanying remittance advice remark code (RARC). Figure 2 outlines a sample of claim adjustment reason codes utilized by insurers.

Figure 2: Sample claim adjustment reason codes

4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
22	This care may be covered by another payer per coordination of benefits.
38	Services not provided or authorized by designated (network/primary care) providers.
55	Procedure/treatment is deemed experimental/investigational by the payer.
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Source: Washington Publishing Company, 2013. Accessed http://www.wpc-edi.com/content/view/695/1 on June 9, 2013.

It sounds simple: Just review the code and determine why the insurer denied the claim. But is it really that easy?

Unfortunately, deciphering and interpreting this feedback from the insurer is anything but elementary. First, the codes are typically in alpha-numeric form, so your employees must map the insurer's code to the description of the reason. Additionally, many codes are cryptic. For example, CARC 16 is: "Claim/service lacks information which is needed for adjudication." What information is lacking? It requires digging for answers: the remittances from many insurers will not provide sufficient detail to answer that question, leaving it up to the employees of the practice's business office to effectively execute laborious research at times to discover what — if any — additional critical information is needed.

The CARC numbers also are frequently accompanied by a two-letter alpha code. These codes, which typically precede the reason and remark codes, indicate which party the insurer feels is responsible to pay the denied amount. The codes of this type include "PR" to indicate patient responsibility and "CO" to indicate contractual obligation — meaning that the participating physician is contractually obligated to accept the denial.

Adding to this confusion is the fact that some insurers still use non-standard, legacy codes. Thus, identifying why a claim was not paid, and who is responsible for payment, can require research beyond merely scanning the insurer's communication.

Despite these challenges, identifying the type of denial is the critical first step in getting claims paid successfully.

Step 2:

Manage

The receipt of a denial inevitably kicks off a series of tasks within the practice. Well-organized medical practices have designed a standard workflow specific to denial resolution. Once the denial is identified, which may occur manually or automatically, an action plan to resolve the denial — getting the claim paid instead of rejected — must commence. The following five action steps focus the work of denial management and ensure that it is conducted in a timely and efficient manner.

Action 1: Directly route denials

Many practices fall short by failing to commence their denial response workflow immediately upon learning of the insurer's decision — not only does this delay revenue to the practice but timely appeal deadlines can be missed.

As a first action, look internally for ways to better organize and speed up the handling of denial-related information. Instead of printing, copying and filing each denied transaction, it is more advantageous to use automation to route denied claims directly into work lists. These work lists are best designed to reflect the natural patterns of the revenue cycle.

For example, route all coding-related denials directly to your coder(s). The coders are then tasked with taking action on each item in their denial management work list. If the business office has assigned various insurers to different business office associates, these account representatives tackle the portions of the work list that relate to their assigned accounts.

Action 2: Sort the work

Whether employees work denials as a component of their jobs or as their exclusive focus, enable them with technology and training to effectively work denials. Sophisticated software allows employees to sort their work list assignments by reason, time, dollar amount and other factors, thereby permitting efficient work processes. In the absence of software that features the ability to sort denials, create a manual system with folders and reminders.

Whether it be an automated system or one that is created manually, developing a structured, organized workflow is critical. By working denials based on category, an employee can streamline the work. For example, within an insurer category work all denials related to a credentialing issue for a particular provider.

Action 3: Create standard workflow

Create a standard workflow for each key type of denial. While it may be tempting to attack the denial problem by simply throwing more resources at it, a strategy of adding more employees to a chaotic, disorganized process is doomed to failure. Instead, develop a denial management guide for your employees to follow. Once they are complying with a carefully designed and monitored protocol, you will be able to determine if you do not have enough people working on denials, your process is faulty, or problems lie elsewhere.

