5 things your denial rate isn't telling you

The revenue cycle landscape is constantly evolving, driven in part by added scrutiny, new rules and updated guidelines that create an increasingly complex claims process. The ongoing battle against denied claims is an inefficient and costly barrier to smooth revenue cycle operations.

Imagine the advantages of friction-free collaboration between payers and providers, with the aim of reducing denials and tedious rework. While lofty, it's a goal worth striving for, as it has the potential to support a more harmonious health care system.

But today's reality requires providers to examine specific opportunities to manage and prevent denials. A number of factors across your organization, including disparate technology, process variations and siloed facilities, can contribute to unnecessary denials and significantly affect timely and complete reimbursement.

How can your organization identify underlying factors that could have a significant cumulative — but undetected — impact on your overall denial rate? What should you look for?

A typical health system stands to lose up to $5 million in revenue due to denials.[1]

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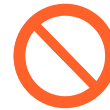
To effectively understand and manage the complexities of denials, you need to go beyond traditional analysis and reporting. A comprehensive approach combining technology, analytics and deep industry knowledge may provide key insights that can help you improve even a seemingly reasonable denial rate.

1 A/R composition

If your denial management process relies too heavily on back-end rework and resubmission, this costly and resource-intensive approach is affecting cash flow more than you may realize. If your organization aggregates outstanding denied or underpaid claim amounts with other types of accounts receivable (A/R), you may not see its negative impact. A denial prevention strategy based on analytic data from smart technology will help you streamline your claims process and improve A/R days and speed to cash.



Denied claims cost hospitals $407 billion each year.[3]

2 Operational consistency

Many organizations take an enterprise-wide view of their denial rates and other performance measures, but variations between hospitals or clinics may reveal distinct opportunities for improvement. By benchmarking at both facility and enterprise levels, you can quickly identify variations in operations and results. While you may have a high overall success rate, eliminating operational disparities in technology, processes and reporting across locations can lead to greater efficiency and compliance, and more appropriate reimbursement. It's also important to go deeper and look for trends based on specific payers, DRGs and service lines. This analysis provides valuable insight into specific issues that could be improved, and best practices that could be replicated across locations.

Some U.S. hospitals report Medicare appeal success rates of just 38.5%.[2]

3 Contract adherence

Another reason low denial rates can be misleading is that they don't account for underpaid claims. Significant revenue loss can go unnoticed without a consistent method for comparing claims and remittances against payer contracts. You can look for variances at the individual claim and scenario levels to identify any underpayments and the full scope of the issue. Contracts are complex and regularly changing, so using an intuitive solution and maintaining current data will help protect your organization against revenue loss.

It costs an average of $118 to rework and resubmit a hospital claim, and the alternative is to write off the balance. Even low-balance denials add up to significant revenue loss.[4]

4 Root causes

While denied claims are assigned reason codes, the implications of those codes can vary across payers. To effectively overturn commercial denials and prevent them in the future, you need a deep understanding of each payer's rules and how they differ. Dig beyond the Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs). Correlate the information on remittances with the individual claims to find underlying problems and the associated revenue. Using analytics to reveal trends and fuel decisions, you can make targeted process and technology adjustments to reduce payer-specific denials and improve efficiency.

5 Inefficiency

Successfully and proactively managing claim denials requires both the right staff and the right technology. The ideal combination of these resources will help you move from denial management (rework) to denial prevention. Struggling with an overwhelming backlog of denials and simply repeating the same corrections and resubmissions perpetuates an inescapable, reactive cycle. The right analytics can help you prioritize efforts, make improvements and impact your bottom line moving forward. Drilling down to a specific payer, service line, department or physician helps to identify the dollar impact of ineffective processes or repeated errors in these areas. Armed with that knowledge, you can implement process improvements, training and specific technology rules to reduce inefficient rework.

Create a cycle of continuous improvement

Regular analysis and remediation is key to consistently improving denial rates, and requires a 360-degree view of the revenue cycle. Focus on preventing denials, not just fixing them. This requires people, technology and a deep look at your internal processes. Ensure that front-end staff understand the implications of inaccuracies in patient data, eligibility and insurance information. Leverage mid-cycle technology and artificial intelligence to perform complex tasks, allowing staff to review and validate documentation and coding accuracy. Keep your systems updated to address each payer's unique requirements and claim edits. Analyze denials to target upstream issues and remediate root causes. Consistent monitoring and adjustment are crucial, and an annual review of discrepancies and inefficiency is essential to staying on track.

Sources:

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