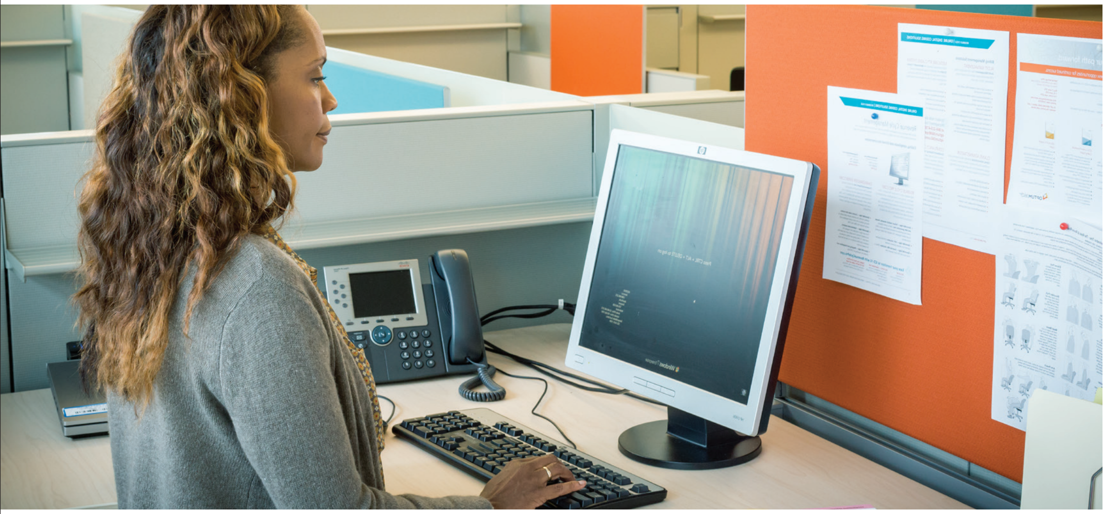
Denial management: Step 4 – Prevent



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 Practice

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.

About the author
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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.

With rich experience in consulting, training, and industry research, Elizabeth has led educational sessions for the nation's most prominent health care professional associations, specialty societies, and medical societies.

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.

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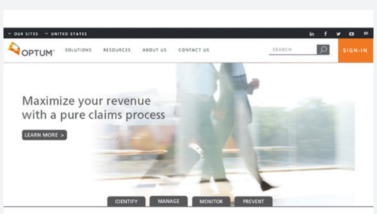

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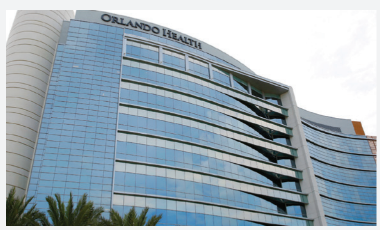
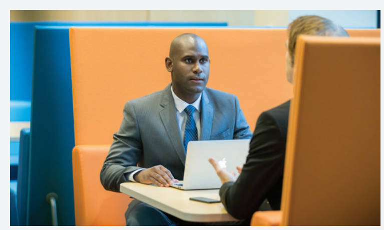
Explore Resources



See how Orlando Health achieved close to a 1% denial rate while handling over 1.7 million patient encounters per year.

Download White Paper



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