To create a standard workflow, identify your practice's most common reasons for denials, such as medical necessity. Record the most frequently seen reason codes associated with that denial (for example, "the diagnosis is inconsistent with the procedure"), and develop a step-by-step action plan for employees to follow when managing one of those denials. Include even the most basic steps — for example,

Best Practice

Directly route denials. Whether automated or manual, route specific denial reasons — the CARCs — directly to the next step in the workflow without requiring review, approval and other unneeded "touches" that cause delays and waste valuable staff time. For example, a denial made because the patient has hit the maximum benefit for the service provided, and which is marked "PR" to indicate the patient bears the financial responsibility, should simply move into guarantor responsibility in the billing system and appear on the next distribution of statement mailings. Intermediate steps, such as printing out the transaction, reviewing it again internally, requiring an approval or check-off, and so on, unnecessarily delay the claim, causing it to further age in the accounts receivables.

"check online claims status" — in your guide. In this fashion, you are able to create a standard workflow — a classic lean management technique that facilitates efficiencies in denial management. Include protocols in your denial management strategy that encourage employees to proactively take corrective actions to avoid duplicative, unnecessary work.

Rather than allowing individual employees to create their own work process, document the workflow with which you want employees to comply — by denial type — thereby ensuring your employees are working from consistent protocols, each and every time. With standard protocols, you can achieve better performance throughout the denial management process by holding employees accountable for their denial management tasks and accomplishments.

Action 4: Use a checklist

Effective denial management relies on many small actions carried out consistently. It also depends on avoiding certain common mistakes that cause denials to linger and, in some cases, end up as uncollectable bad debt on the practice's books. Here's a simple checklist of do's and don'ts.

- ***Don't delay.*** After you identify the problem, begin working on the resolution — immediately. Stamping a claim form with the letters "APPEAL" and mailing it back to the insurer no longer works (if it ever did). Following the denial management guide you have developed, review the insurer's remittance or associated communication about the denial, your internal documentation, and the insurer's policies. Research the code and, even, call the patient if necessary, but don't delay working that denial because most insurers impose time limits on resubmitting claims. You may need every bit of that time.
- ***Avoid automatic re-billing.*** Historically, it was standard industry practice to re-transmit claims to insurers every 30 to 60 days. About a decade ago, this standard practice received significant scrutiny from the government, which questioned the intent — and the fact that automatically re-billing has the potential to inadvertently produce double (or more) payments for a single claim. Automatic re-billing is more than a compliance issue, however; it tends to produce a significant amount of duplicate claims — and duplicate denials. Duplicate denials create a tremendous amount of extra work, as employees must not only research whether the denial was legitimate but also whether it was already paid. Because it appears to be a lot of work getting done — "look, Doctor, I billed 1,000 claims today!" — this phenomenon of re-billing is an all-too-common problem in a business office. For compliance, as well as in-office efficiency, avoid the automatic re-billing of claims.
- ***Pick your battles.*** If your research reveals that you filed the claim incorrectly, correct it and resubmit it. Don't, however, fight for a claim that should have never been submitted in the first place, such as a service that was never documented.
- ***Build your case.*** Learn the insurer's requirements for resubmitting claims that you feel were denied incorrectly. Some insurers may accept a reconsideration request by telephone; many want it in writing. Many require you to complete and file specific electronic or paper forms. Depending on the type of denial, you may need to prepare a letter to describe your case for reconsideration. Write a formal, professional letter that builds your case. To support your rationale for payment, attach necessary documents, such as documentation of the service, relevant medical literature, a record of the original filing of the claim, and copies of sections from the CPT® book or CPT® Assistant that explain the appropriate use of the code in question.

Best Practice

Work insurance correspondence. Heed insurers' correspondence and make it part of the denial management workflow as needed. Not all denials sent from insurers arrive via the explanation of payments. Indeed, stacks of paper from insurers with information related to claims payment are pouring into your medical practice each week. These letters — referred to as "correspondence" by many business office employees — must be routed promptly into the denial workflow. Otherwise, they often get left in a mail slot, file folder, drawer or on someone's "to-do-if-time" list where they may easily be forgotten or further delayed.

