

Denial management: 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, "check online claims status" — in your guide. In this fashion, you are able to create a standard workflow — a classic lean management technique that

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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.

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.

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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.

- ✓ **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.
- ✓ **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.

¹There 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.

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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.

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.

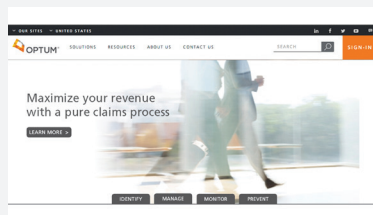
Developing a denial management program takes energy and time. Furthermore, it's not a short-term project; it's an ongoing process that must be continually assessed and adjusted to reflect the ever-changing payment policies of many insurers. Although time consuming, the positive result on the medical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

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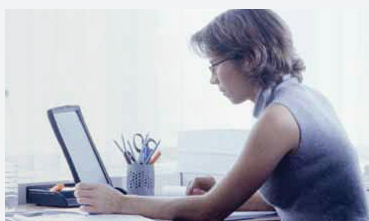
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