- ***Request an expert.*** When you write an appeal letter, demand that a specialist in your area of expertise review your appeal for payment. If the denial is upheld, this request (which is rarely granted) gives you a better shot at securing a second round of review.
- ***Engage the patient.*** Send a copy of your request for denial reconsideration to the guarantor on the account, too.[1] A patient notified of a denial may be concerned that he or she could become financially responsible. This may spur the patient to contact the insurer directly to discuss the situation. The odds of a denial receiving additional reconsideration improve when both the practice and the patient are communicating to the insurer about it.
- ***Inform the authorities.*** While you may wish to call 911 for help with denials, your state insurance commissioner will be more likely to offer a sympathetic ear and, perhaps, aid you in getting an unfair denial overturned. Sometimes, it's just as effective to simply advise the insurer in advance that you plan to communicate with the insurance commissioner's office if your appeal is not taken seriously.
- ***Watch adjustments closely.*** From an administrative perspective, it's important to ensure that your employees are indeed managing denials. Even good employees can make mistakes. Whether through lack of training, overwork or just a bit of slacking off, some employees may write off denied claims as uncollectable bad debt rather than pursuing payment for them. If you're not watching carefully, these premature and usually uncalled-for write-offs may lead you to think your practice is making great improvements in managing its accounts receivables. After all, the more old claims that disappear from the system through write-offs, the lower your average days in accounts receivable. Don't get fooled; run a "100% Contractual Adjustment" report each month. In this report, pull all services that have fully been written off as a contractual adjustment at the line item level. Although some write-offs will be legitimate, this is an excellent report for scrutinizing adjustments. An inspection of this report will ensure that you will be aware if denials are being written off instead of worked.

Action 5: Create online tools

Make sure your staff have online tools to help them create the "best case" argument for appeal. These include specialty-organization briefs on specific procedures, payer rules and guidelines, national coverage and local coverage determinations, and template letters for specific appeal types. This will provide invaluable time savings for your staff and permit them to execute an appeal package that has a higher probability of successful resolution.

Developing a denial management program takes energy and time. Furthermore, it's not a short-term project; it's an ongoing process that must be continually assessed and adjusted to reflect the ever-changing payment policies of many insurers. Although time consuming, the positive result on the medical practice's bottom line will make these efforts well worth your time.

Best Practice

Work suspended charges. Practice management systems can "suspend" charges when necessary claim information is missing from a field, or when there is a question about a component of the transaction or provider's documentation. Make sure your system has a way to track and alert you to suspended charges, however; otherwise, you may receive timely filing denials that can only be adjusted off of your system as uncollectable bad debt. Review suspended charges each month, and set alerts so that you become aware of any that are in danger of reaching 30 days old — many insurers deny claims submitted 45 to 60 days past the service date, but even if they do not, there's no good reason to allow charges to stick around that long.

1. There may be circumstances related to protected health information (PHI) in which this is not advised. Use your best judgement, and seek legal counsel when warranted.

Step 3:

Monitor

The development of an effective denial management program takes more than just assigning an employee to "work" denials and resubmit claims. They — the denial as well as the employee — must be monitored.

To monitor the work of denial management, first, maintain a log of denials — by date received, type of denial, date appealed and disposition — to ensure that your denial management processes are effective. Second, audit the work of employees by selecting a sample of their appeals. Evaluate the steps taken for the appeal, the timeliness of appeal, and the strength of the case submitted to the insurer. Third, make sure your employees have the tools, technology and resources to get the job done.

These three actions will give you the data you need to hold employees accountable for denial management and provide education or take corrective action to improve their performance.

Monitoring also must be conducted at the level of the insurer to gain a better understanding of each insurer's claim denials. While unpleasant to receive, claim denials — particularly the information about the type, number and source of the denial — are invaluable business intelligence for a medical practice. To explore this treasure chest of business information, you can take the following measures:

- **Type:** Sort, categorize and track denials, as demarcated by the reason and remark codes, over time, by provider, amount, insurer and other factors.
- **Number:** Compute denials as a percentage of all claims submitted in order to understand what the volume and reasons for denials may reveal about your practice's revenue cycle performance.
- **Source:** Examine the sources of denials — physician or other provider, site, type of service (i.e., CPT® code) and insurer — to identify potential solutions that can prevent future denials.
- **Time and money:** Report the lost revenue and additional employee time spent to manage denials in order to inform management of the financial impact of insufficient denial management.

It is important that all data about denials also be available at the line item level, not just per claim (a single claim may consist of several, if not dozens, of line items) or account. While reporting denials at a global level might be interesting for a quick overview of the situation, it fails to illuminate the extent of your denials and the opportunities to improve operations to prevent future denials.

Verify your ability to extract these data from your practice management system, or secure a bolt-on denial reporting product. Data about denials should be gathered, sorted and monitored with a focus on identifying trends and opportunities.

With resources constrained in the business office — there's simply more work than time or employees — it's critical to deploy and maintain an effective monitoring process for denials. It is also critical to monitor claim denials by insurer and the specifics of these denials. An in-depth understanding of denials allows insight into the practice's relationship with insurers, helping management determine the cost of doing business with each insurer and facilitating dialogue internally and with insurers to reduce future denied claims.

Best Practices

Create a multidisciplinary team. Create a multidisciplinary team to analyze denial information and decide, as a group, which trends to address first and what resources are required to deploy and manage the agreed-upon solutions.

Hold staff accountable for work and outcomes. When developing a work list system, hold employees accountable for working the items on their work lists and for the success of their work. Though some insurers will not remit payment following an appeal based on the type of appeal, viewing the success of employee efforts will often help pinpoint an employee who needs additional education on denial management. It's not uncommon to see medical practices deploy a sophisticated denial management strategy featuring work lists, disseminate the lists to providers and employees throughout the practice, but never follow up to assure that anything is actually done to resolve those items. Once the information is distributed, hold the staff member accountable for taking corrective action in an appropriate and timely manner — and monitor the results of their appeals. Make it a routine to run reports on work list status. Data to gather include the volume of transactions on each work list and the time that has elapsed between the initial assignment of each work list item and the current date, as well as appeal outcomes.

Step 4:

Prevent

Armed with data regarding denials, the next step is to launch a prevention campaign. Sort denials by category to determine the potential opportunities to revise processes, adjust workflows or re-train employees, physicians and providers. Summon each team involved with the source of the denial category; for example, assemble the front office team to discuss registration-related denials. Manage your denial prevention program at the practice level, however. Developing a cross-functional approach prevents the common problem of one team "fixing" an issue, while another team "corrects" it — teams working in parallel on the same problem may end up working at cross-purposes, duplicating others' work or failing to root out the problem altogether.

Categories of denials that are prime targets for your denial prevention program include:

Registration

Identify the denials by location then examine that site's registration-related denials. Determine whether the issue was the patient's insurance coverage or benefits eligibility, or a combination of both. Produce daily feedback — sorted by employee, if possible — regarding these denials. You may wish to appoint certain employees to take charge of correcting the problems or to simply review them. If you use the latter route, be wary that informational reports of this type tend to get set aside and all-but-ignored because they require no immediate action. Offer additional training to resolve the problems that are identified. Training is best targeted to the needs of the individual employee who requires intervention, as well as periodic refresher updates for the entire team.

Coding

The coding system used by medical practices — procedures represented by CPT® codes and diagnoses denoted by ICD codes — is incredibly complex. Throw in modifiers, and the fact that the diagnoses codes will more than quintuple in the fall of 2014, and you are faced a morass of information through which to wade. With literally millions of code combinations, it's no wonder that claims are denied for coding reasons. The key to solving coding-related denials is seizing the opportunity at the initial determination of the code, not after the fact. Identify common services, and gain expert advice on how to correctly code them. Continue networking with colleagues in your specialty as they may have coding tips to share that you did not discover in your own research. Preventing coding-related denials means providing physicians with excellent training about appropriate code selection and documentation. Don't stop with training, however, use information technology to automate a verification of accuracy, either at the point the codes are selected or when they are reviewed. Because each insurer has claims filing deadlines, establish protocols to alert you of delays in the code selection and review process, too.

Authorizations

There's only one solution to avoiding denials based on lack of authorization, and it is a simple elucidation at that — always get required authorizations. Create a process for employees to follow that ensures every prior authorization is captured for every service that requires one. True, there are a great many of these services, and the need will vary — sometimes, significantly — between the many dozens, if not hundreds, of insurance plans from which your practice accepts patients. Start by instituting a system to automatically query appointments for the prior authorization status of all scheduled services. Additionally, alert employees to investigate prior authorization requirements for all in-office services that are ordered "on-the-spot." This will be a far more workable system than asking schedulers to remember the potential services that might need authorization. Track denials closely, review insurers' responses and quickly communicate to insurers when you spot prior authorization denials that they neglected to tell you about. Finally, route denials back to the source of the problem — the scheduler, for example — when they are received so the staff member can improve performance in the future.

Medical necessity

A frustration for all physicians is receiving denials when the insurer claims the diagnosis provided does not support the need for the service. Fortunately, there are options to respond and, even, reverse some of these denials. First, deploy software that edits charges for coverage determinations, sourced from insurers. Medicare's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) should be integrated into the system, along with other sourced edits from insurers. To develop internal knowledge among providers and billers, gather all of your insurers' policies regarding medical necessity. Query insurers' websites and ask provider representatives, too, because payment policies can change at any time. Then organize the policies by subspecialty or service. If you use an electronic health record (EHR), set it to provide alerts for services that an insurer has deemed not medical necessary or those services which have special requirements for medical necessity. Appeal any denials based on necessity by attaching your documentation of the patient visit, as well as any relevant, current medical literature in support of that service's efficacy. If you perform a service deemed experimental (thus considered "not medically necessary"), ask the medical director of the insurer with that determination to reconsider. Send copies of your appeal letters to patients, encouraging them to get involved, too. Don't be shy about involving referring physicians as well; they should be happy to assist in writing letters in support of an appeal for a service that involves their patient.

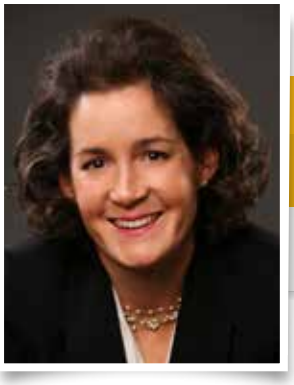
Managing denials is costly in terms of time and money; establishing an effective denial prevention program is crucial to the long-term success of the revenue cycle.

Best Practices

Create a multidisciplinary team. Leverage technology to conduct charge-review: Integrate an automated, sophisticated rules engine into your pre-adjudication charge review process. These tools can identify coding, documentation or other problems before the provider releases charges into the system. Software also can produce critical business intelligence about new insurer denial activity, such as trends in denial reasons by insurer, before their impact diminishes your bottom line.

Conclusion

While claim denials are a chief source of frustration for your billing staff, they also put a damper on your practice's cash flow. By proactively striving to identify, monitor, manage and prevent denials, you can educate your employees, streamline your work, improve internal processes, and get paid what you deserve.



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Elizabeth Woodcock, MBA, FACMPE, CPC is a speaker, trainer and author who is passionately dedicated to helping physician practices achieve and sustain patient satisfaction, practice efficiency, and profitability. An expert at practice operations and revenue cycle management, she is nationally recognized for her outstanding presentations and writings aimed at improving the business of medicine. Her education and expertise, combined with her humor and an engaging delivery, make her popular with physicians and administrators alike.

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Elizabeth is a Fellow in the American College of Medical Practice Executives and a Certified Professional Coder. In addition to a Bachelor of Arts degree from Duke University, Elizabeth completed a Master of Business Administration in healthcare management from The Wharton School of Business of the University of Pennsylvania.